For more information, visit: www.nationaloralhealthconference.com

Presented by:
American Association of Public Health Dentistry (AAPHD) &
Association of State and Territorial Dental Directors (ASTDD)

For more information, visit:
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The AAPHD Foundation

Since its formation in 1997, the AAPHD Foundation has solicited support from AAPHD members. Thank you to those who have answered the call! To date, the Foundation has awarded ten Herschel S. Horowitz Scholarships and will present the 5th Foundation Grant during the NOHC in Fort Worth, Texas.

Special thanks to our founding members and 2013 Contributors. You can help the AAPHD Foundation do even more by joining your colleagues and making your pledge. Stop by the AAPHD Foundation Booth and sign up!

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Contributions may be made online at www.aaphd.org by clicking on the AAPHD Foundation tab. Or, call the AAPHD Office at 217-529-6941. MasterCard and Visa accepted.
Special Thanks to our 2014 Program Planning Committee

- David Cappelli, DMD, MPH, PhD
- Deb DeNure, RDH
- Harry Goodman, DMD, MPH
- Catherine Hayes, DMD, SM, DrMedSc
- Larry Hill, DDS, MPH
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Conference Partners include:
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Aseptico, Incorporated
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AAPHD President’s Welcome

Welcome to the National Oral Health Conference and the 15th joint meeting of the Association of State & Territorial Dental Directors (ASTDD) and the American Association of Public Health Dentistry (AAPHD) and the premier meeting of dental public health. I want to thank everyone who participated in our conference planning especially the members of ASTDD and AAPHD who served as volunteers on the Planning Committee.

Our keynote “Looking Back, Looking Forward: An Empirical look at Access to Dental Care Issues in the U.S.” will provide important insight into how we can learn from the past to prepare for the future in addressing the oral health crisis. The concurrent sessions will certainly pique your interest offering a wide array of topics addressing the broad range of interests of our members.

I want to thank the American Board of Dental Public Health for once again convening a symposium on Tuesday morning.

I encourage you to participate in the two Roundtable Sessions on Monday and Tuesday featuring various national organizations and topics such as program planning and evaluation, community-based interventions, partnerships, and other topics related to dental public health. This is a great way to have informal discussions in small group settings. We’ve had excellent feedback on these sessions in past years so please don’t miss them.

This year we are kicking off our annual AAPHD Signature Event on Tuesday afternoon, which will include a discussion of emerging topics of importance to our members. This year we will hear about the impact of the global mercury ban on dentistry and hear from those in the trenches on community water fluoridation initiatives nationwide. I encourage all to join us as this is a member event and to submit suggestions for future topics for this new AAPHD event at the NOHC.

There are important issues to discuss at our Annual Business Meeting on Tuesday afternoon. Please join us and make sure your voice is heard.

Please join us for our opening reception Sunday night sponsored by Medical Products Laboratories, Inc. and the AAPHD Foundation reception Monday night, sponsored by DNTLworks. Don’t forget Tuesday evening’s dinner and networking event, sponsored by Aseptico, where you can kick up your heels, Texas style!

I also appreciate the many contributions from partner organizations toward conference planning and program implementation, including the DentaQuest Foundation and American Dental Association. I also welcome and extend my deep appreciation for the corporate exhibitors who support this conference. Your innovative product and service solutions are wonders of ingenuity and I encourage attendees to visit our exhibitors.

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Please join me in welcoming the members of our more than 20 Student Chapters. We are thrilled to have so many emerging leaders join our conference this year.

Thank you for attending the conference. I hope you have a very productive, informative, and enjoyable experience.

Catherine Hayes, DMD, SM, DrMedSc
President, AAPHD
Howdy Partners!

Welcome to Fort Worth, Texas for the 2014 National Oral Health Conference. In the Old West, having partners (or ‘pardners’) often made the difference between success and failure and maybe even life or death. Today, we know that partnerships are just as important. This event marks the 15th year that two great partners, the American Association of Public Health Dentistry (AAPHD) and the Association of State and Territorial Dental Directors (ASTDD), have co-hosted this Annual Joint Meeting. These two dental public health professional associations have joined forces to provide you with information and ideas that you can take back to your own states and communities as you work to provide the best in dental care to your citizens and patients.

You will be joining more than 700 dentists, dental hygienists and others interested in oral health at this premier meeting for dental public health. You will be able to attend plenary sessions, workshops, seminars, and oral presentations in the areas of research, policy, programs, education, and community-based care. You will find time to attend roundtable lunches and poster sessions. And, you will be able to network with those working in oral health and share ideas and strategies that will help you in your work.

We are very excited to be in Fort Worth, Texas which is known as the “City of Cowboys and Culture” and is famous for being “Where the West Begins.” Our host hotel, the Omni Fort Worth, is in the heart of downtown and close to many fun and exciting sites, including the Fort Worth Stockyards, a national historic district, and the 35-block Sundance Square, an entertainment and shopping district. We hope you will find a little time to enjoy a wonderful meal with friends, talking shop or just catching up with those you haven’t seen in a while. If you have additional time, Fort Worth is home to a thriving performing arts scene, wonderful museums, and great shopping.

As always, ASTDD would like to thank our very important organizational and corporate partners and exhibitors who bring support and new ideas to our conference through their participation. Please be sure to visit with the exhibitors during the conference and learn more about what they have to offer.

I would like to say a special thank you to the meeting organizers and planning committees who make the NOHC the outstanding event that it is. Their dedication and hard work have been in action for well over a year and allow us all to enjoy our time here, learning and networking.

On behalf of both ASTDD and AAPHD, I welcome you to Fort Worth and the 2014 NOHC and invite you to help us make this conference a memorable and successful one. We believe by the end of the conference you will be able to ride off into the sunset with a saddle bag full of great information, new ideas, and enthusiasm for moving the future of oral health forward in your community.

Kimberlie Yineman
Kimberlie Yineman, RDH, BA
President, ASTDD
THURSDAY, APRIL 24
7:30 a.m. – 5:30 p.m. .............................................. Sundance 1
ABDPH Board Business Meeting & Oral Examination 1 on Project Reports

8:00 a.m. – 12:30 p.m. .............................................. Sundance 2
ABDPH Board Business Meeting & Oral Examination 2 on Assigned Problem

FRIDAY, APRIL 25
7:30 a.m. – 5:30 p.m. .............................................. Sundance 1
ABDPH Oral Examination 2 on Assigned Problem

8:00 a.m. – 12:30 p.m. .............................................. Sundance 2
ABDPH Oral Examination 2 on Assigned Problem

1:00 p.m. – 5:00 p.m. .............................................. Sundance 2
ASTDD Board of Directors Meeting

SATURDAY, APRIL 26
7:00 a.m. – 5:00 p.m. .............................................. Conference Registration Desk
Registration Desk Open

8:00 a.m. – 12:30 p.m. .............................................. Sundance 6
ABDPH Written Examination on General Knowledge

8:00 a.m. – 6:00 p.m. .............................................. Sundance 1
ABDPH Board Business Meeting

8:00 a.m. – 12:00 p.m. .............................................. Sundance 5
ASTDD Board of Directors Meeting

8:00 a.m. – 4:30 p.m. .............................................. Sundance 4
Water Fluoridation: A Skill-building Workshop for Advocates and Spokespersons CDE – 7.5
Matt Jacob, BA; Peter Mitchell, BA; Elizabeth Barajas, BA, EdM; Mary McNamara, BA; Leslee Williams, BS; Shelly Spoeth, BS; Linda Orgain, MPH; Kristen Mizzi, BA
This interactive skill-building session expands and builds on the highly successful Fluoridation Spokesperson Training provided at the 2013 National Oral Health Conference. Attendees will learn how to “frame” the issues around community water fluoridation; increase their ability to speak effectively about community water fluoridation with media, in public forums, in small groups; and during one-on-one conversations; be able to locate and utilize existing resources to promote community water fluoridation; and understand how to assess a community’s beliefs about, understanding of, and desire to implement community water fluoridation. Training and tips for speakers, mock interviews with a voluntary videotaping component, evidence-based fluoridation information and resources and other practical assistance will be provided.

Learning Objectives:
1. Learn how to “frame” the issues around community water fluoridation.
2. Increase ability to speak effectively about community water fluoridation with media, in public forums, in small groups, and during one-on-one conversations.
3. Locate and utilize existing resources to promote community water fluoridation.
4. Understand how to assess a community’s beliefs about, understanding of, and desire to implement community water fluoridation.
5. Increase ability to gather support for community water fluoridation.

Pre-registered attendees only. You must present ticket for entry.

Sponsored by: ASTDD, ADA, CDHP, and The Pew Charitable Trust

10:00 a.m. – 5:00 p.m. .............................................. Sundance 3
AAPHD Executive Council Meeting

12:00 p.m. – 1:30 p.m. .............................................. Sundance 2
ASTDD BOD & AAPHD EC Joint Lunch

1:30 p.m. – 3:30 p.m. .............................................. Sundance 5
AACDP Executive Board Meeting

2:00 p.m. – 4:30 p.m. .............................................. Sundance 6
Making the Most of National Library of Medicine Resources CDE – 2.5
Lynn Whitener, DrPH, MLS
This session will acquaint attendees with materials available from the National Library of Medicine that may enhance and improve their ability to locate quality information for research, writing, and practice. This session will also focus on PubMed searching in general with special attention to the limits and filters that can help narrow searches. Attendees should leave with better knowledge and skills for online information seeking. Attendees should bring with them a laptop or tablet.

Learning Objectives:
1. Familiarity with NLM resources aimed at dental researchers/providers.
2. Ability to assess the utility of web site information and search results.
3. Increased familiarity with PubMed searching.

Pre-registered attendees only. You must present ticket for entry.
This Symposium provides leading edge information on new and/ or innovative initiatives in oral health care that demonstrates successful business models and integration of medical/dental coordination.

7. Oral health literacy answers to issues with prevention and treatment compliance.
8. Pew’s updates on fluoridation.
9. Infection prevention and safety issues for mobile dental equipment and programs.
10. Updates from the National Center On Health and the Oral Health Project.
11. Successful oral care programs and models for geriatric and dementia patients.
12. The most current reports on various workforce models being proposed and tested.

Pre-registered attendees only. If you registered for the AACDP Full Symposium or the PM Only Symposium, you will have a ticket for the Lunch with the Bunch. You must present ticket for entry.

7:30 a.m. – 1:30 p.m. .................................Sundance 3
AAPHD Executive Council Meeting

8:00 a.m. – 11:00 a.m. .................................Sundance 4
Oral Health Surveillance - Everything You Wanted to Know But Were Afraid to Ask – CDE 3.0
Kathy Phipps, DrPH; Don Mariano, DDS, MPH; Jay Kumar, DDS, MPH; Laurie Barker, MSPH
This interactive session will cover five general topic areas: 1) public health surveillance and why it is important to state health agencies; 2) the conceptual framework for a state-based oral health surveillance system including the revised operational definition of an oral health surveillance system; 3) how to develop a state oral health surveillance plan; 4) how to evaluate a state oral health surveillance system, and; 5) the dissemination of oral health data through a variety of means including an oral health burden document. This session will give participants an opportunity to develop outlines for an oral health surveillance plan including data dissemination and evaluation components.

Learning Objectives:
1. Participants will be able to discuss the purpose of public health surveillance and the importance of surveillance for monitoring both acute and chronic disease.
2. Describe the purpose and components of a state-based oral health surveillance system.
3. Discuss the importance of system evaluation and how to evaluate an oral health surveillance system.
4. Describe the importance of data dissemination and methods for disseminating actionable oral health data.

Pre-registered attendees only. You must present ticket for entry.

SUNDAY, APRIL 27

7:00 a.m. – 5:00 p.m. .................................Conference Registration Desk Registration Desk Open

7:15 a.m. – 8:00 a.m. .................................Fort Worth Ballrooms 4-5
AACDP Continental Breakfast (registered attendees only)

8:00 a.m. – 5:00 p.m. .................................Fort Worth Ballrooms 4-5
AACDP Annual Symposium – CDE 7.5
Madge Vasquez, MAPHF; David P Coppelli, DMD, MPH, PhD; Sharon Fulcher-Estes, MA/LPC, BCPC; Katherine Weno, DDS, JD; Steven Geiermann, DDS; Ann Lynch; Sarah J Dirks, DDS; Patrice Pascual, MA; Amid Ismail, BDS, MPH, MBA, DrPH; Marshall Shragg, MPH; Colleen M Brickle, EdD, RDH; Frank Licari, DDS, MPH, MBA
This Symposium provides leading edge information on new and/or effective population-based dental programs, policies, and best practices that will be helpful for those who provide health care to underserved populations including personnel from city, county, and local health departments, neighborhood health centers, community-based dental programs, and other nonprofits and private practitioners. The morning sessions look at several innovative programs targeting a variety of age groups in our host state of Texas, updates from ADHA, and the new directors of CAPiR and CDC’s Oral Health Division. Our mid-day roundtable sessions will cover materials on oral health literacy, water fluoridation, sustainability of safety-net clinics, medical-dental integration, and infection control in mobile clinics. Afternoon sessions offer topics such as the Affordable Care Act and how it will affect community oral health. Promising to be the highlight of the day is a “Meet the Press” discussion panel on the latest workforce issues, models, and outcomes.

Learning Objectives:
1. Gain knowledge of strategies to improve and sustain local oral health programs.
2. Innovate Texas community oral health initiatives.
3. Updates from the ADA/CAPiR, ADHA, and CDC/DOH.
4. How Incurred Medical Expense funding can successfully achieve oral health care for elders.
5. How the Affordable Care Act will impact the oral health of our communities.

SUNDAY, APRIL 27 CONTINUED

4:00 p.m. – 6:00 p.m. .................................Fort Worth Ballroom 5
AACDP Session - CDE 2.0
Nuts and Bolts: Incorporating Comprehensive Oral Health into School-Based Health Centers – Reality or Pipe Dream?
Sarah Wovcha, JD, MPH; Anne Varcasio, RDH, MA; Mark Doherty, DMD, MPH; Beth Lowe, RDH, MPH
School-based health centers (SBHCs) are becoming a recognized means of providing access to high-quality oral health care for children and adolescents. This session will highlight the successes, challenges, and lessons learned in incorporating oral health care services into SBHCs.

Learning Objectives:
1. Identify the characteristics of and challenges faced by two programs that are successfully integrating comprehensive oral health services into SBHCs.
2. Understand that maximizing access to oral health care, improving oral health outcomes, and meeting financial goals are key to sustaining the delivery of comprehensive oral health services in SBHCs.
3. Learn about the development of a resource manual to support the integration of comprehensive oral health services into SBHCs.

Pre-registered attendees only. You must present ticket for entry.

6:00 p.m. – 7:00 p.m. .................................Sundance 2
ASTDD/AACDP Member Reception
ASTDD Members/Associate Members and AACDP Members are invited to a reception where they can meet, mingle, and share ideas.

7:30 a.m. – 1:30 p.m. .................................Sundance 3
AAPHD Executive Council Meeting

8:00 a.m. – 11:00 a.m. .................................Sundance 4
Oral Health Surveillance - Everything You Wanted to Know But Were Afraid to Ask – CDE 3.0
Kathy Phipps, DrPH; Don Mariano, DDS, MPH; Jay Kumar, DDS, MPH; Laurie Barker, MSPH
This interactive session will cover five general topic areas: 1) public health surveillance and why it is important to state health agencies; 2) the conceptual framework for a state-based oral health surveillance system including the revised operational definition of an oral health surveillance system; 3) how to develop a state oral health surveillance plan; 4) how to evaluate a state oral health surveillance system, and; 5) the dissemination of oral health data through a variety of means including an oral health burden document. This session will give participants an opportunity to develop outlines for an oral health surveillance plan including data dissemination and evaluation components.

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1. Participants will be able to discuss the purpose of public health surveillance and the importance of surveillance for monitoring both acute and chronic disease.
2. Describe the purpose and components of a state-based oral health surveillance system.
3. Discuss the importance of system evaluation and how to evaluate an oral health surveillance system.
4. Describe the importance of data dissemination and methods for disseminating actionable oral health data.

Pre-registered attendees only. You must present ticket for entry.
Building Your Communication Plan for Water Fluoridation: Hands-On Approaches for States and Communities – CDE 3.0
Shelly Spoeth, BS; Matt Jacob, BA; Amanda Marr, MS
Community water fluoridation continues to be an evidence-based preventive intervention for tooth decay. In fact, it is one of the most cost-effective ways to deliver the benefits of fluoride to all residents in a community, with every $1 spent yielding $38 in savings each year from fewer cavities treated. In 2013 the Centers for Disease Control and Prevention issued its State Oral Disease Prevention Program funding announcement, including a component on increasing the proportion of the population served by community water systems with optimally-fluoridated water. To support the strategy of educating communities on the benefits of community water fluoridation, this session will provide step-by-step discussions on how to develop a communication plan including goal and objective setting, target audience selection, tactical development, work plans, and evaluation planning. After theoretical communications planning examples are shared, attendees will work together in small groups to use proven planning tools (worksheets, handouts) to develop their own plan. Hands-on activities will provide a chance for cross-community collaboration and take home tactical resources.

Learning Objectives:
1. Describe components of successful communications plans.
2. Identify successful ways to communicate about the issue of community water fluoridation.
3. Create a communications plan about community water fluoridation specific to their community.

Pre-registered attendees only. You must present ticket for entry.

ASTDD Board of Directors Meeting
9:00 a.m. – 12:00 p.m.

ABDPH Board Business Meeting
9:00 a.m. – 12:00 p.m.

ASTDD Annual Member/Associate Member Lunch, Business Meeting, and Member Sharing
All ASTDD Members, Associate Members, and Organizational Associate Members are invited to enjoy lunch with your ASTDD colleagues followed by elections and facilitated member sharing about 1) grant writing and 2) development and use of Best Practice Approach Reports and State Activity submissions. Participants will share successes and frustrations with grantwriting, and ASTDD consultants will provide tips. You will learn the process and tips for writing excellent BP State Activity submissions and have the opportunity to score sample sealant program submissions using the ASTDD BP rubric.

Those without meal tickets are still welcome to join the meeting, but a ticket must be presented for lunch.

AACDP Lunch with the Bunch Roundtable Discussions
1:30 p.m. – 5:30 p.m.

American Network of Oral Health Coalitions Annual Meeting – by Invitation Only
2:00 p.m. – 5:00 p.m.

DPH Residency Directors Meeting
6:00 p.m. – 8:00 p.m.

Opening Reception
Always a “fan favorite,” the NOHC Opening Reception is a must every year. You don’t want to miss this first opportunity to see old friends and meet new colleagues. Networking, food, drink, good conversation, and YOU are the highlight of the evening.

Sponsored in part by our friends at Medical Products Laboratories, Inc.

YOUR OPINION COUNTS!
Although it is not required we encourage all attendees to complete an Overall Conference Evaluation. Your feedback will assist us in planning for future conferences.

To complete an Overall Conference Evaluation simply go to www.ceevaluations.net The initial screen should prompt you to enter your CDE# and last name as listed on your name badge. Simply click the “Proceed to Overall Evaluation.” When finished click the “Save/Logout” button.

We appreciate your participation!
Continuing Education

The American Association of Public Health Dentistry is an ADA CERP Recognized Provider. The ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www.ada.org/cerp.

This continuing education activity has been planned and implemented in accordance with the standards of the ADA Continuing Education Recognition Program (ADA CERP) through joint efforts between the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors.

Conference participants can earn up to 22.5 continuing education hours, with additional hours granted for pre-conference sessions.

To receive continuing education credit, participants must check in at the conference, attend the sessions, and complete the required evaluation forms. Participants submitting required evaluation forms will receive verification stating credits earned upon completion of all requirements as instructed by each accrediting institution. The formal continuing education programs of this program provider are accepted by the Academy of General Dentistry for Fellowship/Mastership credit.

The current term of acceptance extends from 11/1/2012 through 12/31/2014. Provider ID# 214686

Disclosure

All participating faculty, planners and providers are expected to disclose to the conference planners and audience any significant financial interest or other relationship with:

1) the manufacturer of any commercial products and/or provider of commercial services discussed in an educational presentation, and

2) any commercial supporters of the activity.
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The Pew Charitable Trusts
Washington, DC

Laurie Barker, MSPH
CDC Division of Oral Health
Atlanta, GA

Colleen M. Brickle, EdD, RDH
Normandale Community College
Bloomington, MN

David P. Cappelli, DMD, MPH, PhD
University of Texas Science Center San Antonio Dental School
Department of Comprehensive Dentistry
San Antonio, TX

Sarah J. Dirks, DDS
Geriatric Dental Group of South Texas
San Antonio, TX

Mark Doherty, DMD, MPH
DentaQuest Institute
Westborough, MA

Sharon Fulcher-Estes, MA/LPC, BCPC
Community Dental Care
Dallas, TX

Steven P. Geiermann, DDS
American Dental Association
Chicago, IL

Amid Ismail, BDS, MPH, MBA, DrPH
Temple University Kornberg School of Dentistry
Philadelphia, PA

Matt Jacob, BA
Children’s Dental Health Project
Washington, DC

Jay Kumar, DDS, MPH
New York State Department of Health
Albany, NY

Frank Licari, DDS, MPH, MBA
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Washington, DC

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Salter Mitchell
Alexandria, VA

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The Pew Charitable Trusts
Washington, DC

Linda Orgain, MPH
CDC Division of Oral Health
NCCDPHP
Atlanta, GA

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Children’s Dental Health Project
Washington, DC

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Morro Bay, CA

Marshall Shragg, MPH
Minnesota Board of Dentistry
Minneapolis, MN

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Hager Sharp
Washington, DC

Anne Varcasio, RDH, MA
Bureau of Dental Health
New York Department of Health
Albany, NY

Madge Vasquez, MPAff
St David’s Foundation Dental Program
Austin, TX

Katherine Weno, DDS, JD
Centers for Disease Control and Prevention
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<th>Time</th>
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<tr>
<td>7:00 a.m.</td>
<td>Registration Desk Open</td>
<td>Conference Registration Desk</td>
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<tr>
<td>7:00 a.m.</td>
<td>Breakfast with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>8:00 a.m.</td>
<td>Opening Ceremony, Welcome and Opening Keynote - CDE 1.5</td>
<td>Fort Worth Ballrooms 1-5</td>
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<tr>
<td>10:00 a.m.</td>
<td>Opening Plenary - CDE 1.5</td>
<td>Fort Worth Ballrooms 1-5</td>
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<tr>
<td>10:15 a.m.</td>
<td>ASTDD Awards</td>
<td>Fort Worth Ballrooms 1-5</td>
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<tr>
<td>10:00 a.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>11:30 a.m.</td>
<td>AAPHD Special Merit and Student Awards</td>
<td>Fort Worth Ballrooms 1-5</td>
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<tr>
<td>12:00 p.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>12:15 p.m.</td>
<td>Roundtable Lunch - CDE 1.5</td>
<td>Texas Ballrooms F-J</td>
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<tr>
<td>12:00 p.m.</td>
<td>Roundtable Lunch - CDE 1.5</td>
<td>Texas Ballrooms F-J</td>
</tr>
<tr>
<td>12:00 p.m.</td>
<td>Exhibits open</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>12:00 p.m.</td>
<td>AAPHD Student Chapter Meeting</td>
<td>Fort Worth Ballrooms 6-8</td>
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<tr>
<td>12:00 p.m.</td>
<td>Posters Open</td>
<td>Texas Ballroom Prefunction Foyer</td>
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<tr>
<td>2:15 p.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>2:30 p.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>2:30 p.m.</td>
<td>Concurrent Sessions - CDE 1.5</td>
<td>Fort Worth Ballrooms 6-8</td>
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<tr>
<td>2:30 p.m.</td>
<td>The Importance of Quality Improvement in Oral Healthcare</td>
<td>Fort Worth Ballrooms 6-8</td>
</tr>
<tr>
<td>2:30 p.m.</td>
<td>ABC’s of Social Media – Forging Your Path between the Promises and Potential Pitfalls</td>
<td>Fort Worth Ballrooms 1-3</td>
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<tr>
<td>2:30 p.m.</td>
<td>Working in Collaboration to Improve the Oral Health of Pregnant Women, Infants, and Children in Head Start</td>
<td>Fort Worth Ballroom 4</td>
</tr>
<tr>
<td>2:30 p.m.</td>
<td>A New England Community Water Fluoridation Campaign: An Innovative Approach to Oral Health Policy Change</td>
<td>Fort Worth Ballroom 5</td>
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<tr>
<td>3:00 p.m.</td>
<td>Exhibit Hall Open</td>
<td>Texas Ballrooms A-E</td>
</tr>
<tr>
<td>3:00 p.m.</td>
<td>Poster Session - CDE 1.5</td>
<td>Texas Ballroom Prefunction Foyer</td>
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<tr>
<td>3:30 p.m.</td>
<td>CDC Water Fluoridation Update - CDE 1.0</td>
<td>Sundance 1</td>
</tr>
<tr>
<td>4:30 p.m.</td>
<td>ABDPH Future Examination Orientation</td>
<td>Sundance 2</td>
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<tr>
<td>4:30 p.m.</td>
<td>Dinner on your own</td>
<td>Sundance 3</td>
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<tr>
<td>4:30 p.m.</td>
<td>ADHA Hosted Networking Reception</td>
<td>Sundance 3</td>
</tr>
<tr>
<td>5:30 p.m.</td>
<td>NNOHA/ASTDD SOHP/PCA Collaborative Project Networking Dinner by invitation only</td>
<td>Fort Worth Ballroom 1-2</td>
</tr>
<tr>
<td>6:00 p.m.</td>
<td>ASTDD SAOH Committee Dinner Meeting</td>
<td>Cast Iron Restaurant</td>
</tr>
<tr>
<td>6:30 p.m.</td>
<td>ABDPH Annual Diplomates Dinner and Meeting by invitation only</td>
<td>Fort Worth Ballroom 4</td>
</tr>
<tr>
<td>7:00 a.m.</td>
<td>Registration Desk Open</td>
<td>Conference Registration Desk</td>
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<tr>
<td>7:00 a.m.</td>
<td>Breakfast with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>7:00 a.m.</td>
<td>AADCP Business Meeting</td>
<td>Sundance 3</td>
</tr>
<tr>
<td>8:00 a.m.</td>
<td>ABDPH Plenary Session - CDE 2.0</td>
<td>Fort Worth Ballrooms 1-5</td>
</tr>
<tr>
<td>9:00 a.m.</td>
<td>AAPHD Foundation Dessert Reception &amp; Entertainment – Contribution and RSVP Requested</td>
<td>Water Horse Pool Bar</td>
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<tr>
<td>10:00 a.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>10:15 a.m.</td>
<td>ASTDD Awards</td>
<td>Fort Worth Ballrooms 1-5</td>
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**MONDAY, APRIL 28**

**TUESDAY, APRIL 29**
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>10:45 a.m. – 11:00 a.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
</tr>
<tr>
<td>11:00 a.m. – 12:30 p.m.</td>
<td>Concurrent Sessions - CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
</tr>
<tr>
<td>12:30 p.m. – 12:45 p.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>12:45 p.m. – 2:00 p.m.</td>
<td>National Organization Roundtable Luncheon - CDE 1.0</td>
<td>Texas Ballrooms F-J</td>
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<tr>
<td>2:00 p.m. – 2:15 p.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>2:15 p.m. – 3:15 p.m.</td>
<td>Concurrent Sessions - CDE 1.0</td>
<td>Fort Worth Rooms 1-5-6-8</td>
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<td>8:00 a.m. – 9:30 a.m.</td>
<td>ASTDD BOD Meeting</td>
<td>Sundance 3</td>
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<tr>
<td>7:00 a.m. – 5:00 p.m.</td>
<td>Registration Desk Open</td>
<td>Conference Registration Desk</td>
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<td>7:00 a.m. – 8:00 a.m.</td>
<td>Breakfast with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<td>8:00 a.m. – 9:30 a.m.</td>
<td>Plenary Session – CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
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<td>9:30 a.m. – 10:00 a.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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<tr>
<td>10:00 a.m. – 11:30 a.m.</td>
<td>Concurrent Sessions – CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
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<tr>
<td>11:30 a.m. – 1:00 p.m.</td>
<td>Lunch on your own</td>
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<tr>
<td>1:00 p.m. – 2:30 p.m.</td>
<td>Concurrent Sessions – CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
</tr>
<tr>
<td>2:30 p.m. – 2:45 p.m.</td>
<td>Break</td>
<td>Fort Worth Prefunction</td>
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<tr>
<td>2:45 p.m. – 4:15 p.m.</td>
<td>Closing Plenary – CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
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**WEDNESDAY, APRIL 30**

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<thead>
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<td>Registration Desk Open</td>
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<td>ASTDD BOD Meeting</td>
<td>Sundance 3</td>
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<tr>
<td>8:00 a.m. – 9:30 a.m.</td>
<td>Plenary Session – CDE 1.5</td>
<td>Fort Worth Rooms 1-5-6-8</td>
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<tr>
<td>9:30 a.m. – 10:00 a.m.</td>
<td>Break with Exhibitors</td>
<td>Texas Ballrooms A-E</td>
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**THE MEETING ROOMS**

“The Meeting Rooms” are small meeting rooms available Monday through Wednesday from 7:00 a.m.-11:59 p.m. Each are on a first-come, first-reserved basis. Texas Longhorn Ballroom is set up for up to 12 board room style. Black Angus Boardroom is set up for up to 10 board room style. You must sign in to use the rooms. There will be sign up sheets outside each room. It can be reserved in half-hour increments for up to two hours. The room set cannot be changed.
MONDAY, APRIL 28
7:00 a.m. – 5:00 p.m. ................................................. Conference Registration Desk
Registration Desk Open

7:00 a.m. – 8:00 a.m. ...................................................... Texas Ballrooms A-E
Breakfast with Exhibitors

8:00 a.m. – 9:45 a.m. ...................................................... Fort Worth Ballrooms 1-5
Opening Ceremony, Welcome and Keynote Presentation
Marko Vujicic, PhD
The past decade has brought important shifts in dental care use for adults and children – in very different directions. Dental care use is up among kids, driven by gains among low-income groups, and down among adults across all income groups. Analysis shows that one major driver is a shift in dental benefits coverage which, in turn, is being driven by employer and consumer behavior as well as state Medicaid policies. Financial barriers to dental care and emergency room use for dental conditions are increasing for young and low-income adults. The Affordable Care Act will do little to reverse these trends. This engaging and fact-filled presentation, an overview of recent trends in access to and use of dental care in the U.S., will provide an opportunity for state and national policymakers, backed up by empirical evidence, to begin to address the critical access to dental care issues within tomorrow’s health care environment.

Learning Objectives:
1. Identify trends and significant shifts in dental care over the past decade.
2. Identify key drivers moving these trends.
3. Recommend policies to begin to address the critical access to dental care within tomorrow’s health care environment.

Dr. Vujicic is Sponsored in part by the ADA

ADA American Dental Association®
America’s leading advocate for oral health

9:45 a.m. – 10:00 a.m. ...................................................... Texas Ballrooms A-E
Break with Exhibitors

10:00 – 11:30 a.m. ...................................................... Fort Worth Ballrooms 1-5
Opening Plenary – CDE 1.5
Alternative Pathways to Access and Prevention
Jane Koppelman, MPA; Jane Grover, DDS, MPH; Calvin Hoops, CDHC; Maureen Ohland, DDS, MS, MLS
This session will provide perspectives on various models of allied dental providers and the impact of these models both economically and on access to care among underserved groups.

Learning Objectives:
1. Understand the economic impact of allied providers on their place of work.
2. Describe how allied providers are actually being integrated into practice.
3. Summarize their impact on access to care for underserved populations.

11:30 a.m. – 12:00 p.m. ...................................................... Fort Worth Ballrooms 1-5
AAPHD Special Merit and Student Awards

12:00 p.m. – 12:15 p.m. ...................................................... Texas Ballrooms A-E
Break with Exhibitors

12:15 p.m. – 2:15 p.m. ...................................................... Texas Ballrooms F-J
Roundtable Lunch – CDE 1.5
The luncheon will be around small tables with facilitated discussion on scientific research, program planning and evaluation, community-based interventions, partnerships and other topics related to dental public health. A complete list of topics and presenters will be included in the conference registration packet. Participants will be able to attend two roundtables during the 2-hour session.

Learning Objectives:
1. Discuss new ideas related to the promotion of oral health.
2. Evaluate specific approaches for improved oral health that may be applicable for use in one’s work setting.
3. Formulate new ideas related to dental health disparities.

Ticketed Event – Must present ticket for entry

12:15 p.m. – 2:15 p.m. ...................................................... Fort Worth Ballrooms 6-8
Student Chapter Session
Members of AAPHD Student Chapters and Student Chapter Advisors are welcome to attend. The agenda includes a preview of new videos available for use by student chapters, a panel on policy issues, and open discussion for sharing of information among the Chapters.

Student Chapter lunch will be provided compliments of P & G Oral Health/Crest/Oral-B
12:15 p.m. – 2:15 p.m. ........................................... Texas Ballrooms A-E
Exhibits Open
Back by popular demand. Exhibits will be open during the lunch break. Grab a bite and visit with our exhibitors.

Posters Open ........................................... Texas Ballroom Prefunction
Presenters will not be available for discussion, but attendees may view the posters during this time.

2:15 p.m. – 2:30 p.m. ........................................... Texas Ballrooms A-E
Break with Exhibitors

2:30 p.m. – 4:00 p.m.  Concurrent Sessions – CDE 1.5

The Importance of Quality .................................... Fort Worth Ballrooms 6-8
Ronald Hunt, DDS, MS; Krishna Aravamudhan, BDS, MS
Workshop Format – Ticketed Event – Must present ticket for entry
Concepts and methods of accountability through quality improvement and performance measurement are expanding steadily throughout healthcare and are beginning to appear in dentistry. This interactive workshop will inform participants about the quality movement and the importance of quality improvement in oral healthcare. The workshop will feature two presentations and two small group discussions. Presentation 1 will address: What is quality? What is the quality movement? How is quality measured? Who will lead quality improvement in dentistry? Discussion 1 will address: Why is quality improvement important in dentistry? What are the barriers to quality improvement in dentistry? What strategies can overcome the barriers? Presentation 2 will address: What is the Dental Quality Alliance (DQA)? What are its measure activities and how does it select measures? How does the DQA test its measures? Discussion 2 will address: Which DQA measures are most important? Which additional measures should the DQA pursue?

Learning Objectives:
1. Describe the key features of the quality movement in healthcare.
2. Outline the reasons quality improvement is important in dentistry.
3. Identify the major types of stakeholder members of the Dental Quality Alliance.
4. List the major activities of the Dental Quality Alliance.
5. Describe the types of measures developed by the Dental Quality Alliance.

ABC’s of Social Media: .................................... Fort Worth Ballrooms 1-3
Forcing Your Path Between the Promises and Potential Pitfalls
S D Shantinath, DDS, MPH, PhD; Mary-Katherine Smith, DrPH, MPH, MCHES; David Denali, PhD, MPH, MSW; Kartik Pashupati, PhD
Workshop Format – Ticketed Event – Must present ticket for entry
The purpose of this workshop session is to give participants an overview of key elements of social media and place it within the larger context of public health, health education, and behavior change; to understand how to carry out basic trend analyses of content in social media (e.g., to track discussions about a public health topic such as water fluoridation) and to understand elements of evaluation of social media projects.

Learning Objectives:
1. Understand some of the basic functionalities and repertoire of social media and identify one or two methods that the participant can apply in their work.
2. Understand the larger context within which their social media effort is situated – and link it with goals, theories, and outcomes.
3. Have an understanding of how social media use might differ across various populations in the United States (e.g., age groups and ethnicities).
4. Understand key elements of an evaluation plan as it applies to social media based projects or programs.

Working in Collaboration to .................................... Fort Worth Ballroom 4
Improve the Oral Health of Pregnant Women, Infants, and Children in Head Start
Jane Casper, RDH, MA; Susan Deming, RDH, BS; Kathy Hunt, RDH
The National Center on Health (NCH) Oral Health Project in collaboration with the American Dental Hygienists’ Association (ADHA) is working to improve the oral health status of pregnant women, infants, and children in Head Start. ADHA has identified a Head Start dental hygienist liaison (DHL) for every state and the District of Columbia to provide a communication link between NCH and Head Start state and local oral health activities and programs. In addition, DHLs collaborate with state organizations and ongoing networks (e.g., Dental Home Initiatives), to address oral health education, disease prevention, and access-to-care issues. Through an interactive question and answer format, this seminar will provide an overview of the approaches used, discuss success stories and challenges, and allow for audience participation.

Learning Objectives:
1. Discuss successful strategies for collaboration to improve the oral health of pregnant women, infants, and children enrolled in Head Start.
2. Describe materials produced by the National Center on Health focused on oral health and the integration of oral health into overall health.
3. Develop ways to interface with DHLs and Head Start programs in their own states.

A New England Community .................................... Fort Worth Ballroom 5
Water Fluoridation Campaign: An innovative Approach to Oral Health Policy Change
Jodie Silverman, MPA; Aleya Martin, MPH; Tamaki West, MA
Despite its proven safety and effectiveness, community water fluoridation (CWF) implementation remains a challenge and is often thwarted, while de-fluoridation efforts are also ramping up throughout the country. A small, well organized minority that relies on junk science and appeals to fear-based messaging means that fluoridation can no longer win on its scientific merits alone. With support from the DentaQuest Foundation, Health Resources in Action (HRiA) is implementing a new approach to CWF via coalition building and grassroots organizing and by deploying a social marketing strategy to understand and leverage community values. These approaches have been applied with great success in the public health field, but have had limited application to oral
health practice and policy. To date, two New England statewide coalitions have received mini-grants to identify a local coalition and hire a campaign coordinator to work together with HRiA on this initiative. An environmental scan was conducted by HRiA to identify factors contributing to the success or failure of CWF. Focus groups and stakeholder interviews were also conducted to gain rich insight into community norms to inform the messaging campaign. Details of this innovative approach to CWF efforts will be discussed with learnings shared.

**Learning Objectives:**
1. Gain an understanding of the importance of gathering input and guidance from the local community throughout the CWF process.
2. Describe the use and integration of social marketing and community mobilizing to advance community water fluoridation.
3. Understand how to discuss, advocate for, and enact CWF in the current political, economic, and social context.

4:00 p.m. – 5:30 p.m. .................................................. Texas Ballrooms A-E Exhibit Hall Open

4:00 p.m. – 5:30 p.m. .................................................. Texas Ballroom Prefunction Poster Session – CDE 1.5

**Posters** based on submitted abstracts of interest to attendees will be available for viewing and discussion by presenters. See pages 57-82 for a complete list of topics and presenters.

**Learning Objectives:**
1. Discuss oral health conditions related to general health issues such as cancer and diabetes.
2. Discuss issues related oral health conditions such as dental caries in children and older adults.
3. Discuss ideas on how oral health can be improved through delivery system and programs; the dental public health workforce; and health care reform, among others.

4:30 p.m. – 5:30 p.m. .................................................. Sundance 1 CDC Water Fluoridation Update – CDE 1.0

**Kip Duchon, PE**

The CDC Water Fluoridation Program Update provides new information to state program staff on CDC data applications, training materials, and water fluoridation program, focusing on engineering and implementation aspects of community water fluoridation. State dental directors, state and local level fluoridation specialists, and others involved in water fluoridation will benefit by attending this session.

**Learning Objectives:**
1. Describe updates and new developments in CDC's data applications for Community Water Fluoridation.
2. Summarize and identify how to access training materials from CDC.
3. Explain the services and resources provided by the CDC Water Fluoridation Program.

5:15 p.m. – 6:00 p.m. .................................................. Sundance 2 ABDPH Future Examination Orientation

5:30 p.m. .................................................. Dinner on your own

5:30 p.m. – 6:30 p.m. .................................................. Sundance 3

**ADHA Hosted Reception**
Ticketed event. Must present ticket for entry.

6:00 p.m. – 9:00 p.m. .................................................. Fort Worth Ballroom 1-2

**NNOHA/ASTDD SOHP/PCA Collaboration Project Networking Dinner** – By Invitation Only

6:00 p.m. .................................................. Cast Iron Restaurant

**ASTDD School and Adolescent Oral Health Committee Dinner Meeting** – Committee Members only

6:30 p.m. – 10:00 p.m. .................................................. Fort Worth Ballroom 4

**ABDPH Annual Diplomates’ Dinner and Meeting** – By Invitation Only

6:30 p.m. – 9:00 p.m. .................................................. Fort Worth Ballroom 3

**American Network of Oral Health Coalitions Member Dinner** – By Invitation Only

9:00 p.m. – 12:00 a.m .................................................. Water Horse Pool Bar

**AAPHD Foundation Dessert Reception under the Stars!**
On Monday evening, join your friends at the AAPHD Foundation Dessert Reception under the stars for food, music and fun! Ticket price is $50 and includes: Death By Chocolate Bar; S’Mores Bar, and a Cobbler Bar. Non-alcoholic beverages are also included along with a $25 contribution to the Foundation. Cash bar available along with entertainment.

Check at registration to see if tickets are still available. Attendance is limited. **Sponsored in part by our friends at DNTLworks**

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**MONDAY CONTINUED**

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**ADDPH Plenary Session – CDE 2.0**

American Board of Dental Public Health Symposium – Sustainability in Providing Dental Care to Vulnerable Populations across the Lifespan

**Michael Helgeson, DDS; Wayne W Cattam, DMD, MS; Neal A Demby, DMD, MPH**

The purpose of this symposium is to learn about the essential strategies employed and key elements characterizing successful,
sustainable programs providing dental care to vulnerable populations across the life span. The presenters will discuss their success in attaining sustainability of private organizations serving pediatric and younger and older adults from vulnerable populations in the broad community, as well as pre-doctoral and post-graduate training programs in community health center settings.

Learning Objectives:
1. Describe strategies for attaining sustainable organizations in the private sector and training programs in the community health center setting for providing dental care to vulnerable populations.
2. Describe key elements characterizing successful, sustainable private organizations providing dental care to vulnerable populations across the life span.
3. Describe key elements characterizing successful, sustainable pre-doctoral and post-graduate training programs providing dental care to vulnerable populations across the life span.

10:00 a.m. – 10:15 a.m. ........................................ Texas Ballrooms A-E
Break with Exhibitors

10:15 a.m. – 10:45 a.m. .........................Fort Worth Ballrooms 1-5
ASTDD Awards

10:45 a.m. – 11:00 a.m. ........................................ Texas Ballrooms A-E
Break with Exhibitors

11:00 a.m. – 12:30 p.m. Concurrent Sessions – CDE 1.5

Oral Health in Home Visiting ..................Fort Worth Ballrooms 6-8
Programs: A Perfect Opportunity
Michelle Landrum, RDH, MEd; Kathy Hunt, RDH, ECP II; Diane Flanagan, RDH

Workshop Format – Ticketed Event – Must present ticket for entry
Federal and state sponsored home visiting programs provide support and education to low-income and other high-risk pregnant women and families with infants and toddlers. Home visits provide a perfect opportunity to work with families to adopt preventive oral health behaviors before dental problems arise. However, few home visiting programs incorporate oral health as an important educational component within their programs. Using an interactive case-based approach, this workshop will illustrate how to integrate oral health into home visiting programs utilizing trigger questions and behavior change techniques such as motivational interviewing. Facilitators from Children's Health Alliance of Wisconsin and Kansas Head Start Association will share lessons learned and lead workshop participants through role-playing, sample activities, and open dialogue.

Learning Objectives:
1. Identify common evidence-based, government-sponsored home visiting programs and the how to locate them within their state.
2. Describe how to integrate oral health into existing home visiting programs from lesson learned in two states.
3. Model a home visit that includes motivational interviewing techniques for parent goal setting.
4. Identify oral health resources and materials available for home visiting programs.

Taming the Frontier: Bringing Oral Health into Rural Health
Amy Martin, PhD; Graham Adams, PhD; Mark Doherty, DMD, MPH
Currently, there is no actionable national strategy to integrate Oral Health into Rural Health. The University of South Carolina's Rural Health Research Center, the SC Office of Rural Health, and the DentaQuest Institute's Safety Net Solutions program have combined resources through a HRSA Statewide Oral Health Workforce Grant in SC to improve both oral health access and outcomes for rural underserved populations. Carrying this work and lessons learned forward, the partners have embarked upon the creation of a national initiative that would integrate oral health into rural health at the national, state, community, and practice levels through a Rural Dental Capacity Enhancement Project, a Water Fluoridation and Advocacy Project, a Teledentistry Feasibility Study, and creation of a Community Oral Health Coordination Training Center. Strategies include provision of rural health/oral health practice management to 18 rural dental practices; a formal recruitment and retention program for private practice dentists in rural communities; a seminar series and curriculum development focused on the practice of dentistry in rural safety-net settings; access and support for fluoridated water to several rural communities; identification of potential applications of teledentistry; and enhancing the oral health skills of Community Health Coordinators to focus upon early childhood oral health intervention, integration of oral health into both primary care and the perinatal experience, and other multiple evidence-based oral health prevention-focused practices.

Learning Objectives:
1. Understand the rural and rural health environment more completely including the who, the where, the how many. Who is Rural America and what does their health system look like?
2. Understand the barriers to health and oral health in rural America. See how the demographics, geography, health status, health, and oral health trends relate to the barriers and learn who the providers are that currently provide health/oral health care in that system.
3. Based upon an understanding of the preceding, learn the details of an actionable, practicable, and replicable strategy to integrate oral health into the rural system of health care.

Integration of Dental Care into the Accountable Care Organizations – The Oregon Model
Mike Plunkett, DDS, MPH; Eli Schwarz, DDS, MPH, PhD
Since the Oregon Legislature passed legislation in 2011, health transformation has been on fast forward in the state. The overriding goal for the process has been the triple aim of improving health for the population; improving care for individuals; and lowering the cost of care. An agreement between the state and the Centers for Medicare and Medicaid Services (CMS) has established the quality and incentive metrics by which the state and its 16 Coordinated Care Organizations (CCOs) will be measured. Integration of physical and mental health care of 650,000 Medicaid-enrolled members is in process with dental care to follow in 2014. The health exchange, Cover Oregon, opened as planned, and the Oregon Health Authority (OHA) monitors and supports the process through Innovator Agents. The session will
highlight the fascinating implementation of the ACA in one of the trailblazing states in the nation and the future development potential.

Learning Objectives:
1. Attendees will have an overview of the implementation of the Affordable Care Act in one of the first states to completely commit itself to the health transformation process.
2. An understanding of the complex multi-layered series of activities comprising the legislative process, the Oregon Health Authority reorganization, establishment of Coordinated Care Organizations and the health exchange marketplace, engaging the health professions and the managed care industry, and the acceptance by the Medicaid enrolled members.
3. Examples of the structure of the quality and performance metrics used to hold Coordinated Care Organizations and the State accountable for the intended outcomes of this process.

Oral Presentations #1 Fort Worth Ballrooms 1-3

This session will feature oral presentations of scientific research of interest to attendees. Presentations are listed beginning on page 38. Please note: The abstracts are not listed in order of presentation.

1. STOP FISHING FOR DATA! IMPLEMENTATION OF THE MINNESOTA ORAL HEALTH SURVEILLANCE SYSTEM (MNOHSS, PRONOUNCED “MINNOWS”)
   Genelle Lamont, MPH, PhD Candidate; Bilquis Khan, MSc, MBA, MSc; Merry Jo Thoele, MPH, RDH
2. THE VOTES ARE IN: SUCCESSFULLY ADVOCATING FOR DENTAL COVERAGE FOR LOW-INCOME ADULTS
   Kelly Richburg
3. SIMPLIFYING ESTIMATION OF RESOURCE COSTS FOR SCHOOL-BASED SEALANT PROGRAMS
   Shillpa Naavaal, BDS, MPH, MS; Dawn Arlotta, MPH, CHES; Kari Jones, PhD; Susan Griffin, PhD
4. WATER FLUORIDATION STATUS IN LOS ANGELES COUNTY CITIES OVER A 23-YEAR PERIOD
   Maritza Cabezaz, DDS, MPH; Fred Dominguez, MD, MPH
5. UNDERSERVED CHILDREN IN PHILADELPHIA, PENNSYLVANIA, EXPERIENCE DECREASE IN DECAY RATE AFTER EIGHT YEARS OF COMMUNITY ORAL HEALTH INITIATIVES
   Julianna Gelinias, BS, RDH

Learning Objectives:
1. Describe the challenges and lessons learned in the implementation of an oral health surveillance system.
2. Outline the actions that led to the restorations of the adult Medicaid program in Washington State.
3. Describe a methodology to simplify estimating resource costs for school-based sealant programs.
4. Describe how Geographic Information Systems (GIS) can be used to show the distribution of water fluoridation in a community.
5. Describe how a mobile dental clinic has decreased decay rates through community oral health initiatives.

12:30 p.m. – 12:45 p.m. Texas Ballrooms A-E

Break with Exhibitors

12:45 p.m. – 2:00 p.m. Texas Ballrooms F-J

National Organization Roundtable Luncheon – CDE 1.0
Must present luncheon ticket for entry. Boxed lunch will be provided. Extra hand-outs may be available from participating organizations. Network with colleagues and presenters to discover how national organizations and federal agencies are improving the oral health of underserved populations. Table presentations will not repeat but extra handouts will be available.

Learning Objectives:
1. Compare the missions and activities of various national organizations and federal agencies.
2. Describe how selected national organizations and federal agencies are improving the oral health of underserved populations.

2:15 p.m. – 3:15 p.m. Concurrent Sessions – CDE 1.0

Senior Oral Health: Fort Worth Ballroom 6-8

Using Data to Affect Policy
Mike Manz, DDS, MPH, DrPH; Barbara Smith, RDH, PhD

Workshop Format – Ticketed Event – Must present ticket for entry. Participants should bring a laptop or tablet.
The purpose of this workshop is to provide participants with resources to develop a fact sheet for senior oral health issues using a variety of data sources (BRFSS, NHANES, MEPS, CASOA, BSS, DRC, etc.) specific to their community/state. Using a template the session speakers have developed and infographic templates, participants will “fill in the blanks” with their relevant data. However, it’s more than “just data.” How to use the data more effectively with policy makers that will also be presented and discussed. Presenters will provide technical assistance to participants in “framing” their data with an eye toward policy to improve senior oral health.

Learning Objectives:
1. Identify relevant data sources for senior oral health at the state, community, and national level to inform decision-makers in their state.
2. Demonstrate the ability to populate a fact sheet or infographic template with data specific to their state.
3. Identify potential partners and resources for obtaining senior oral health data (e.g. existing surveys, sources of funds for state-specific BRFSS questions, etc.).
4. Describe how and which data to use that will have the desired policy impact.

Keep Kids Smiling: Promoting Fort Worth Ballroom 5

Children’s Oral Health through Partnerships Between Public Health and Medicaid
Brent Martin, DDS, MBA; Bob Russell, DDS, MPH

Delivering quality oral health services to low-income children can be a challenge, and states work hard on multiple levels
to accomplish this important goal. When Medicaid works collaboratively with public health, everyone benefits. This session will demystify the process of creating a strong partnership between a State Office of Oral Health and its sister Medicaid agency. It will also explore the substantial advantages two states, Iowa and Massachusetts, have achieved by creating and sustaining such a partnership.

**Learning Objectives:**
1. Review the basics of dental coverage for children in Medicaid.
2. Learn the top ten strategies for creating and sustaining a state-level partnership on oral health between Medicaid and public health.
3. Understand how one state uses Medicaid dollars to ensure sustainability of public health oral health programs.
4. Understand how another state has substantially integrated Medicaid and public health to the advantage of oral health services delivery.

**Using Medical/Dental Integration to Support Chronic Disease Management**
*Fort Worth Ballrooms 1-3*

**Seán Boynes, DMD; Dori Bingham, BA**

The overall vision of integrated health care includes an acceptance of oral health as an integral part of overall health and well-being. Poor oral health can itself lead to many systemic issues and adverse outcomes, and it also plays a significant role in the management of a number of chronic health issues. This session will describe the elements necessary for an integrated delivery model and provide examples of successful medical/dental integrations. The session will also provide guidance in how to determine, quantify, and evaluate systemic outcomes of integration for patients with chronic health conditions, including patients with special needs.

**Learning Objectives:**
1. Understand how dentistry improves medical outcomes and the role of dental care providers as screeners for medical conditions.
2. Evaluate current methodology for integrated care to improve the oral health of patients with special needs.
3. Learn strategies for enhancing inter-professional relationships.
4. Understand key strategies for creating an operations infrastructure supporting effective medical/dental integration.

**AAPHD Signature Educational Event Part 1 - Community Water Fluoridation**
*Fort Worth Ballrooms 4*

**Jodie Silverman, MPA; Johnny Johnson, Jr. DMD, MS; Kurt Ferre, DDS; Mary Altenberg, MS, CHES**

Although tremendous strides have been made in community water fluoridation in the past 69 years, there are still challenges faced by local and state advocates and government officials. As the oral health community and our partners look towards the future of water fluoridation, we need to update our strategies to address current challenges in providing this highly effective preventive strategy to the public. This session will provide information on ongoing efforts nationwide in addressing community water fluoridation challenges.

**Learning Objectives:**
1. Be current on national activities and their outcomes on community water fluoridation.
2. Discuss tools for community engagement related to community water fluoridation.
3. Share lessons learned from communities that underwent current challenges.

**3:15 p.m. – 5:00 p.m.**  
*Texas Ballrooms A-E*  
**Exhibit Hall Open**

**3:15 p.m. – 5:00 p.m.**  
*Stockyards 1*  
**Engaging Medical Clinicians in Pediatric Oral Health – By Invitation Only**

**3:30 p.m. – 4:00 p.m.**  
*Fort Worth Ballroom 4*  
**AAPHD Signature Educational Event Part 2 - The Minamata Mercury Convention, Health Care Providers, and the Public’s Health – CDE .50**

**Peter Orris, MD, MPH, FACP, FACOEM**

The Minamata Convention on Mercury was signed by over 91 countries on the 10th of October 2013, and rapidly ratified by the United States following several decades of increasing awareness of the toxicity of mercury and mercury-related compounds. Concern about the developmental neurotoxic effects of low doses of methyl mercury, converted in the environment from the elemental form, propelled the 2-year negotiation process. The largest human source of mercury environmental contamination is coal-fired power plants, and the highest localized exposure, as well as second most important global source, is artisanal gold mining. The health care sector generates perhaps 10% of the total, principally due to the use of mercury in devices such as thermometers and sphygmomanometers—and secondarily in dental amalgam. These contributions have been reduced considerably due to the increasingly rapid movement to alternative methods of measurement and dental restoration over the past decade.

**Learning Objectives:**
1. Know the evidence of environmental toxicity of methyl mercury.
2. Know the alternatives available for use in health care.
3. Be aware of the international movement within health care away from mercury usage.

**4:00 p.m. – 5:30 pm**  
*Fort Worth Ballroom 4*  
**AAPHD Annual Business Meeting**

All AAPHD Members are requested to attend the AAPHD Annual Business Meeting during which issues of importance to the mission and vision of the association will be discussed.

**4:00 p.m. – 5:30 p.m.**  
*Fort Worth Ballroom 1*  
**SOHP/PCA Collaboration Project Presentations – CDE 1.5**

Teams comprised of the State Dental Directors and the Primary Care Association’s oral health leads from Colorado, Hawaii, Illinois, Kentucky, Ohio, and Oklahoma have been working under the guidance of a coach to identify and plan a collaborative project that will improve the oral health of the residents of those six states. The six states will share information about their projects and their success, challenges and lessons learned.

**Learning Objectives:**
1. Become familiar with the methodology and tools to identify, plan, and implement collaborative activities between SOHPs and State PCAs.
2. Learn about potential State Oral Health Programs and Primary Care Associations collaborative activities.
3. Be able to anticipate and plan for possible challenges.
6:00 p.m. – 11:00 p.m. .......................................................... Billy Bob’s Texas
Tuesday Evening Dinner and Networking Event at Billy Bob’s Texas
Be sure to wear your cowboy hats, boots, and jeans for an evening of “Texas Fun.” Live music, dancing, food, and beverage all included at this Texas landmark! Transportation provided.

7:00 a.m. – 5:00 p.m. ......................................................... Conference Registration Desk
Registration Desk Open

7:00 a.m. – 8:00 a.m. ......................................................... Texas Ballrooms A-E
Breakfast with Exhibitors

7:00 a.m. – 8:00 a.m. .......................................................... Sundance 3
ASTDD BOD Meeting

8:00 a.m. – 9:30 a.m. ......................................................... Forth Worth Ballrooms 1-5
Plenary – CDE 1.5
What’s Next for Dental Coverage in the ACA’s Health Insurance Marketplaces?
Andrew Snyder, MPA; Evelyn Ireland, CAE; Colin Reusch, MPA; Chad Brooker, JD
The health insurance Marketplaces authorized through the Affordable Care Act (ACA) began operation in October 2013. An estimated 24 million Americans will gain health coverage through Marketplaces over the next 10 years. The ACA included pediatric dental coverage as an essential health benefit, but the implementation of dental benefits in health insurance Marketplaces has posed problems for state and federal policy makers. This session will present findings from a December 2013 expert meeting that developed recommendations for state and federal policymakers to improve provision of dental services through Marketplaces and improve coordination of dental and medical coverage in future years. Topics will include pediatric and adult coverage, benefit design, affordability, and plan selection. Representatives from dental plans and from a state-based Marketplace will then provide their perspectives on the first year of ACA open enrollment, and their priorities for dental coverage in future years.

Learning Objectives:
1. Participants will understand policy issues related to dental coverage through health insurance Marketplaces, including pediatric coverage, adult coverage, benefit structure, affordability, and consumer experience.
2. Participants will be able to articulate policy and programmatic options that policymakers at the state and federal levels could adopt to improve provision of dental services through Marketplaces.
3. Participants will understand dental plan and state official priorities for future years of ACA implementation of dental coverage through Marketplaces.

9:30 a.m. – 10:00 a.m. ......................................................... Texas Ballrooms A-E
Break with Exhibitors

10:00 a.m. – 11:30 a.m. Concurrent Sessions – CDE 1.5
Developing, Implementing, and …….. Fort Worth Ballrooms 6-8
Using Practical Evaluation of Oral Health Programs
Don Compton, PhD; BJ Tatro, PhD; Bilquis Khan, MSC
Workshop Format – Ticketed Event – Must present ticket for entry.
The purpose of this interactive workshop is to increase participants’ understanding of how to make oral health evaluation
studies more useful to potential users. While the first step of the CDC Evaluation Framework is to involve stakeholders in the development, implementation, and use of evaluation, few practical resources are available that provide guidance about how and when the stakeholder involvement will occur. A "mock" evaluation consultation group meeting will be conducted during this session to design an evaluation of an oral health initiative.

**Learning Objectives:**
1. Describe key issues to be addressed in designing an evaluation.
2. Identify one approach to involving stakeholders in evaluation studies.
3. Articulate methods for increasing evaluation use by primary intended users and stakeholders.

**Finding Their Voices: Encouraging Andrea Frantz, BS; Scott Tomar, BA, DMD, MPH, DrPH; Matt Jacob, BA Leading health organizations continue to recommend community water fluoridation. Although the overall trend shows fluoridation is expanding, opponents continue to attack this proven health practice at state and local levels. As respected professionals and prominent members of their communities, dentists have unique leverage to shape public attitudes. Indeed, a 2013 article in the *Journal of the American Dental Association* identified dentists' advocacy as "a key factor" in sustaining fluoridation. However, the *JADA* article noted that "current undergraduate dental curricula do not adequately prepare dentists for this role, and continuing dental education may be insufficient to change clinical practice." This session will examine challenges and explore strategies for encouraging more current and future dentists to share the science-based case for fluoridation with patients, community leaders, and policymakers. Participants will receive a worksheet that helps them identify existing venues in their states for educating stakeholder groups about fluoridation's benefits.

**Learning Objectives:**
1. Identify the reasons why dentists (and other dental professionals) play a crucial role in shaping public attitudes about the value of community water fluoridation.
2. Understand what dentists learn or don't learn about fluoridation in their education/training and where dentists can gain more knowledge of fluoridation.
3. Use a worksheet to identify venues in their state or community where they and/or other dental professionals can proactively educate the public about fluoridation.

**Funding, Growing, and Strengthening Nancy Martin, RDH, MPH; Tracy Garland, MUP; Terry Chandler, RDH Federal, state, and local health programs continue to feel substantial pressures to operate with smaller budgets. Proactively planning for sustainability is essential for program survival. This session will present strategies to sustain programs and to cultivate a more diverse funding base. Presenters will discuss traditional sustainability planning approaches to diversifying funding sources, identifying other potential resources, and leveraging partnerships. Federal, state, and local oral health programs will provide practical examples of effective sustainability activities.

**Learning Objectives:**
1. Define the basic principles of sustainability.
2. Identify the essential components of a sustainability plan.
3. Identify at least one additional resource for diversification of funding.
4. Identify at least one additional partner that your program can approach to develop other revenue streams for program sustainability.
5. Describe techniques to integrate diverse funding streams into overall oral health program sustainability.

**Oral Presentations #2 Elizabeth Kinion, EdD, MSN, BSN**

1. **ENHANCING AN AMERICAN INDIAN COMMUNITY’S UNDERSTANDING OF EARLY CHILDHOOD CARIES WITH BASELINE DATA**
2. **EMERGENCY DEPARTMENT UTILIZATION FOR NON-TRAUMATIC DENTAL CONDITIONS IN MINNESOTA - TRENDS, DISPARITIES, & POTENTIAL FOR COST SAVING**
3. **COMMUNITY HEALTH CENTER (CHC) HEALTH DASHBOARD IMPLEMENTING AN ORAL HEALTH DASHBOARD TO STRENGTHEN PROGRAM QUALITY AND IMPROVE HEALTH OUTCOMES**
4. **FACTORS RELATED TO DENTISTS’ DECISION TO PARTICIPATE IN MEDICAID: A CONJOINT ANALYSIS**

**Learning Objectives:**
1. Identify the prevalence of Early Childhood Caries (ECC) in children using Community Based Participatory Research (CBPR).
2. Describe the trends in the utilization of hospital emergency department for non-traumatic dental conditions and associated costs.
3. Describe the development and challenges to using an oral health dashboard in community health centers.
4. Describe the trade-offs dentists face when deciding to accept new Medicaid patients using a conjoint design.

11:30 a.m. – 1:00 p.m. **Lunch on Your Own**

Take the opportunity to walk uptown to enjoy lunch on your own at one of Fort Worth's local eateries. There is time to walk, eat, relax, and still get back in time for afternoon sessions. Information on restaurants is included in your conference materials when you check in.
**Public-Private Partnerships to ENGAGE with Public-Private Partnerships to**  
**Public-Private Partnerships to**  
**Public-Private Partnerships to**

**Dental Referrals for At Risk**  
Laura Brey, BA, MS; Holly Hunt, BS, MS; Sara Rich, MPA  
The 2010 – 2011 Census of School-Based Health Centers documents ongoing growth of the integration of preventive and comprehensive oral health services in school-based health centers. Many of these programs employ non-traditional innovative approaches that bring hygienists and community dentists onsite at schools for cleaning and treatment rather than referring students to community dental offices. School-based preventive services provided by primary care providers face a number of challenges such as practice acts, reimbursement policies, and referral completion. After selected oral health school-based programs are reviewed and challenges presented, an interactive audience discussion will take place around overcoming challenges of providing school age children dental care, including follow-up treatment in or outside the school setting. The audience will make recommendations for solutions to the challenges and prioritize strategies and resources for successful programs.

**Learning Objectives:**

1. Describe how primary care providers integrated preventive oral health services (screenings, assessments, visual exams, fluoride varnish, and referrals) into well-child/adolescent visits in 40 school-based health centers in 6 states.
2. List one policy, one delivery, and one referral challenge encountered by primary care providers related to providing preventive oral health services in schools.
3. Describe three non-traditional approaches for delivering comprehensive school-based oral health programs that are integrated into school-based health centers.
4. Identify and discuss viable strategies and resources for overcoming these policy, delivery, and referral challenges.

**Workshop Format – Ticketed Event – Must present ticket for entry.**

**Engaging the Pediatric Primary**  
Bonnie Magliochetti, RDH, RN; Eve Kimball, MD; Lauren Orsini, MPH  

**Learning Objectives:**

1. Understand the EPiC model – Educating Physicians in the Community (Educating Physicians in the Community)
2. List one policy, one delivery, and one referral challenge encountered by primary care providers related to providing preventive oral health services in schools.
3. Describe three non-traditional approaches for delivering comprehensive school-based oral health programs that are integrated into school-based health centers.
4. Identify and discuss viable strategies and resources for overcoming these policy, delivery, and referral challenges.

**Workshop Format – Ticketed Event – Must present ticket for entry.**

**Oral Presentations #3**  
This session will feature oral presentations of scientific research of interest to attendees. Presentations are listed beginning on page 38.

**Please note: The abstracts are not listed in order of presentation**

1. **EMERGENCY DEPARTMENT VISITS FOR NON-TRAUMATIC DENTAL PROBLEMS IN OREGON STATE**  
   Benjamin Sun, MD, PhD; Eli Schwarz, DDS, MPH; Donald Chi, DMD, PhD; Annick Yagapen, BA; Susan Malveau, MSc; Zuniq Chen, MSc; Ben Chan MSc; Sankirtana Danner, MSc; Erin Owen; Emerson Ong; Vickie Morton; Robert Lowe

2. **DEVELOPMENT OF AN INNOVATIVE COMMUNITY-BASED DENTAL HOME AND OUTREACH PROGRAM TO IMPROVE SERVICE DELIVERY AND CHILDREN'S ORAL HEALTH IN LOS ANGELES**  
   James Crall, DDS, ScD

3. **COMPARISON OF ESTIMATES OF HAVING A DENTAL VISIT IN THE PAST YEAR AMONG ADULTS FROM FOUR SURVEYS**  
   Mei Lin, MD, MSc; Laurie Barker, MSPH; Chien-Hsun Li, MS, MA; Liang Wei, MS, MPH; Michael Manz, DDS, MPH, DrPH; Susan Griffin, PhD

4. **IMPACT OF MEDICAID DENTAL FEE INCREASE ON CHILD UTILIZATION RATES AND EXPENDITURES**  
   Howard Bailit, DMD, PhD; Tryfon Beazoglou, PhD

5. **THE MOTIVATION OF ORTHODONTISTS TO PURSUE PUBLIC HEALTH TRAINING**  
   Anna - Beatrice Le Goff, DDS-MPH Student Scholar, Class of 2014; Burton L. Edelstein, DDS, MPH
Learning Objectives:
1. Identify factors for emergency department visits for non-traumatic dental problems.
2. Describe the development of outreach programs and dental homes to improve delivery of care and oral health status of children.
3. Understand how prevalence estimates of dental visits among adults vary among surveys.
4. Describe the impact of Medicaid fee on utilization rates, expenditures, and dentist participation.
5. Describe a theory-based model to explain an orthodontists' decisions to pursue formal public health training.

2:30 p.m. – 2:45 p.m. ............................................Fort Worth Prefunction Break

2:45 p.m. – 4:15 p.m. ...........................................Fort Worth Ballrooms 1-5

Closing Plenary – CDE 1.5
The Revolution in Science, Delivery Models, and Financing of Community-Based Dental Care
Paul Glassman, DDS, MA, MBA; William Maas, DDS, MPH; Burton Edelstein, DDS, MPH
A revolution is going on in three areas that simultaneously impact the way we deliver dental care. They are:
1. New science in minimally invasive dentistry and understanding of chronic disease management for dental diseases that now allows allied personnel to quickly and effectively prevent and treat pre-carious and beginning carious lesions in community settings with minimal infrastructure and equipment.
2. New delivery models such as telehealth, expanded roles for current allied dental providers, and new providers providing care in community locations.
3. Beginning deployment of new financing models that will drive all actors in the system to want to deploy the tools listed in #1 and #2.

This session will review these trends and the implications for improving the oral health of underserved populations and achieving the Triple Aim in oral health.

Learning Objectives:
1. Describe the current science of minimally invasive dentistry as it relates to the management of dental caries.
2. Describe the application of telehealth technologies in the delivery of oral health care to underserved populations.
3. Discuss the potential for new financing models to drive providers of oral health care to use new science and delivery models to achieve the triple aim in oral health care.

I am working to improve my people’s oral health

Growing up in the Pascua Yaqui Tribe in Guadalupe, Arizona, I saw firsthand the devastation that untreated dental disease wreaks on people’s health and lives. Kids, adults, elders suffering with painful, disfiguring infections in their teeth and gums.

Now I’m doing something about it. Through an educational program designed by the American Dental Association, I became a Community Dental Health Coordinator. I’m trained to provide the oral health education that empowers families to take charge of their own health. I deliver preventive services like dental sealants and fluoride treatments to stop dental disease before it starts. And I help people who need additional treatment get and keep appointments with dentists.

Native American people deserve the best dental care. I know the barriers that keep people from accessing quality oral health care. As a CDHC, I’m breaking down those barriers. To learn more about Community Dental Health Coordinators, visit ADA.org/cdhc.
Graham Adams, PhD  
South Carolina Office or Rural Health  
Lexington, SC

Mary Altenberg, MS, CHES  
Community Dental Services  
Albuquerque, NM

Krishna Aravamudhan, BDS, MS  
ADA Practice Unit  
American Dental Association  
Chicago, IL

Jay Balzer, DMD, MPH  
ASTDD  
Boulder, CO

Dori Bingham, BA  
DentaQuest Institute  
Westborough, MA

Sean Boynes, DMD  
CareSouth Carolina  
Hartsville, SC

Laura Brey, BA, MS  
School-Based Health Alliance  
Washington, DC

Chad Brooker, JD  
Access Health Center  
Hartford, CT

Jane Casper, RDH, MA  
DHMH Office of Oral Health  
Columbia, MD

Terry Chandler, RDH  
Future Smiles  
Las Vegas, NV

Don Compton, PhD  
CDC  
Atlanta, GA

Wayne Cottam, DMD, MS  
AT Still University of Health Sciences  
Mesa, AZ

Neal A Demby, DMD, MPH  
Lutheran Health Care  
Brooklyn, NY

Susan Deming, RDH, BS  
Michigan Department of Community Health, Oral Health  
Lansing, MI

David Line Denali, PhD, MPH, MSW  
AT Still University  
School of Health Management  
Kirkville, MO

Mark Doherty, DMD, MPH  
Safety Net Solutions  
Westborough, MA

Kip Duchon, PE  
Centers for Disease Control and Prevention  
Atlanta, GA

Burton Edelstein, DDS, MPH  
Columbia University  
New York, NY

Kurt Ferre, DDS  
Creston Children's Dental Clinic  
Portland, OR

Diane Flanagan, RDH  
Children's Health Alliance of Wisconsin  
Milwaukee, WI

Andrea Frantz, BS  
American Student Dental Association  
Temple University Chapter  
Philadelphia, PA

Tracy Garland, MUP  
Oral Health Funders Group  
Seattle, WA

Paul Glassman, DDS, MA, MBA  
University of the Pacific School of Dentistry  
San Francisco, CA

Jane Grover, DDS, MPH  
American Dental Association  
Chicago, IL

Michael Helgeson, DDS  
Apple Tree Dental  
Minneapolis, MN

Calvin Hoops, CDHC  
Esperanza Health Center, Inc  
Philadelphia, PA

Ronald J Hunt, DDS, MS  
College of Dental Medicine-Arizona, Midwestern University  
Glendale, AZ

Kathy Hunt, RDH  
Kansas Cavity Free Kids  
Wamego, KS

Holly Hunt, BS, MS  
Centers for Disease Control and Prevention  
Atlanta, GA

Evelyn Ireland, CAE  
National Association of Dental Plans  
Dallas, TX

Matt Jacob, BA  
Children's Dental Health Project  
Washington, DC

Johnny Johnson, Jr., DMD, MS  
Tarpon Springs, FL

Bilquis Khan, MSC  
Minnesota Department of Health  
Saint Paul, MN

Eve Kimball, MD  
PAAAP Healthy Teeth Healthy Children  
Media, PA
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<td>New Hampshire Department of Health</td>
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<td>Maureen A Ohland, DDS, MS, MLS</td>
<td>University of Minnesota School of Dentistry</td>
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<td>Peter Orris, MD, MPH, FACP, FACOEM</td>
<td>Occupational and Environmental Medicine University of Illinois Hospital and Health Sciences System</td>
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*Contributed paper presenters are listed under session information. Poster presenters are listed with their abstract.
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ABDPH Past Presidents

Walter J. Pelton – 1950-1955
William A. Jordan – 1956
Walter J. Pelton – 1957
John W. Knutson – 1958
Phillip E. Blackerby – 1959
Robert A. Downes – 1960
Chester V. Tossy – 1961
Donald J. Galagan – 1962
John T. Fulton – 1963
Arthur Bushel – 1964
Polly Ayers – 1965
Norman F. Gerrie – 1966
John K. Peterson – 1967
Albert L. Russell – 1968
David F. Striffler – 1969
Wesley O. Young – 1970
Wesley O. Young – 1971 (Acting)
Harry W. Bruce Jr. – 1972
Frank E. Law – 1973
David A. Soricelli – 1974
Naham C. Cons – 1975
John C. Greene – 1976
John T. Hughes – 1977
Quentin M. Smith – 1978
William T. Johnson – 1979
Edward M. Campbell – 1980
Stanley Lotzkar – 1981
John E. Butts – 1982
Herschel S. Horowitz – 1983
Durward R. Collier – 1984
Richard F. Murphy – 1985
J. Earl Williams – 1986
Richard D. Mumma – 1987
Robert C. Faine – 1988
Richard C. Graves – 1989
Joseph M. Doherty – 1990
Gene P. Lewis – 1991
Chester W. Douglass – 1992
Dushanka V. Kleinman – 1993
Myron Allukian Jr. – 1994
R. Gary Rozier – 1995
E. Joseph Alderman – 1996
Linda C. Niessen – 1997
Stephen B. Corbin – 1998
Jayanth Kumar – 1999
Jayanth Kumar – 2000
Robert H. Dumbaugh – 2001
Brian A. Burt – 2002
Caswell A. Evans – 2003
Raymond A. Kuthy – 2004
Robert J. Collins, Jr. – 2005
Teresa A. Dolan – 2006
B. Alexander White, Jr. – 2007
Reginald Louie – 2008
A. Isabel Garcia – 2009
Catherine Hayes – 2010
Rebecca S. King – 2011
Steven M. Levy – 2012
George Taylor – 2013

Special thanks to the following:

- Frances Kim and Mary Altenberg, Co-Chairs AAPHD Education Committee
- AAPHD Education Committee for coordinating contributed papers/poster session
- Dr. Linda Kaste, Dr. Raghunath Puttiah, Dr. Ritu Bansal, Dr. Mert Aksu, and Dr. Divesh Byrappagari for reviewing the AAPHD Student Merit Award submissions
- Sena Narendran for organizing student awards/poster session

Thank you to the following for their efforts to create an exceptional program.

David Cappeli, DMD, MPH, PHD
Debi DeNure, RDH
Harry Goodman, DMD, MPH
Catherine Hayes, DMD, SM, DrMedSc
Larry Hill, DDS, MPH
Bev Isman, RDH, MPH, ELS
Michael Monopoli, DMD, MPH, MS
Carol Smith, RDH, MSHA
Pamela J. Tolson, CAE
Chris Wood, RDH, BS
Kimberlie Yineman, RDH, BA
Recipients of Awards of the American Association of Public Health Dentistry

Public Service Award
Presented to an individual for substantial contribution through action related to public health dentistry issues.

2014 Children’s Dental Health Project
2013 The Honorable Bernard Sanders
2012 Susan Griffin
2011 Shelly Gehshan
2010 US Senator Sherrod Brown
2009 Mary Otto
2008 Rasmuson Foundation
2007 Richard H. Carmona
2006 Lawrence A. Tabak
2005 US Senator Susan Collins
2004 Rob Reiner
2003 US Senator Raymond A. Rawson
2002 US Senator Jeff Bingaman
2001 VADM David Satcher
1998 Scott Litch and Judy Sherman
1997 The Honorable Steny Hoyer
1996 The Honorable Edward Kennedy and Assemblywoman Jackie Speier
1995 Joe Garagiola
1991 Kay Johnson
1990 Julius Richmond
1989 The Honorable John David Waihee, III
1988 Marian Wright Edelman
1987 C. Everett Koop
1986 The Honorable Claude Pepper
1985 The Honorable Henry Waxman
1984 President Jimmy Carter

Distinguished Service Award
Presented to an individual for excellent and distinguished service to public health dentistry.

2014 Diane Brunson
2013 Caswell Evans, Jr.
2012 E. Joseph Alderman
2011 William Maas
2010 Mark Siegal
2009 Burton Edelstein
2008 Helen Gift
2007 William Bird
2006 Linda Niessen
2005 Dushanka Kleiman
2004 Scott L. Tomar
2003 Lois Cohen
2002 Myron Allukian, Jr.
2001 Brian Burt
2000 R. Gary Rozier
1999 Alice Horowitz
1998 Naham C. Cons and John K. Peterson
1997 Joseph M. Doherty and Helen K. Doherty
1996 John C. Greene
1995 Robert E. Mecklenberg
1994 Martha Liggett
1993 Dennis Leverett
1992 Durward Collier
1991 Irwin D. Mandel
1990 Stanley Lotzkar
1989 Max H. Schoen
1988 David Edward Barman
1987 Herschel Horowitz
1986 David Sorcelli
1985 John T. Hughes
1984 Donald J. Galagan
1983 Albert L. Russell
1982 Polly Ayers
1981 Frank E. Law
1980 John W. Knutson
1979 James Morse Dunning
1978 Ernest A. Pearson, Jr.
1977 David F. Striffler
1975 Charles W. Gish
1973 John T. Fulton
1972 Kenneth Easlick

President’s Award
Presented at the discretion of the President to an individual for significant contributions to the welfare of the Association.

2014 Chester Douglass
2013 Diane Brunson
2012 Amos Deinard
2009 Reginald Louie
2008 Eugenio Beltrán
2007 Alice Horowitz
2006 Nicholas Mosca
2005 Steven Geiermann
2004 Joseph Doherty and Stuart Lockwood
2003 Stanley Lotzkar
2001 James Toothaker
1999 Teresa Dolan
1998 Jane A. Weintraub
1997 Raymond Kuthy
1996 Robert J. Collins
1994 Stephen B. Corbin
1989 Richard D. Mumma, Jr. and Joseph M. Doherty
1988 Edward N. Brandt, Jr. and Crystal Gayle
1987 Robert E. Mecklenburg
## Recipients of Awards of the Association of State and Territorial Dental Directors

### Outstanding Achievement Award
*Presented to a past or present member for significant contributions to ASTDD and dental public health.*

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### Distinguished Service Award
*Presented to an individual or organization for excellent and distinguished service to dental public health.*

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<td>2002</td>
<td>VADM David Satcher</td>
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<td>2001</td>
<td>Wendy E. Mouradian</td>
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<td>Burton L. Edelstein</td>
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<td>1999</td>
<td>Dolores Malvitz and Donald Schneider</td>
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<td>1998</td>
<td>Gerry Beverley</td>
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<td>1997</td>
<td>Robert A. Sappington</td>
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<td>1996</td>
<td>Jack Dillenberg</td>
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<td>1995</td>
<td>John Rossetti</td>
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<td>1994</td>
<td>Darrell Sanders</td>
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<td>1993</td>
<td>Alice Horowitz</td>
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<td>1991</td>
<td>Tom Reeves</td>
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<td>1990</td>
<td>Ken Goff and Jim Collins</td>
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<td>1987</td>
<td>Jim Saddoris and Mary Winkeljohn-Kough</td>
</tr>
<tr>
<td>1984</td>
<td>Cora Leukhart and John Small</td>
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</table>

### President’s Award
*Presented at the discretion of the President to individuals or organizations who have contributed to the advancement of state dental programs and dental public health.*

<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>2013</td>
<td>Reginald Louie</td>
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<tr>
<td>2012</td>
<td>John Rossetti</td>
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<tr>
<td>2011</td>
<td>Jaynath V. Kumar</td>
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<tr>
<td>2010</td>
<td>Hispanic Dental Association</td>
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<tr>
<td>2009</td>
<td>Kathy Mangskau</td>
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<td>2008</td>
<td>Joseph M. Doherty</td>
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<tr>
<td>2007</td>
<td>Donald Marianos</td>
</tr>
<tr>
<td>2006</td>
<td>Beverly Isman, Julie M. W. Tang, Nicholas G. Mosca and Judith A. Feinstein</td>
</tr>
<tr>
<td>2005</td>
<td>Monette McKinnon and Christine Wood</td>
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<tr>
<td>2004</td>
<td>Nicholas Mosca</td>
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<td>2003</td>
<td>Steven Geiermann</td>
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<tr>
<td>2001</td>
<td>Stuart Lockwood</td>
</tr>
<tr>
<td>2000</td>
<td>Michael W. Easley</td>
</tr>
<tr>
<td>1999</td>
<td>The Honorable Christopher S. Bond</td>
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Exhibitors in Booth Number Order

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<thead>
<tr>
<th>Booth #</th>
<th>Company</th>
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<tbody>
<tr>
<td>1</td>
<td>Henry Schein, Inc</td>
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<td>2</td>
<td>American Public Health Association</td>
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<td>3</td>
<td>Children International</td>
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<td>4</td>
<td>Association of State and Territorial Dental Directors</td>
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<tr>
<td>5</td>
<td>Children’s Dental Health Project</td>
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<tr>
<td>6 &amp; 7</td>
<td>DNTLworks Equipment Corporation</td>
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<td>8</td>
<td>Carestream Dental</td>
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<td>Sentry Dental Products</td>
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<td>Pulpdent Corporation</td>
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<td>National Maternal and Child Oral Health Resource Center</td>
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<td>Medical Products Laboratories, Inc</td>
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<td>13</td>
<td>CDC Division of Oral Health</td>
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<td>Lutheran Medical Center</td>
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<td>15</td>
<td>Elevate Oral Care</td>
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<td>Dental Health Products, Inc</td>
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<td>Oral Health America</td>
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<td>AAPHD Foundation</td>
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<td>DentaQuest Institute</td>
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<td>Dental Health &amp; Wellness</td>
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<td>21</td>
<td>KaVo Kerr Group</td>
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<td>22</td>
<td>Texas Oral Health Coalition</td>
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<td>Preventech</td>
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<td>24 &amp; 25</td>
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<td>26</td>
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<td>Premier Dental Products Company</td>
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<td>Pride Dental Laboratory</td>
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<td>American Academy of Pediatric Dentistry</td>
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<td>31</td>
<td>National Children’s Oral Health Foundation</td>
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Exhibitors in Alpha Order

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<td>American Academy of Pediatric Dentistry</td>
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<td>22</td>
<td>Texas Oral Health Coalition</td>
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Exhibit Hall Hours:

**Monday**
- 7:00 am – 8:00 am
- 12:15 pm – 2:15 pm
- 4:00 pm – 5:30 pm

**Tuesday**
- 7:00 am – 8:00 am
- 12:15 pm – 2:00 pm
- 3:15 pm – 5:00 pm

**Wednesday**
- 7:00 am – 8:00 am
- 9:30 am – 10:00 am
Thank you to our Conference Sponsors

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kgoфф@aseptico.com  
Darryl Weis  
dweis@aseptico.com  
Aseptico has always been committed to innovation, quality, and value for the customer. Aseptico has manufactured portable dental equipment for the Department of Public Health for over 20 years. Our products are regulatory compliant with FDA, ISO 13485 Quality Management System Standards, and certified to UL and CSA standards.

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Representatives:  
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kkelly@mplusa.com  
Scot Stone  
SStone@mplusa.com  
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**American Dental Association**
Silver Level Sponsor  
Booth # 30  
211 E Chicago Ave  
Chicago, IL  60611  
312-440-2858  
Representative(s):  
Hilton Israelsen  
israelsonh@ada.org  
Nicole Catral  
catraln@ada.org  
The American Dental Association is the nation’s largest dental association, representing 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public’s health and promoted the art and science of dentistry since 1859. The ADA seeks to improve public health outcomes through collaboration.

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303-693-1410  
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tmeighan@dntlworks.com  
Bob Kennedy  
bkennedy@dntlworks.com  
Steve Knight  
sknight@dntlworks.com  
DNTLworks Equipment Corporation; Anyone, Anywhere, Anytime. That is the motto we use along with our partners, the dental care providers. Our superior array of portable, mobile, and self-contained equipment gives any dental professional the necessary tools to provide the best treatment to those who need it most.

**Dental Health & Wellness**
Silver Level Sponsor  
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7700 Forsyth Blvd  
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314-917-9413  
Representatives:  
Nancy Davis  
nandavis@centene.com  
Established to deliver quality dental healthcare, Dental Benefits Manager, Dental Health & Wellness is a subsidiary of Centene Corporate (Centene), a Fortune 500 company with nearly 30 years of experience in Medicaid managed care programs. Dental Health & Wellness is committed to improving the oral health of the community one smile at a time which leads to improved overall health of individuals.
Association of State and Territorial Dental Directors
Booth # 4
3858 Cashill Blvd
Reno, NV  89509
775-626-5008
Representatives:
  Christine Wood  cwood@astdd.org
  Bev Isman  bev.isman@comcast.net
The Association of State and Territorial Dental Directors (ASTDD) is committed to improving the nation’s oral health by promoting strong state oral health programs, formulating oral health policy, increasing awareness of oral health, and preventing oral disease.

Carestream Dental
Booth # 8
1765 The Exchange
Atlanta, GA  30339
770-226-3898
Representatives:
  Michael Beltrami  michael.beltrami@carestream.com
  Jim Dycus  jim.dycus@carestream.com
Carestream Dental provides industry-leading imaging, software, and practice management solutions for dental and oral health professionals. With more than 100 years of industry experience, Carestream Dental products are used by seven out of ten practitioners globally and deliver more precise diagnoses, improved workflows, and superior patient care.

CDC Division of Oral Health
Booth # 13
4770 Buford Hwy, NE MS F-80
Atlanta, GA  30341
770-488-5301
Representatives:
  Linda Orgain  lbo6@cdc.gov
CDC’s Division of Oral Health works to prevent and control oral diseases and conditions and reduce oral health disparities. Its vision is a nation where all people enjoy good oral health that contributes to leading healthy, satisfying lives. CDC works to extend proven strategies to prevent oral diseases, strengthen oral health infrastructure, monitor oral diseases, and guide infection control in dentistry.

Dental Health Products, Inc.
Booth # 16
2614 N Sugar Bush Road
New Franken, Wi  54229
800-626-2163 x 2324
Representatives:
  Holly Risner  hrisner@dhpi.net
  LeDeana DeClark  ladeanad@dhpi.net
Dental Health Products, Inc. is a nation-wide full-line dental supplier serving public & private institutions in the dental industry for over 22 years. Authorized dealer for all major name brand products, solutions and services.

Henry Schein, Inc.
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135 Duryea Road
Melville, NY  11747
631-390-8155
Representatives:
  Marc Capots  marc.capots@henryschein.com
  Vance Taylor  vance.taylor@henryschein.com
  Dan Westerheide  dan.westerheide@henryschein.com
  Kip Rowland  kip.rowland@henryschein.com
Henry Schein distributes a comprehensive range of healthcare products, offering a complete line of medical & dental supplies, durable medical equipment, vaccines & pharmaceuticals, diagnostic tests & equipment, and medical & dental equipment & furniture. Henry Schein offers technology and software. Henry Schein is a national distributor with five distribution centers.

KaVo Kerr Group
Booth # 21
11787 Fruehenauf Drive
Charlotte, NC  28273
303-674-0726
Representatives:
  Karen Lauder  karen.lauder@kavokerrgroup.com
  Adam Dickson  adam.dickson@kavokerrgroup.com
KaVo Kerr Group is a global portfolio of industry leading dental brands that is unified by values of trust, experience, choices, quality, and smart innovation. With over 500 years of combined experience, KaVo Kerr Group delivers innovative, environmentally friendly, and cost effective products that meet the demand of healthcare providers. Our brands are leaders in hygiene, restorative materials, dental equipment, imaging, specialty, and special markets. Our portfolio of brands include KaVo, Kerr, Pelton & Crane, Marus, Axis Endo, Pentron, Orascoptic, DEXIS, Gendex, Instrumentarium, SoreDEX, i-CAT, Ormco, Kerr Total Care NOMAD, and Implant Direct.
Lutheran Medical Center
Booth # 14
150 55th Street
Brooklyn, NY 11220
718-630-8418
Representatives:
Edward Vigna edvigna8@gmail.com
LMC Dental is the educational sponsor of postdoctoral dental residency training programs accredited by the Commission on Dental Accreditation of the American Dental Association. Currently, we offer seven programs in the following dental specialties: General Practice Residency (GPR), Advanced Education in General Dentistry (AEGD), Pediatric Dentistry, Endodontics, Oral Facial Pain, Periodontics, and Anesthesiology.

Premier Dental Products Company
Booth # 27
1710 Romano Drive
Plymouth Meeting, PA 19462
610-239-6017
Representatives:
Daniell Rosenbaum dentalinfo@premusa.com
Julie Charlestein dentalinfo@premusa.com
For over a century, Premier® Dental Products Company has developed and manufactured innovative technologies for dental professionals worldwide. Products include: Enamel Pro® Varnish, Enamel Pro® prophy paste, Traxodont® Hemodent® paste retraction system, Two Striper® diamonds, Solo single patient diamonds, 2pro® disposable prophy angles, instruments, dual-arch Triple Tray® and Perfecta® whitening.

Preventech
Booth # 23
4330 Matthews Indian Trail Rd, Suite C
Indian Trail, NC 28079
704-849-2416
Representatives:
Al King alking@preventech.com
Mitzi Bass mmbdentalssupplies@gmail.com
Preventech® develops and markets innovative preventive care products focused on dental disease prevention. Our product line includes VELLA 5% Fluoride Varnish, PIVOT Disposable prophy Angles, NEXT Prophy Paste, and DAYLI 1.1% Fluoride. All of our products are Made in America. 800-474-8681 or visit www.preventech.com.

Pulpdent Corporation
Booth # 10
80 Oakland St
Watertown, MA 02472
800-343-4342
Representatives:
Larry Clark larry@pulpdent.com
Sue Dodd sales@pulpdent.com
Jack Garland sales@pulpdent.com
Pulpdent manufactures high-quality products for the dental profession, including adhesives, composites, provisional materials, sealants, cements, etching gels, calcium hydroxide products, endodontic specialties, and bonding accessories.

SciCan, Inc
Booth # 26
701 Technology Drive
Canonsburg, PA 15317
800-572-1211
Representatives:
Jeff Ziegler jziegler@scican.com
Rich Strader rstrader@scican.com
Products: Statim sterilizer, Bravo autoclave, Hydrim instrument washers, Statis Handpieces, and Optim 33TB disinfectant

Sentry Dental Products
Booth # 9
795 Coronis Way
Green Bay, Wi 54304
920-337-0201
Representatives:
Edwin Novak edwin@sentrydental.com
Carrie Regier info@sentrydental.com
Nancy Novak info@sentrydental.com
David Regier info@sentrydental.com
Sentry Dental Products’ Value Varnish Program features Nu Shield Clear, a superior quality 5% sodium fluoride paint on varnish at extraordinarily attractive prices. Our hope is that our Value Varnish Program enables treatment of more children in a most cost effective fashion. Sentry also provides Pit & Fissure sealants, cements, gloves, masks, and other disposables under its Value Varnish Program.
AAPHD Foundation
Booth #18
3085 Stevenson Drive, Suite 200
Springfield, IL  62703
217-529-6941

American Academy of Pediatric Dentistry
Booth # 29
211 E Chicago Ave
Chicago, IL  60611
312-337-2169
Representatives:
  Jan Silverman  jsilverman@aapd.org
The American Academy of Pediatric Dentistry (AAPD), the recognized authority on children's oral health, promotes evidence-based policies and clinical guidelines; educates and informs policymakers, parents and guardians, and health care professionals; fosters research; and provides continuing professional education for dentists who treat children. For further information, visit http://www.aapd.org or http://www.mychildrensteeth.org.

American Public Health Association
Booth # 2
800 I Street NW
Washington, DC  20001
339-222-8917
Representatives:
  Kathy Lituri  lituri@bu.edu
The American Public Health Association, a diverse community of public health professionals, has championed the health of all people and communities for more than 140 years. The Oral Health Section of APHA has nearly 350 members, mostly dentists and dental hygienists, working in public health practice, administration, research, or teaching.

Children International
Booth # 3
2000 East Red Bridge Road
Kansas City, MO
816-943-4997
Representatives:
  Andrea Dunne-Sosa  adunne@children.org
Children International (CI) offers basic dental services to ~340,000 impoverished children and youth in Latin America, Asia, Africa, and the USA. CI prepares children and youth to escape the traps of poverty by supporting their critical needs, building resilience, and engaging them in transformative activities.

Children’s Dental Health Project
Booth # 5
1020 19th Street NW, #400
Washington, DC  20036
202-417-3594
Representatives:
  Shante Alerte  salerte@cdhp.org
The Children’s Dental Health Project is a national nonprofit advancing innovative solutions so that all children achieve oral health. We work with partners to: (1) Strengthen systems to prevent childhood tooth decay; (2) Expand oral health services that meet the Triple Aim; (3) Build states’ capacity to improve oral health; and (4) Extend awareness to encourage healthy behaviors. Visit our booth to get to the heart of our work with policymakers, state oral health programs, and others. We have tools and information to share, many developed through our CDC Cooperative Agreement.

DentaQuest Institute
Booth # 19
2400 Computer Drive
Westborough, MA  01581
508-329-2402
Representatives:
  Da-Nell Rogers  danellrogers@gmail.com
  Laura Skaret  laura.skaret@dentaquestinstitute.org
  Caroline Darcy  caroline.darcy@dentaquestinstitute.org
  Danielle Goldsmith  danielle.goldsmith@dentaquestinstitute.org
  Dorilee Bingham  dori.bingham@dentaquestinstitute.org
  Brian Novy  brian.novy@dentaquestinstitute.org
  Rob Compton  rob.compton@dentaquestinstitute.org
  Mark Doherty  Mark.Doherty@dentaquestinstitute.org
The DentaQuest Institute’s Safety Net Solutions (SNS) provides technical assistance and practice management consultation to safety net dental programs throughout the country. SNS develops specialized and unique practice enhancement recommendations in areas such as operations, systems, finances, quality, and integration of medical and dental services.

National Children’s Oral Health Foundation
Booth #31
4108 Park Rd, Suite 300
Charlotte, NC  28209
704-350-1600
Representatives:
  Fern Ingber  fingber@ncohf.org
  Robin Vann  rvann@ncohf.org
National Children’s Oral Health Foundation: America’s ToothFairy® is dedicated to eliminating children’s suffering from dental disease by supporting delivery of educational, preventive, and treatment services. With a growing Affiliate network of non-profit community programs, Kids Club, professional and student service programs, America’s ToothFairy protects the smiles of at-risk children.
National Maternal and Child Oral Health Resource Center
Booth # 11
Box 571272
Washington, DC 20057-1272
202-784-9551
Representatives:
Katrina Holt khol@georgetown.edu
Sarah Kolo sk22@georgetown.edu
Beth Lowe eal38@georgetown.edu
The resource center provides high-quality information and materials to health professionals working in states and communities to improve oral health services for children, adolescents, and their families. Services include responding to information requests, collecting programmatic materials and sharing information about their availability, and developing and disseminating publications at no charge.

Oral Health America
Booth # 17
180 N Michigan Ave, Suite 1150
Chicago, IL 60601
312-836-9900
Representatives:
Brittany Wright brittany.wright@oralhealthamerica.org
Tina Montgomery tina.montgomery@oralhealthamerica.org
Dora Fisher dora.fisher@oralhealthamerica.org
Beth Truett beth.truett@oralhealthamerica.org

Pride Dental Laboratory
Booth # 28
13518 NE 258th Court
Raiford, FL 32803
800-599-5919
Representatives:
Mark Rosenberg mrosenberg@pride-enterprises.org
PRIDE Dental Laboratory offers a full range of services using traditional techniques and state of the art CAD design and Computer Aided Manufacturing. Partner with PRIDE to offer your patients AFFORDABLE, premium restorations made entirely in the USA. Let us help you, help those in need.

Texas Oral Health Coalition
Booth # 22
4614 Bowie Drive
Midland, TX 79703
432-413-8843
Representatives:
Beth Stewart b.stewart@txohc.org
TxOHC exists to promote and support optimal oral health across the lifespan and is the primary organization in Texas that provides a nonpartisan forum that allows a diverse network of stakeholders to collaborate and create innovative and viable solutions to improve the overall oral health for all Texans.

Not-For-Profit Exhibitors

Save the Date
National Oral Health Conference
April 27-29, 2015
Pre-Conference
April 25-26, 2015
Kansas City, Missouri
Watch: www.nationaloralhealthconference.com for details.
Abstracts for Oral Presentations

1. **STOP FISHING FOR DATA! IMPLEMENTATION OF THE MINNESOTA ORAL HEALTH SURVEILLANCE SYSTEM (MNOHSS, PRONOUNCED “MINNOWS”)**

   **Genelle Lamont (1), MPH, PhD Candidate; Bilquis Khan (1), MSc, MBA, MSc; Merry Jo Thoele (1), MPH, RDH**

   **Minnesota Department of Health, St. Paul, USA (1)**

   **OBJECTIVES:** To increase public accessibility to oral health data by providing a time-saving, one-stop source of data through the Minnesota Public Health Data Access Portal, by integrating best practices in health literacy to allow greater understandability and usability of data, and to describe challenges and lessons learned.

   **METHODS:** Select relevant Minnesota oral health indicators to include in the system based on: guidance from the Association of State and Territorial Dental Directors and CDC Evaluation Framework for usability, feasibility, and accuracy; and consistency with the National Oral Health Surveillance System and Minnesota Oral Health Program objectives. Acquire datasets by developing relationships with data stewards and signing data-use agreements when needed. Reformat datasets to meet Minnesota Information Technology programming requirements. Work with the Minnesota Environmental Public Health Tracking Program to create data queries, GIS maps, static figures and graphs, and key messages.

   **RESULTS:** MNOHSS will include thirteen core indicators for inclusion on the oral health page on the portal. Challenges to building an interactive oral health surveillance system include availability of data, time, resources and partners, internal and external approval processes, and funding.

   **CONCLUSIONS:** MNOHSS will launch in January 2015. Easily accessible updated oral health data in Minnesota will allow public health, dental health professionals, and other stakeholders to identify health disparities, track trends in disease and service utilization, identify unmet needs, and target resources more efficiently. Successful implementation and sustainability of MNOHSS is heavily reliant on building strong collaborative partnerships with data stewards and funding agencies.

   **Source of Funding:** Delta Dental of Minnesota Foundation

2. **THE VOTES ARE IN: SUCCESSFULLY ADVOCATING FOR DENTAL COVERAGE FOR LOW-INCOME ADULTS**

   **Kelly Richburg (1)**

   **Washington Dental Service Foundation, Seattle, WA, USA (1)**

   In 2013, the Washington Dental Service Foundation (WDSF) and its partners successfully advocated for the restoration of the Medicaid adult dental program, which had been cut in 2011 due to budgetary constraints.

   **Objective:** This presentation will outline the actions that led to this victory, empowering participants to generate support for adult dental coverage in their states.

   **Method:** One of the keys to this success was the number and diversity of partners that engaged in the advocacy effort, including representatives from business, healthcare, and children’s and seniors’ advocacy groups. These partners engaged in numerous one-on-one meetings with legislators, state agency officials, and the Governor’s staff. Several messages proved to be effective at these meetings, including the opportunity to leverage federal dollars to fully cover the cost of dental coverage for adults newly eligible for Medicaid as a result of the Affordable Care Act. Another message that resonated was the cost savings that could be realized if people obtained routine dental care, rather than going to the emergency room for dental problems. Advocates also brought forward new research showing that dental care can significantly reduce medical costs for patients with chronic diseases, including diabetes. Beyond the one-on-one meetings, the messages were widely disseminated through a robust media campaign, including paid radio ads and editorials and op-eds in newspapers throughout the state.

   **Results/Conclusion:** The efforts of the broad-based coalition convinced the Governor and a divided Legislature that providing dental coverage to more than 775,000 low-income adults is a smart investment.

   **Source of Funding:** Washington Dental Service Foundation, which is fully supported by Delta Dental of Washington.

3. **SIMPLIFYING ESTIMATION OF RESOURCE COSTS FOR SCHOOL-BASED SEALANT PROGRAMS**

   **Shilpa Naavaal (1), BDS, MPH; Dawn Arlotta (1), MPH, CHES; Kari Jones (2), PhD; Susan Griffin (1), PhD**

   **Centers for Disease Control and Prevention, Atlanta, GA, USA (1)**

   **Quantitative Health Research, Tampa, FL, USA (2)**

   **Objective:** Describe a methodology to simplify estimating resource costs for school-based sealant programs (SBSP).

   **Methods:** We used information reported by SBSP in 13 CDC-funded states, dental manufacturers and Bureau of Labor Statistics (BLS), to estimate resource costs for 1) equipment (15 year useful life and 3% discount rate), 2) instruments, 3) consumables, 4) labor, 5) administration, and 6) other (e.g., mileage).

   **Results:** Because reported costs for equipment, instruments, and consumables were consistent across SBSP, we could assign values to these categories based on program characteristics. For example, for SBSP using dental-hygienist-and-assistant teams and resin-based sealants, the assigned annual cost of a sealant station would be $730.80 and the assigned per-child cost for consumables would be $5.47 - $4.08 for soft goods and $1.39 for sealant (assuming 3 teeth sealed) - and $1.30 for disposable instruments. While reported hourly labor costs were consistent with values reported by BLS (e.g., $33.99 per hygienist hour and $16.86 per assistant hour), time to provide sealants to a child varied across programs from 23 minutes to over an hour. Using the median average time to screen and seal a child (45 minutes) the labor cost per child would be $38.72. Reported administrative costs and ‘other’ costs varied widely.

   **Conclusions:** These findings suggest the potential to streamline cost estimation for resource categories. However, development of an electronic spreadsheet may be necessary to assist SBSP personnel in tracking labor and administrative hours and ‘other’ cost components.

   **Source of Funding:** None

4. **WATER FLUORIDATION STATUS IN LOS ANGELES COUNTY CITIES OVER A 23-YEAR PERIOD**

   **Maritza Cabezas (1), DDS, MPH; Fred Dominguez (1), MD, MPH**

   **Los Angeles County Department of Public Health, Los Angeles, CA, USA (1)**

   **Objective:** Los Angeles County (LAC), with approximately 10 million residents and covering over 4,000 mi<sup>2</sup>, has a very complex water system. It would take an eidetic memory to visualize the fluoridation status of each area. This presentation was intended to show how this system...
evolved over a 23-year period and resulted in an irregular distribution of fluoridated water in LAC cities.

**Method:** Maps created using Geographic Information Systems (GIS) show fluoridation growth over 23 years. The fluoridation status of each city was compiled from data in the Water Quality Reports of each water companies' website. In cases where these reports weren't available, we called requesting information. We also used data provided by the engineers of the California Department of Public Health Drinking Water Program and the CDC Community Water Fluoridation website. City population data was gleaned from the U.S. Census.

**Results:** GIS maps served to demonstrate that levels of fluoridation are unevenly distributed in LAC. The maps also assisted dentists and pediatricians to more effectively prescribe fluoride supplements by understanding the status of their patients' drinking water; showed that water companies' service areas do not follow city boundaries; facilitated creating community support for fluoridation by visualization of discrepancies; provided accurate information on the location and levels of fluoridation to decision-makers; and displayed disparities when correlating the fluoridation status by geographical areas and the percentage of adults that could not afford dental care.

**Conclusions:** GIS maps clearly illustrated the distribution of water fluoridation and should be standard tools in all communities.

**Source of Funding:** Los Angeles County Department of Public health - Oral Health Program budget.

5. **UNDERSERVED CHILDREN IN PHILADELPHIA, PENNSYLVANIA, EXPERIENCE DECREASE IN DECAY RATE AFTER EIGHT YEARS OF COMMUNITY ORAL HEALTH INITIATIVES**

Julianna Gelinas (1), BS, RDH
St. Christopher's Foundation for Children, Philadelphia, PA, USA (1)

**OBJECTIVE:** To improve the oral health of the children in North Philadelphia through comprehensive programming including school-based outreach, education and treatment.

**METHODS:** In 2006, St. Christopher's Foundation for Children launched its Community Oral Health Initiatives, a comprehensive set of programs providing access to oral health education and treatment for children in designated North Philadelphia Dental Health Provider Shortage Areas. A Ronald McDonald Care Mobile (mobile dental clinic) provides a dental home for young children in Head Start, public and private schools, and the community-at-large. Culturally competent staff dentists and hygienists provide diagnostic, preventive, and restorative services. Additional age-appropriate oral health education is presented at four grade levels in the affiliated schools. Supportive programs offer oral health education for expectant parents, healthcare and social service workers, and the community-at-large. The number of new patients presenting on the Care Mobile with untreated decay has been tracked and analyzed since 2007.

**RESULTS:** Over 8,000 patients entered the program as new patients since 2007. Children ages 2 to 8 years showed a steadily declining decay rate over the six year period. Children ages 2 to 4 years demonstrated the greatest improvement in oral health with as much as 19% fewer new patients having untreated decay.

**CONCLUSION:** Through early intervention, improved oral health literacy, and mobile comprehensive and continuous oral health care, the Community Oral Health Initiatives have improved oral health in young children as evidenced by a decline in the number of children with untreated decay.

**Source of Funding:** St. Christopher’s Foundation for Children

6. **ENHANCING AN AMERICAN INDIAN COMMUNITY’S UNDERSTANDING OF EARLY CHILDHOOD CARIES WITH BASELINE DATA**

Elizabeth Kinion (1), EdD, MSN, BSN
Montana State University, College of Nursing (1)

**Objective:** Identify the prevalence of Early Childhood Caries (ECC) in the children who attended Head Start on a rural frontier Al Reservation.

**Method:** Community Based Participatory Research (CBPR) a partnership between the tribe and the university established in 2008 was strengthened during ensuring years. Once community members learned about ECC they were eager to know more about ECC in their community. IRB approvals were obtained from the Tribal College and the university. The research team consisted of two faculty mentors, one from the tribal college, and one from the university, and three tribal college research assistants. Data Collection included parental responses to A Basic Screening Survey for Parents; Screening for S. mutans in Head Start children via the Dentocult SM strip mutans chair side screen, and a visual oral mouth assessment.

**Results:** Parents (N=80) completed the Basic Screening Survey, 60% indicated the child brushed their teeth; 40% indicated an adult and child brushed the teeth; 80% would give the child water to drink between meals, although 75% currently provide child sugar based drinks between meals. 20% reported access to dental care was a major concern. Head Start children (N=60) were screened. Age ranged from 2 to 6 years. 70% of children had S. mutans in plaque or saliva, with 50% having medium to high levels. Observation revealed 10% of children required urgent/emergency care.

**Conclusions:** Community response was very positive; the visual presentation of S. mutans was informative. Culturally appropriate Health education and access to care is being addressed.

**Source of Funding:** Montana INBRE, AARA Project. Primary Award No. 3P20RR-16455-091 Allen Harmsen PhD Pi; Subaward No.G184-10-WR130

7. **EMERGENCY DEPARTMENT UTILIZATION FOR NON-TRAUMATIC DENTAL CONDITIONS IN MINNESOTA - TRENDS, DISPARITIES, & POTENTIAL FOR COST SAVING**

Sahiti Bhaskara (1,2), BDS, MPH Candidate; Merry Jo Thoele (1), MPH, RDH; Jon Roesler (1), MS
Minnesota Department of Health, St. Paul, MN, USA (1) University of Minnesota School of Public Health, Minneapolis, MN, USA (2)

**Objectives:** Describe trends in Hospital Emergency Department (EDs) utilization for non-traumatic dental conditions; characterize and model disparities in oral health care utilization based on geographic, socio-economic and other variables to guide targeted community interventions; develop and implement methodologies to estimate avoidable ED utilization costs.

**Methods:** Statewide ED visits from 2007- 2012 were identified from Minnesota's hospital discharge data, including demographic, diagnostic, procedure, and charge variables. Annual, hospital-specific cost-to-charge conversion ratios were obtained from CMS. Data from Minnesota Department of Human Services was used to determine costs for similar non-traumatic
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dental procedures in non-hospital settings. Adjusted general linear models were used for the cost analysis and adjusted logistic regression models, to characterize determinants of ED use.

Results: Preliminary results show increasing rate of utilization of EDs overall with highest rates among younger adults and those with lower socio-economic status. Multivariate analyses with additional risk factors will be presented. Total charges for the year 2009-10 were $80,356,318 with a median of $291/visit. Further results from the cost analyses will be presented. A combined model to predict high risk for ED use and associated costs will also be presented.

Conclusions: Growing use of EDs as a safety net is a sensitive indicator of the widening disparity in access to oral health care in Minnesota. While identifying high risk populations for policy and programmatic interventions, this study will also facilitate crucial information for systems-level changes around this issue. This model can further be used to evaluate intervention programs.

Source of Funding: Centers for Disease Control and Prevention US8DP001579 (DP08-802) and US8DP004899 (DP13-1307)

8. COMMUNITY HEALTH CENTER (CHC) HEALTH DASHBOARD - IMPLEMENTING AN ORAL HEALTH DASHBOARD TO STRENGTHEN PROGRAM QUALITY AND IMPROVE HEALTH OUTCOMES

Chad Lennox (1), MPH; Barbara Springer (2) Washington Dental Service Foundation, Seattle, WA, USA (1) Delta Dental of Colorado Foundation, Denver, CO, USA (2)

Objective: The session will describe the process used to develop the draft oral health dashboard, will introduce the measures, and will engage participants in an open dialogue on opportunities, challenges, and limitations to using an oral health dashboard within individual health centers.

Method: This project concept began in 2012 at the request of a small group of CHC dental directors who were interested in developing a dashboard with targeted and specific measures and determining if it could be an efficient and effective tool to drive quality.

Based on their mutual commitment to community health centers, Delta Dental of Colorado Foundation (DDCF) and Washington Dental Service Foundation (WDSF) came on board as project partners and contributors. In April 2013, the two organizations hosted a two-day convening for 25 CHC and national representatives where the group identified a set of measures and developed a draft dashboard.

Results: In March 2014, the test phase of the project will be completed. The session will describe results including the: 1) feasibility to collect, analyze and use the data; 2) the resources necessary to fully implement the dashboard, and 3) recommendations and feedback on the set of measures and their ability to accurately and effectively drive improvements.

Conclusion: Following the successful completion of the pilot testing, strategies and tools will be developed to assist CHCs in using the dashboard. An updated dashboard and user guide will be distributed to CHCs throughout Washington and Colorado and made available nationally, in partnership with NNOHA.

Source of Funding: Washington Dental Service Foundation, which is fully supported by Delta Dental of Washington. Delta Dental of Colorado Foundation, which is fully supported by Delta Dental of Colorado.

9. FACTORS RELATED TO DENTISTS’ DECISION TO PARTICIPATE IN MEDICAID: A CONJOINT ANALYSIS

Elham Kateeb (1,2), BDS, MPH, PhD; Gary Gaeth (2), PhD; Susan McKernan (2), DDS, MS, PhD; Ray Kuthy (2), DDS, MPH; Peter Damiano (2), DDS, MPH
Al Quds University, East Jerusalem, Occupied Palestinian Territory (1) University of Iowa, Iowa, USA (2)

Objective: We used a conjoint design to assess the trade-offs dentists face when presented with real life scenarios about new Medicaid patients. Conjoint data describe and predict factors that influence dentists’ decision to treat a Medicaid patient when faced with combinations of program and patient attributes.

Methods: An online conjoint survey was sent to 308 dentists in summer 2013. Using rating and ranking data from a previous survey of all Iowa dentists, four organizational, community, patient and policy factors were identified and used to build a nine item choice conjoint task.

Results: Surveys were completed by 60% of dentists (N=185). The probability of dentists accepting new Medicaid patients was highest (62.2%) for the following scenario: “Reimbursement rate was 85%; there were no other practices in the area accepting Medicaid, the patient sometimes misses an appointment and the claim may or may not be approved on initial submission”. When we hold other factors constant, conjoint data showed that increasing the Medicaid reimbursement from 55% to 85% increases the acceptance rate of new patients by 25%.

Conclusions: Within the scenarios presented, conjoint analysis revealed the subconscious tradeoffs dentists make when they decide to accept a new Medicaid patient. For example, although dentists preferred a higher reimbursement rate, the majority of dentists were willing to accept a new Medicaid patient when they were offered less reimbursement but promised that the patient would never miss an appointment and the claim would be approved on initial submission.

Source of Funding: Dentaquest grant

10. EMERGENCY DEPARTMENT VISITS FOR NON-TRAUMATIC DENTAL PROBLEMS IN OREGON STATE

Benjamin Sun (1), MD, PhD; Eli Schwarz (1), DDS, MPH, PhD; Donald Chi (2), DMD, PhD; Annick Yagapen (1), BA; Susan Malveau (1), MSc; Zunjiu Chen (1), MSc; Ben Chan (1), MSc; Sankirtana Danner (1), MSc; Erin Owen (3), Emerson Ong (4), Vickie Morton (1), Robert Lowe (1) Oregon Health & Science University, Portland OR, USA (1) University of Washington, Seattle WA, USA (2) Health Policy Research Northwest, Eugene OR, USA (3) 4Office for Oregon Health Policy and Research, Salem OR, USA (4)

Objectives: Emergency department dental visits are markers for inadequate dental care access. Hypothesis tested: ED dental visits are frequent, concentrated in Medicaid and uninsured populations, and costly.

Methods: We analyzed 2010 data from two sources. 1) Encounter data on all ED visits from a sample of Oregon hospitals using ED primary diagnosis code ICD-9: 520-525 with Payer as independent predictor. Multivariate regression assessed the adjusted association between dental visit and payer. 2) Oregon All-Payer All-Claims dataset on all ED visits by insured patients providing unique data on procedures, medications, and billing codes unavailable in hospital files. Costs were imputed by assigning payment tables to billing codes.

Results: Of 60 eligible hospitals, 24 provided ED data (higher proportion of urban and high volume facilities). Of
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745,348 ED visits, 15,018 (2%) were for non-traumatic dental problems. Less than 1% resulted in hospitalization. Payer was a powerful predictor of an ED dental visit (reference-commercial; Medicaid OR 4.0, 95CI 3.8-4.4; Uninsured OR 5.4, 95CI 5.0-5.7; Medicare 1.9, 95CI 1.7-2.1). APAC included 10,183 ED dental visits. Frequently prescribed medications included opioids (60%) and antibiotics (60%). The mean cost per visit was $280.

Conclusion: ED visits for non-traumatic dental problems are frequent, concentrated in Medicaid/ uninsured populations, and rarely result in clinically relevant interventions. Extrapolation to all Oregon hospitals suggests annual costs as high as $8 million. These findings are particularly relevant for states that are expanding Medicaid through the Affordable Care Act. Improving community based dental access may improve care and reduce costs.

Source of Funding: Oregon Oral Health Funders Collaborative

11. DEVELOPMENT OF AN INNOVATIVE COMMUNITY-BASED DENTAL HOME AND OUTREACH PROGRAM TO IMPROVE SERVICE DELIVERY AND CHILDREN’S ORAL HEALTH IN LOS ANGELES

Tarun Sandhu (1), BDS, MPH
UCLA, Los Angeles, CA, USA (1)

Objectives: 1) Improve community clinics’ capacity to deliver quality oral health care to over 50,000 young children; 2) Increase parents’ and child care providers’ awareness of the importance of oral health for preschool children; 3) Develop a sustainable community “dental home” model.

Methods: UCLA is collaborating with Safety Net Solutions (SNS), the Child Care Alliance of Los Angeles (CCALA) and the Community Clinic Association of LA County to implement a multi-faceted program in partnership with 22 clinics in Los Angeles County. Major program components include: a) clinic interventions to improve performance (including development of a quality improvement learning collaborative); b) disease management and training for dental and medical staffs, community health workers and child care providers; c) community systems development; d) innovative use of HIT for data acquisition, disease management and evaluation; and e) service-learning expansion. Funds provided by First 5 LA are allocated by UCLA to implement Clinic Enhancement Plans developed by SNS advisors. Child care provider training is conducted by UCLA-trained CCALA trainers. GIS technology is used to identify high-need areas and community resources.

Results: Enhancement plans and funding allocations for the initial 12 FQHC and FQHC look-alike clinics have been completed. Enhancement Plan implementation began in January, 2014. A child care provider oral health training curriculum has been developed and used to train 5 CCALA trainers, who in turn are training child care providers.

Conclusions: Development of multi-dimensional, community-based integrated service delivery and outreach programs can improve high-risk young children’s oral health and oral health care.

Source of Funding: First 5 LA (Los Angeles County Children and Families First - Proposition 10 Commission)

12. COMPARISON OF ESTIMATES OF HAVING A DENTAL VISIT IN THE PAST YEAR AMONG ADULTS FROM FOUR SURVEYS

Mei Lin (1), MD, MSc; Laurie Barker (1), MSPH; Chien-Hsun Li (2), MS, MA; Liang Wei (3), MS, MPH; Michael Manz (4), DDS, MPH, DrPH; Susan Griffin (1), PhD
Centers for Disease Control and Prevention, Atlanta, GA, USA (1) Northbrook Grammun Information Systems, Rockville, MD, USA (2) DB Consulting Group, Inc., Atlanta, GA, USA (3) University of Michigan, Ann Arbor, MI, USA (4)

Objectives: To compare prevalence estimates of having a dental visit in the past year (DV) among adults aged≥18 years from the Behavioral Risk Factor Surveillance System (BRFSS) to estimates from the Medical Expenditure Panel Survey (MEPS), National Health Interview Survey (NHIS), and National Health and Nutrition Examination Survey (NHANES).

Methods: We estimated DV for 2002 and 2010 using BRFSS, MEPS and NHIS, and for 1999-2004 using NHANES. We used the 2000 standard population to calculate age-race/ethnicity adjusted estimates overall and by age, race/ethnicity, education level, poverty status, and dentate status. T-tests (p≤0.05) were used to compare DV between BRFSS and the other surveys; and between 2002 and 2010 within BRFSS, MEPS and NHIS.

Results: In 2002, the overall DV estimate from BRFSS (69.8%) was significantly greater than estimates from MEPS (43.9%), NHIS (61.5%) and NHANES 1999-2004 (59.4%). Similar patterns of between-survey comparisons in DV were observed in 2010 and in most subpopulations. Overall DV decreased slightly but significantly from 2002 to 2010 within surveys: BRFSS (69.8% vs. 68.7%), MEPS (43.9% vs. 40.8%), and NHIS (61.5% vs. 60.4%). The direction of changes from 2002 to 2010 differed across surveys and subpopulations.

Conclusions: Overall DV estimates were highest from BRFSS and lowest from MEPS and slightly decreased from 2002 to 2010. When monitoring state progress in DV among adults using BRFSS (the primary source of state-level surveillance data for this indicator) towards national goals that use MEPS, NHIS, or NHANES, differences in estimates, survey methodologies and questions across surveys should be considered.

Source of Funding: None

13. IMPACT OF MEDICAID DENTAL FEE INCREASE ON CHILD UTILIZATION RATES AND EXPENDITURES

Howard Bailit (1), DMD, PhD; Tryfon Beazoglou (1), PhD
University of Connecticut, Farmington, CT, USA (1)

Objectives: Assess the impact of CT Medicaid fee increase on child utilization rates, expenditures, and dentist participation.

Methods: In 2008, child Medicaid dental fees were increased from the 7th to the 70th percentile of private sector 2005 fees. Using Medicaid enrollment and encounter data, utilization rates and expenditures before (2006) and after (2010) the fee increase were determined.

Results: The percentage of 12 month continuously enrolled children visiting a dentist increased from 46.0% to 69.1%. For ever enrolled children, visits increased 208,127 to 476,837 and expenditures $22.5M to $104.8M. The percentage of General and Pediatric dentists submitting one or more Medicaid claim increased from 15% to 60%.

Conclusions: Raising Medicaid fees to market competitive levels increased utilization rates. Continuously enrolled Medicaid and privately insured children now have similar utilization rates.

Source of Funding: Connecticut Health Foundation
14. THE MOTIVATION OF ORTHODONTISTS TO PURSUE PUBLIC HEALTH TRAINING

Annia - Beatrice Le Goff (1), DDS, MPH Student Scholar, Class of 2014; Burton L. Edelstein (1), DDS, MPH; Professor and Chairman of Section of Social and Behavioral Sciences
Columbia University College of Dental Medicine, New York, New York, USA (1)

OBJECTIVE: To test a novel theory-based model explaining orthodontists’ decisions to pursue formal public health training.

METHODS: The theories of planned behavior, self-determination, self-efficacy and ecological systems were amalgamated into an explanatory model from which 4 primary hypotheses and 36-survey items were developed. A closed-ended survey instrument using Survey-Monkey was developed and piloted with 10 public-health trained orthodontists with varying socio-demographic characteristics. No modifications were required based on pilot responses and feedback. The survey was distributed to 67 additional potential subjects identified through web searches with multiple search engines seeking to identify orthodontists who also list public health degrees (Certificate, MPH, Dr.PH, PH.D). Data was entered into Excel for descriptive statistical and chi-square analysis.

RESULTS: The 39 respondents (51% response rate) were 49% male; 51% female; 19% minority; 26% graduates of Harvard School of Public Health; 40% completing training before 1990 and 60% from 1991-2010. 41% of respondents reported that a faculty mentor influenced their decision to pursue public health. 50% who pursued public health before orthodontics (n=33) and all 6 respondents who trained in public health concurrently with or after orthodontics reported “genuine interest in public health” as the most important factor influencing public health training. 38% who pursued public health before orthodontics and 100% who pursued public health after orthodontics reported “currently utilizing their public health training.”

CONCLUSION: This analysis provides information useful to programs recruiting public health and orthodontic candidates who are genuinely interested in public health careers thereby maximizing the efficiency of their training programs.

Source of Funding: HRSA grant D8HP20031 Predoctoral Training Program in General, Pediatric, Public Health Dentistry and Dental Hygiene

2014 National Oral Health Conference®
We hope you will find this useful for notes on speakers and session for the online evaluation process.
Below is a list of topics that will be discussed during the Roundtable Luncheon on Monday, April 28, 2014 from 12:15pm-2:15pm. Please take a few moments to review this list and choose at least two topics of interest prior to the luncheon. The number listed next to the title is the table number assigned to that topic. Tables will be arranged in numerical order. Be sure to grab a box lunch before sitting down. Once attendees are settled at their tables, the first discussion will begin. After about 30-40 minutes, the moderator will direct attendees to move to a second table. We suggest that you have more than two topics chosen ahead of time since there is no guarantee you will find an open seat at your first choice. Seating will be first-come, first-seated, and the maximum number of participants at a table is limited to ten.

1. **WV ORAL HEALTH PROGRAM FOR ADULTS: ASSISTING CLIENTS IN PURSUIT OF EMPLOYMENT**
   Paula W. Legge, BA, Supervisor of WV Adult Dental Services
   The Pre-Employment Dental Project is a West Virginia WORKS support service for the purpose of transitioning adults from “welfare to work” (low income persons with children) in the home. County Family Support Specialists identify eligible individuals and complete a referral good for one year giving them $3,300 (a lifetime benefit) in covered dental services. Referrals can be renewed after a year if the person is still in the program and has benefited. Participating dental providers agree to accept reimbursement rates as specified in the fee schedule. Since 2000, the Pre-Employment Project has been instrumental in assisting persons in securing employment and advancement as well as improving self-esteem and oral health in general. Also, for over thirteen years the Project has been a very successful collaboration between two state agencies utilizing federal funds – the Bureau for Children and Families and the Bureau for Public Health.
   **Source of Funding:** Temporary Assistance for Needy Families (TANF) – Federal Funds

2. **SAVE A SMILE**
   Tonya K. Fuqua, DDS, Program Director, Save a Smile, Cook Children’s Community Health Outreach Department
   Save a Smile (SAS) is an innovative, nationally recognized, collaborative program dedicated to providing restorative and preventive dental care to low-income children through volunteer dentists/specialists. SAS was founded in 2003 by Cook Children’s in Tarrant County, Texas. A licensed master social worker (LMSW) manages community health workers who work directly in schools with students and their families to determine and assist with any social service needs they may have in addition to their dental issues (emergency assistance, transportation, translations, medical, optometry appointments, etc.). Children eligible are pre-kindergarten through third grade at high risk for dental disease from schools pre-selected by the program. Dental screenings (limited oral evaluations) are conducted annually by volunteer dentists to identify children with current or potential dental problems. Depending on the severity of the dental problem, age of the child, translation requirements, and financial/insurance status, a referral is made to the appropriate volunteer dental provider participating in SAS. Volunteer dentists are matched with qualifying patients and dental care is given in the dentists’ private offices, free of charge to the families and comprehensive in scope.
   **Source of Funding:** Civic, Corporate and Community Partners

3. **SMILES FOR LIFE ADULT SCREENING AND REFERRAL PROGRAM-A COMMUNITY PARTNERSHIP**
   Jason M. Roush, DDS, West Virginia Oral Health Program State Dental Director
   Smiles for Life developed after the 2009 Mission of Mercy (MOM) project over two days where 1,300 adults in which treated and received “most needed” dental treatment. Smiles for Life is a true public/private partnership fulfilling an unmet need in the community. Adult clients are screened through the health department and placed with area dentists who provide volunteer services from their own offices. Smiles for Life is unique in WV and the United States. Mid-Ohio Valley Health Department (MOVHD) Public Health Dental Hygienists act as gatekeepers, screening clients and gathering information to best serve clients and save time for the volunteer dentist. Most client records are transmitted electronically, a form of teledentistry. The Smiles for Life model provides a consistent, infection controlled source of care in lieu of a once a year mass clinic like a Mission of Mercy. Providers can be most efficient donating services from their own space while utilizing their own staff, equipment, and preferred dental materials. The Smiles for Life model is cost efficient compared to a private dental practice or fully staffed treatment facility. Preliminary data indicates that Smiles for Life contributes to a 14% reduction in Emergency Room visits for dental pain and infection, as well as it provides a resolution for the clients’ infection. In the first two years of operation, $700,000 in donated services and time has helped 865 adults receive needed dental treatment.
   **Source of Funding:** Sisters of St. Joseph Charitable Fund, Claude Worthington Benedum Foundation

4. **SUCCESS IN SOCIAL MEDIA DOES NOT COME BY CHANCE-IT ALL STARTS WITH A PLAN. LEARN HOW TO DEVELOP A SOCIAL MEDIA STRATEGIC PLAN FOR YOUR DENTAL ORGANIZATION, COALITION, OR PRACTICE.**
   Claudia A Serna, BDS, RDH, MPH, Florida International University
   Nowadays, people use social media as a tool to post comments and reviews, actively gather news and information, and share this with others. Social media platforms need to be constantly monitored since it is crucial to listen to their audience
Roundtable Topics

5. GADGETS, GIZMOS AND BASIC SCREENING SURVEYS
Kathy Phipps, DrPH, ASTDD Data Consultant

Is your state or local health jurisdiction planning on conducting a Basic Screening Survey (BSS) in the next year? Are you wondering what your options are for collecting BSS data? Do you dread the idea of receiving reams of paper from your BSS? If yes, then this roundtable is for you. In 2013, more than 50% of American adults had a smart phone and about 40% had a tablet or an e-book reader. Because of this it may be time to retire your paper forms and laptop computers and begin using these newer and relatively inexpensive electronic devices for collecting BSS data. During this session we will discuss and demonstrate a variety of different electronic methods for collecting BSS data using devices ranging from tablets to smart phones including Apple products and Android platforms. We will highlight the new Epi Info Companion for Android (http://epiinfoandroid.codeplex.com) and the associated BSS data collection forms developed by the Association of State and Territorial Dental Directors for Head Start, elementary school, and older adult surveys. The pros and cons of each system along with experiences from states will be provided.

Source of Funding: None

6. CARE IN SENIOR LIVING FACILITIES
Dr. Stuart Boekeloo, DDS, MBA, Aleydis Centers L.L.C.

Although there are over 40,000 facilities in the U.S., no one group or entity has researched the disjointed care performed in such facilities. Dr. Boekeloo became involved with this topic when an award winning assisted living facility in his hometown asked him to be the facility dentist. He was perplexed to learn that the facility had no designated area for care. He was encouraged to use the hair salon to render care as is the common method nationwide. He learned that the podiatrist often used the facility conference room as a treatment area. Dr. Boekeloo became concerned with the obvious lack of infection control, privacy, dignity, and HIPAA mandates, not to mention licensing violations. These facilities often have amenities that rival the best resorts. Hair salons, libraries, computer labs, woodworking shops etc., to name a few. It is clear that on site care will increase as baby boomers move into this phase of life. Dr. Boekeloo will share his findings after years of research and discuss the need for on-site multi-care treatment rooms, as well as proposed legislation enforcing this concept.

Source of Funding: None

7. PREPARING FOR OPPORTUNITIES TO PARTNER WITH INFANT MORTALITY INITIATIVES TO ADDRESS THE ORAL HEALTH OF WOMEN AND INFANTS
Chris Farrell, RDH, MPA, Michigan Dept. of Community Health Oral Health Program

Infant mortality is a leading indicator of the health of a nation. In 2008 the U.S. ranked 27th in infant mortality among industrialized nations. State programs are working collaboratively to identify methods, including oral health promotion, to improve birth outcomes. Michigan has embarked on a plan to reduce infant mortality and improve the health of women and children. This round table discussion will explain the federal Collaborative Improvement & Innovation Network to Reduce Infant Mortality and how oral health professionals can get involved. The Michigan Oral Health Program will outline efforts to address the oral health needs of pregnant women and infants within their Infant Mortality Initiative. Participants will be engaged to identify their “readiness” for addressing oral health through initiatives focused on targeted populations, not specifically oral health.

Source of Funding: None

8. NATIONAL CENTER ON HEALTH, ORAL HEALTH PROJECT
Katrina Holt, MPH, MS, RD, National Center on Health

The federal Office of Head Start established the National Center on Health (NCH) to help ensure that Head Start agencies have access to high-quality information, training, and technical assistance to effect the best possible outcomes for those enrolled in Head Start. NCH builds on the capacity of Head Start staff to effectively serve pregnant women, infants, and children by implementing a comprehensive health program that includes physical health, mental health, nutrition, and oral health with a focus on health promotion, disease prevention, and early intervention. NCH’s oral health activities include identifying, developing, and disseminating science- and practice-based resources; monitoring data; providing trainings and technical assistance; and fostering communication and collaboration between Head Start staff and stakeholders at the national, regional, state, and local levels. The center includes the following partners: the American Academy of Pediatrics; the Education Development Center; Georgetown University, Center for Child and Human Development; Georgetown University, National Maternal and Child Oral Health Resource Center in collaboration with the Association of State and Territorial Dental Directors; the University of California at Los Angeles, Health Care institute; and the University of North Carolina at Chapel Hill, National Training Institute for Child Care Health Consultants.

Source of Funding: Office of Head Start

9. NEW YORK STATE PERINATAL AND INFANT ORAL HEALTH QUALITY IMPROVEMENT PILOT PROJECT AND MCHB’S NATIONAL INITIATIVES
Jayanth V. Kumar, DDS, MPH, Bureau of Dental Health, New York State Department of Health

The Health Resources and Services Administration (HRSA) recently awarded three states—New York, Connecticut; West Virginia—for the Perinatal & Infant Oral Health Quality...
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Improvement (PIOHQI) Pilot Grant. This four-year grant is a part of three-phase Perinatal and Infant Oral Health National Initiatives of the Maternal and Child Health Bureau (MCHB) and will assist these three states to 1) demonstrate implementation of innovative community-based oral health programs for pregnant women and infants at risk with statewide reach; 2) be part of the Perinatal and Infant Oral Health State-National Collaborative Network for development of a national strategic framework and 3) mentor additional states, later funded by PIOHQI Expansion grant, to replicate the innovative approaches that successfully improve oral health status of pregnant women and infants most at risk. New York State plans to integrate oral health into the statewide Maternal and Infant Community Health Collaboratives (MICHC) – a project designed to improve health outcomes of high-risk mothers and infants. MICHC uses a case management model as well as social media and text messages to address various barriers to perinatal health care and information among high-risk mothers while addressing workforce and financial barriers in the perinatal health care system.

During this roundtable presentation, attendees will learn about the PIOHQI project and what innovative approach a state is using. In addition, overall goals of the MCHB’s Perinatal and Infant Oral Health National Initiatives and grant funding opportunity will be discussed.

Source of Funding: None

10. MARICOPA COUNTY FIRST TEETH FIRST FLUORIDE VARNISH PROGRAM–STRATEGIES FOR PROGRAM IMPLEMENTATION AND BUILDING COLLABORATION WITH STATE MEDICAID HEALTH PLANS ADMINISTERED BY THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Kimberly Richards, Office of Oral Health, Maricopa County, Department of Public Health

In 2011 the First Teeth First Oral Health Program began delivery of services to children ages zero through five years. In 2013 First Teeth First has grown to be the largest program of its kind in the nation screening 15,488 children. The program is administered by the Maricopa County, Department of Public Health, Office of Oral Health, and provides oral health screening, referral and fluoride varnish to decrease the risk of early childhood caries.

Education is a primary focus, by applying interventional strategies such as utilizing the oral health screening as a “teachable moment” to illustrate the vertical transmission of bacteria from parent to child. Motivational interviewing principles are incorporated to elicit positive change around nutrition, behavior, and oral hygiene practice to increase overall health for all family members. First Teeth First co-locates services at strategic sites to reach target populations, including Maricopa County Women, Infant and Children (WIC) clinics and immunization clinics.

An aspect unique to the program is the case management of urgent need cases through partnerships fostered with health plans for the state Medicaid program, Arizona Health Care Cost Containment System (AHCCCS) and the community clinics in the county.

This roundtable will discuss the collaborative model implemented by First Teeth First to address the prevention of early childhood caries through caries risk reduction and address barriers to care by partnering with Medicaid health plans and community clinics.

Source of Funding: First Teeth First Arizona

11. THE UTILIZATION OF SALIVARY DIAGNOSTICS IN A MATERNAL ORAL HEALTH PROGRAM TO REDUCE RISK OF ADVERSE PREGNANCY OUTCOMES

Kirsten Roling, DDS, Office of Oral Health, Maricopa County, Department of Public Health

Periodontal disease and associated pathogens have been implicated in adverse pregnancy outcomes including preterm labor and low birth weight. Periodontal therapy may reduce adverse pregnancy outcomes, through a dual therapeutic approach by the obstetrician and dentist. In lieu of periodontal probing that provides limited diagnostic value, salivary testing is an optional diagnostic tool to determine the level and species of periodontal pathogens and targeted treatment modalities. Screening and test results are then shared with the treating obstetrician and dentist to help reduce the risk of poor pregnancy outcomes. The First Teeth First, Maternal Oral Health Program, administered by the Office of Oral Health, Maricopa County Department of Public Health, was implemented in 2012 and provides oral health screenings, education, and referrals for pregnant women in WIC clinics across Maricopa County, Arizona.

Source of Funding: First Teeth First Arizona

12. CAMPAIGN FOR DENTAL HEALTH – SPREADING THE POSITIVE WORD ABOUT FLUORIDATION

Holli Russinof, MUPP, American Academy of Pediatrics

The Campaign for Dental Health (CDH) was created to ensure every American has access to the most affordable, effective, and basic oral health intervention—fluoridation. We are a network of local, state, and national groups and scientists working together to protect our nation’s gains in oral health. The CDH uses creative strategies to combat fluoridation challenges as well as support communities who are working to fluoridate for the first time. The ilikemyteeth.org web site serves as the anchor for the campaign with quick facts about fluoride, a blog, resources for health care providers, partners, and scientists, child sites for use by local campaigns, and quick links to social media outlets. The CDH is also building a community of pro-fluoridation advocates that can help communities respond quickly and accurately when challenges occur. At this roundtable, we will discuss the resources CDH has to offer and entertain questions/comments and need for support from attendees who may be facing fluoridation challenges or who are charged with preserving the practice in the community.

Source of Funding: Pew Charitable Trusts

13. KEEP KIDS SMILING: PROMOTING ORAL HEALTH THROUGH THE MEDICAID BENEFIT FOR CHILDREN & ADOLESCENTS

Laurie Norris, JD, Centers for Medicare and Medicaid Services

CMS will discuss its recently released children’s oral health strategy guide, focusing on proven strategies to help states increase use of dental services by children enrolled in Medicaid. Approaches include policy changes, maximizing provider participation, directly addressing children and families, and partnering with oral health stakeholders. Recently released Think Teeth oral health education materials will also be discussed.

Source of Funding: Federal funding
14. THE NEW DRINK PYRAMID: PICKS UP WHERE THE MYPLATE. GOV NUTRITION ICON LEAVES US WONDERING HOW TO MAKE HEALTHY DRINK CHOICES  
Daria Nicole Stone, DMD, University of Kentucky  
The original USDA Food Pyramid taught Americans how to make healthy food choices, but was silent on the issue of drink choices. Over time, that original pyramid (which proved effective in lowering saturated fat and cholesterol consumption and decreased US death rates for heart disease) evolved into the MyPlate icon, and for the first time, included a drink. The blue liquid in the cup simply says, “Dairy,” leaving much room for interpretation, and giving little instruction on other choices.  
So, what should we drink? How much? How often? The new, simple, straightforward, colorful, and fun “Drink Pyramid” gives some clear answers. Using pictures and mnemonic clues, it is easy to understand and to remember, even for children. In two pilot studies with Kentucky elementary school children, 80-90% of 1st and 3rd graders remembered every tier of the Drink Pyramid after only seeing it once, and drink choices and behaviors were improved, with children drinking more water and less soda pop.  
A new website, www.drinkpyramid.com, includes information about the new Drink Pyramid as well as supplies that can be used in educational campaigns: appropriately sized cups (4 ounces for children aged 1-6, and 8 ounces for children aged 7-12), refrigerator magnets to reinforce the message at home and remind parents what should be in the refrigerator, posters for teachers to use in classrooms, hallways, and cafeterias, and interactive display boards that can be used as part of health literacy campaigns where children can interactively “build” the drink pyramid together.  
Source of Funding: None

15. FLUORIDATION CAMPAIGNS AND UNINTENDED CONSEQUENCES  
Jane S McGinley, RDH, MBA, American Dental Association  
Even the best planned fluoridation campaigns can have unintended consequences – good and bad. How can a fluoridation defeat be viewed as having some positive outcomes? How can the passage of a state fluoridation mandate (normally considered a good outcome) actually limit the implementation of fluoridation programs? How can fluoridation activity in neighboring states_communities have an effect on your efforts? How might your efforts have a positive or negative effect on other local fluoridation programs? The roundtable discussion will include examples of these outcomes and assist attendees in identifying possible positive and negative unintended consequences that may occur as a result of their efforts.  
Source of Funding: None

16. VISUAL THINKING STRATEGIES –CAN ART BE COMBINED WITH PUBLIC HEALTH EDUCATION?  
Thayer E Scott, MPH, Henry M Goldman School of Dental Medicine  
Visual Thinking Strategies (VTS) is an innovative educational method that involves close examination of artwork while a trained VTS educator facilitates a non-judgmental discussion for approximately 15 minutes. Participants’ various perspectives and interpretations of the artwork are reflected back to them by the VTS educator without conveying the ‘answer,’ allowing participants to make their own unique interpretations and find their own answers. Several studies suggest that VTS can stimulate critical thinking and problem solving, improve communication, acceptance of different viewpoints, teamwork, attention/concentration, and visual skills. VTS is currently being used with all levels of education ranging from grade school to professional level training. To date, both Harvard Medical School and BU Dental School employ this technique to strengthen visual discernment and attention to detail, with the aim of enhancing diagnostic skills.  
While the link between visual examination of art and diagnosis may be intuitive, we speculate that practice observing and detecting patterns in artwork might also be translated into identifying and communicating higher level patterns and connections in data figures and tables. The aim of this roundtable is to introduce the VTS method through a brief demonstration of a visual thinking strategies session, and will be followed by a discussion of our pilot experience utilizing the VTS method as a fun way to help students increase their insights in understanding and interpreting, discerning, and communicating patterns in data figures and tables.  
Source of Funding: None

17. ANTIBIOTIC-ASSOCIATED CLOSTRIDIUM DIFFICILE INFECTION: WHAT IS THE ROLE OF THE DENTAL PROFESSION?  
Barbara Smith, PhD, MPH, RDH, American Dental Association  
Clostridium Difficile infection (CDI) is a potentially severe complication of antibiotic administration. However, dental professionals may not be aware of the changing epidemiology of the disease, the need for rapid identification of CDI to initiate therapy and prevent complications, and the potential public health risks. Dentists play a key role in patient education as they prescribe antibiotics. Simple strategies can be implemented in the dental practice to communicate with patients and potentially save lives, prevent pain and suffering, and reduce the cost of managing healthcare acquired infections.  
This Roundtable will provide an overview of CDI and seek input on how the dental team can specifically address this issue. The conversation will also focus on elderly patients who are at particularly high risk for CDI and the severe complications that may result from this disease. Join us and share your thoughts on the role of the dental profession in implementing strategies to mitigate the disease if it occurs, and to be good stewards in the prescription of antibiotics.  
Source of Funding: None

18. APPRECIATING THE VALUE OF AUDITS, WHILE QUESTIONING THOSE THAT DEFY COMMON SENSE  
Steven P Geiermann, DDS, American Dental Association  
Healthcare professionals have always known that quality assurance typically involves some form of peer review and/or chart audit. Healthcare providers want to provide the best quality care to patients and be compensated to an appropriate degree in a timely manner. Audits can be instructive, enlightening, and can even be used to incentivize best practices. Yet, some audits prompted by the Accountable Care Act, namely the Recovery Audit Contracting Program (RAC), have pushed the perception of audits far to the “punitive side” in the minds of many individual practitioners and group practices. Misunderstanding on the part of both providers and auditors threaten to force existing providers out of the system and scare away new providers considering participation. How can CMS, state dental Medicaid programs, third party payors, and practicing dental providers come together to educate and find common ground with those who conduct audits of all kinds? Where is the middle ground, as none of us condone fraud or compliance abuse? Come and hear what oral health stakeholders
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are doing to address these issues and to lend your voice to the discussion. Be part of the solution!

Source of Funding: None

19. THE ROLE OF THE DENTAL HYGIENIST IN RESPONDING TO DISPARITIES IN CHILDREN’S ORAL HEALTH
Anne Varcasio, RDH, MA, American Dental Hygienists Association, Council on Public Health
The American Dental Hygienists Association’s core ideology is to lead the transformation of the dental hygiene profession to improve the public’s oral and overall health. This Roundtable presentation supports this core ideology by providing an educational opportunity for dental hygienists and dental hygiene educators to discuss the roles of dental hygienist in supporting public oral health strategies in their practices and educational programs.

The Roundtable session will provide an opportunity to identify the roles of dental hygienists in support of community water fluoridation and school-based dental sealant programs. The Roundtable session will focus on the following:

Identify the role of dental hygienists in promoting evidence-based community water fluoridation and school-based sealant programs in clinical practice and community settings.

Identify social factors that support fluoridation and sealant programs and the role of the dental hygienist in promoting public health activities.

Inspire further discussion on the role of dental hygienists for reducing disparities in children’s oral health.

Source of Funding: None

20. NEW STRATEGIES TO ADVANCE COMMUNITY WATER FLUORIDATION
Kristen Mizzi, Pew Children’s Dental Campaign; Emily Firman, MPH, MSW, Washington Dental Service Foundation
Community Water Fluoridation now serves about 75% of Americans on public water systems. Despite the support of the Centers for Disease Control and Prevention, which named fluoridation one of ten great public health achievements of the 20th Century, and nearly every medical, dental, and health organization in the nation, decisions to fluoridate or remove fluoridation from water supplies are often made at a local level by city councils, water boards, or by public referenda. These processes often lead to unnecessary and counterproductive debates, indecision by elected officials, or losses at the polls as a result of voters whose decisions are swayed by small, misinformed groups of fluoridation opponents.

Recently, in an effort to ensure more people have access to the benefits of fluoridated water and to ensure communities continue to fluoridate, some states have pursued, adopted, or adapted policies supportive of fluoridation. For example, states have passed legislative mandates requiring defined systems that are not fluoridated to implement the benefit, pursued policies that protect consumers’ rights to maintain fluoridation, and endorsed community water fluoridation even without legislation.

This Roundtable discussion will highlight recent efforts to advocate for fluoridation policy changes at the state level, including efforts to pass “prior notice” legislation and secure endorsement of fluoridation by state boards. Presenters and participants will share strategies, successes, lessons learned, and potential future legislative and regulatory options.

Source of Funding: Pew Charitable Trusts; Washington Dental Service Foundation

21. THERE’S AN APP FOR THAT: INTRODUCING NEW SMILESMAKER PLATFORMS FOR ELECTRONIC BASIC SCREENING SURVEY DATA ENTRY
Annaleise Cothron, BS, MS, University of Texas Health Science Center at San Antonio
At the National Oral Health Alliance colloquium addressing Oral Health Metrics (2013), a recommendation was made to explore systematic approaches to gather, integrate, and utilize oral health data on a national scale. Collection of data that is standardized, reliable, and valid is essential to generate comparisons that foster policy change at the local, state, and national levels. SmilesMaker®, an innovative electronic data entry tool, has been utilized by school-based prevention programs in South Texas for several years. Collecting longitudinal Basic Screening Survey data quickly and efficiently, with or without internet access, has been the key specification in development and design of this unique tool. SmilesMaker® has now been expanded to incorporate new features, including a dashboard monitoring tool to provide real-time feedback and reporting to enhance programmatic decision-making based on real-time outcomes of data collection. The new auto-sync function allows for smooth transition of data when collecting offline, either through the SmilesMaker® App or the local copy housed on your laptop. The SmilesMaker® Web Portal creates a web-based data entry system designed for use on desktop, laptop, or any tablet device. Reporting features incorporated into SmilesMaker® as well as the ability to download formatted data for sophisticated analyses gives informational tools to programs for more efficient operations, targeted interventions of high-risk populations, and implications for meaningful use on the local, state, and national levels.

Source of Funding: Supported by the DentaQuest Foundation and HRSA T12HP19338

22. ORAL HEALTH OUTREACH INITIATIVE IN NORTHEAST OHIO
Margaret E. Ferretti, DMD, Case Western Reserve University School of Dental Medicine and Rainbow Babies & Children’s Hospital of University Hospitals
Dental care is the most common unmet health care need in Ohio’s children. Access for basic and extensive oral health care is a challenge. Patients and parents who face the hurdles of missing school or work in order to keep their appointments have contributed to the increasing number of children with dental needs unmet. 51% of the children in Ohio in 2009 experienced some form of tooth decay by the third grade; almost 340,000 in Ohio have never seen a dentist. The initiative of our pediatric dental outreach program is to provide access to dental care in areas where it is limited.

The aim of this roundtable is to present a model of a pediatric dental outreach program that has successfully provided dental services to local, urban, and rural communities in Northeast Ohio for children who have limited access to dental care.

An institutional and hospital-based pediatric dental outreach program using on-site preventive care and follow up treatment in a mobile care unit was developed to provide dental services for children in early Head Start, Head Start, elementary, and middle schools to children through 12 of age. This model outreach program has allowed us to provide oral health care at 365 centers and schools for 26,400 children from 2007 to 2013.

Participation in this roundtable will allow for understanding and implementation of combined preventive services and follow up treatment program. There will be an explanation of startup
23. PERFORMANCE MANAGEMENT OF THE COMMUNITY WATER FLUORIDATION PROGRAM IN NEW YORK STATE
Erin C Knoeri, MPH, New York State Department of Health
The New York State Department of Health's multi-year strategic plan has seven priority areas including "Become a Model Performance-Based Organization," which focuses on continuously establishing performance standards, utilizing data to measure and monitor progress, and reporting regularly to stakeholders. The goal of Performance Management is to increase efficiency and effectiveness to create steps to improve health outcomes in communities.

The prevention of dental caries was identified as a priority maternal and child health outcome and the improvement of water quality as a priority environmental health outcome in the Prevention Agenda, New York State's Health Improvement Plan for 2013-2017. Both sections of the Prevention Agenda list Community Water Fluoridation (CWF) as an objective: “By 2017, increase the percentage of NYS population receiving fluoridated water by at least 10%. (Baseline: 71.4% in 2012).” The Department's Bureau of Dental Health (BDH) has applied the core concepts of Performance Management including performance standards, measurement, and reporting along with quality improvement to assess the Prevention Agenda objective and New York’s CWF Program.

The Roundtable session will outline the steps BDH took to: Determine and define the CWF activities and performance standards. Identify data and monitor progress for all capacity, process, and outcome performance measures. Analyze data and report to stakeholders. Develop and test quality improvement steps.

Source of Funding: None

24. NON-TRADITIONAL TOBACCO PRODUCTS – A GROWING TREND
Sharon Clough, MS Ed, American Dental Association
The use of non-traditional tobacco products is on the rise. Most troubling, is the increased use of non-traditional tobacco products by adolescents and young adults. Studies indicate that the use of electronic cigarettes by middle school and high school female students has doubled. Hookah use has increased by more than 40% for non-Hispanic white high school students. Among high school students, smokeless tobacco is the third most commonly used tobacco product. The discussion of tobacco use prevention is not limited to traditional tobacco products.

To counsel patients about tobacco use prevention or cessation, or advocate for strategies to reduce use of these products, knowledge of the types of both traditional and non-traditional tobacco products is a must. What are the various types of non-traditional tobacco products? Why is the use of non-traditional tobacco products becoming so popular? Learn answers to these questions and more by joining this roundtable discussion.

Source of Funding: None

25. TEACHING WITH TEETH
Anne Clancy, RDH, MBA, Chicago Community Oral Health Forum
Chicago Community Oral Health Forum (CCOHF) has developed a full oral health curriculum that is taught in the Chicago Public Schools, which is the 3rd largest district in the United States with a population of 405,644 students. CCOHF’s curriculum ranges from Pre-K through 12th grade.

CCOHF’s oral health educators demonstrate to CPS students the causes of and the preventive measures for cavities and gum disease, as well as proper brushing and flossing techniques. Through education about healthful eating, oral trauma prevention, smoking cessation, oral piercings, and sport safety, students are better able to maintain optimal oral health. Practice models include visual aids, large-scale model sets of teeth for OHI technique, and hands-on activities as a teach-back method of learning. These resources allow students to prepare for a stress-free dental visit, as well as emphasize the importance of biannual dental checkups.

CCOHF developed a “Train-the-Trainer” program, which instructs other community educators on effective ways to teach. The curriculum covers rules, attention maintenance techniques, the importance of visual aids, and the basics of oral hygiene self-care. The program teaches other educators how to effectively use the curriculum, and includes evaluation and tracking forms for reporting.

The curriculum encourages schools to provide education that supports healthy children and their wellness. Such education benefits students, physical education teachers, nurses, food personnel, and wellness team members.

Source of Funding: Wm. Wrigley Jr. Company Foundation

26. EXPLORING THE POTENTIAL FOR FOUNDATION GRANTS TO FUND WATER FLUORIDATION
Barbara C. Newhouse, MPH, CDC, Division of Oral Health
Many communities need assistance in funding water fluoridation equipment, either for replacement at existing facilities or for a new fluoridation installation. One possible funding source is to obtain foundation grants. Foundations are looking for value-added opportunities to improve communities and fluoridation can be a significant opportunity for involvement. This roundtable will discuss the potential ways for a State Coalition or other organization to seek funds, how to apply for funds, how to build a successful grantee-funder relationship, and how to create a record of success.

Source of Funding: None

27. STRENGTHENING SCHOOL-BASED DENTAL SEALANT PROGRAMS THROUGH POLICY DEVELOPMENT, INNOVATION AND PARTNERSHIPS
Amy Umphlett, MPH, Oral Health Unit, Oregon Health Authority
When state oral health programs are faced with stagnant or reduced budgets, it becomes difficult for state programs to build infrastructure necessary to perform essential functions. This roundtable is a case study that describes how Oregon has been able to create and continue to expand a statewide school-based dental sealant program with limited resources through policy development, innovation and partnerships.

Oregon’s School-based Dental Sealant Program has expanded every year since its inception in 2006, with 158 schools served during the 2012–13 school year compared to 11 schools in 2006-07. The program is now piloting the usage of iPads for field data collection and providing expanded clinical services. Working closely with partners, dental collaborations are being
organized statewide and policy initiatives are moving forward within the legislature.

Please join us at this roundtable to learn more about:

- How a state oral health program uses innovation and technology to expand a school-based dental sealant program on a stagnant budget. Includes an iPad demonstration.
- How Oregon has used policy development to expand its statewide school-based dental sealant program.
- The value of collaborative partnerships with community partners to implement a successful program.
- How Oregon's School-based Dental Sealant Program links to new health transformation initiatives underway in Oregon – Coordinated Care Organizations and Early Learning Council.

Source of Funding: Health Resources and Services Administration (HRSA) Grants to States to Support Oral Health Workforce Activities

28. THE DEVELOPMENT AND IMPLEMENTATION OF A CULTURALLY COMPETENT STORYTELLING BASED EDUCATIONAL INTERVENTION TO PREVENT EARLY CHILDHOOD CARIES IN AMERICAN INDIAN/ALASKA NATIVE POPULATIONS IN CALIFORNIA.

Aley Joseph, MPH, MS, California Rural Indian Health Board

This roundtable will discuss the development and implementation of a storytelling-based educational intervention on dental health for American Indian/Alaska Native (AIAN) populations. Storytelling has been a treasured part of Native culture that brings to life values such as wellness, the next generation, and wisdom of elders. The Native Oral Health Project (NOHP) is a developmental project, supported by the NIDCR, that takes advantage of new and existing partnerships developed by the California Tribal Epidemiology Center (CTEC) and Dental Support Center (DSC) of the California Rural Indian Health Board (CRiHB), with organizations and members of the AIAN community in California, as well as academic experts in oral health. We use these networks to develop, implement, and assess the feasibility and acceptability of an educational intervention to prevent early childhood caries among AIAN children. The intervention is a traditional story that incorporates 10 oral health messages aimed at caregivers of young children. Discussion of NOHP Development will focus on measures taken to establish partnerships and communication with key stakeholders, including traditional storytellers and a community advisory board, and the development of a traditional story (intervention) to incorporate contemporary messaging while ensuring the retention of its traditional foundation. Discussion of NOHP Implementation will focus on the execution of storytelling sessions, strategies to recruit and retain participants, gathering feedback, and challenges faced. Finally, we will briefly discuss plans for future implementation on a wider geographic scale, while building upon community collaborations and partnerships formed in this developmental project.

Source of Funding: This work was made possible through the support of the National Institutes of Dental and Craniofacial Research (NIDCR) of the National Institutes of Health (NIH) through Exploratory/Development grant R21DE021573. Technical assistance and support has been provided by the NIDCR-funded Early Childhood Caries Collaborating Centers (known as EC4) at Boston Univ. (US4DE019275), Univ. California San Francisco (US4 DE 019285), and Univ. Colorado Denver (US4 DE019259).

29. DEVELOPMENT OF REGIONAL SEALANT PROGRAMS USING AN INNOVATIVE WORKFORCE MODEL

Armando E Soto-Rojas, DDS, MPH, Indiana University School of Dentistry

The Indiana University School of Dentistry (IUSD) and the Oral Health Program at the Indiana State Department of Health (ISDH) in partnership with school corporations in Northwest Indiana and two Federally Qualified Health Centers (FQHC) is testing a pilot program to prevent dental caries in low-income children. IUSD and ISDH aim to increase the number of low-income children who receive dental sealants. This roundtable will describe the development and implementation of regional sealant programs in rural areas utilizing an innovative hygienist-based workforce model in Indiana. Our goals were: (1) to recruit dentists and dental hygienists to work in new school-based dental programs (SBDP) supported by FQHCs during year one; (2) to provide funds to support initial operation of the programs and purchase portable dental equipment to provide services in these clinics during year two; and (3) to provide logistical support to develop and establish these new school-based dental sealant programs. Ultimately the program goal will benefit participating clinics by augmenting their oral health care capacity and local schools by increasing the number of pain free children. We will describe the development of the program policies and procedures and lessons learned through the initial implementation process, the program’s day to day operation; we will also describe a model for program evaluation and assessment of both oral health outcomes and process of implementation. Finally, we will describe the need for new models for SBDP, program policies, and procedures, and lessons learned through the day to day operation, and program evaluation and assessment.

Source of Funding: 120821_NoA HRSA 1 T12HP24723-01-00

30. GLOBAL TREATY TO PHASE DOWN THE USE OF DENTAL AMALGAM: THE MINAMATA CONVENTION ON MERCURY. POLICY DEVELOPMENT BY THE AMERICAN PUBLIC HEALTH ASSOCIATION.

Howard F. Pollick, BDS, MPH, School of Dentistry, UCSF

Events leading up to the Minamata Convention on Mercury included a letter, dated February 23, 2012, endorsed by the World Federation of Public Health Associations recommending ‘Support for phase outs of mercury use in dentistry in the EU and globally’. In response, members of the Oral Health Section of the American Public Health Association submitted an evidence-based proposed policy on ‘Dental Amalgam—Preserving a Proven Dental Material’: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1442 This policy was approved by the APHA Governing Council on 10/30/2012. The policy was highlighted by the American Dental Association (ADA News, Nov 7, 2012: http://www.ada.org/7937.aspx ). ADA, IADR, and other representatives had been heavily involved in discussions on dental amalgam and had attended global meetings leading up to the Minamata Convention.

Because it was proposed late in the regular timeline, the APHA policy remained policy for only 12 months. Following discussion with members of other APHA sections who had voiced opposition or concerns with the policy, the APHA Joint Policy Committee rejected a subsequent submission in 2013 of a revised proposed policy, mainly because of individual objections. At the 2013 annual meeting, on November 5, APHA Oral Health Section members met with three who opposed the proposed policy to discuss future direction for APHA. Subsequent to that...
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meeting, on November 6, the Minamata global treaty was signed by the United States. The treaty calls for a phase down of the use of dental amalgam, rather than a phase out. Details of the phase down in the treaty will be discussed.

Source of Funding: None

31. SEALS – TRY IT, YOU WILL LIKE IT!
Clare Larkin, RDH, MSED, Minnesota Department of Health

Do you work with school-based/linked sealant programs (SBLSP)? Do you wonder how to assess efficiency and effectiveness of your interventions and how to evaluate your success? Join us as we share our experiences and explore the Sealant Efficiency Assessment for Locals and States (SEALS) software! Whether you are a new or proficient user of this EXCEL-based software, there will be something for you to learn. We will share our positive experiences and lessons learned in using SEALS to evaluate our school-based/linked sealant programs and provide practical tips to address the challenges we faced. We will also demonstrate the features and capacity of SEALS to capture, store, and analyze sealant data as well as its limitations. Those who have been using SEALS will be encouraged to share success stories and challenges in using the software.

The objectives are to: explore the SEALs software program through an open discussion format; provide practical tips to participants on how to address the challenges of using the EXCEL-based program; collect information from users and potential users to share with CDC and the sealant communities of practice; and encourage school-based/linked sealant programs to utilize SEALs to assess efficiency and effectiveness of their programs.

Together, participants will create a comprehensive list of user experiences and suggestions to share with CDC to enhance and improve SEALs. Participants will be encouraged to utilize SEALs to assess program efficiency and effectiveness and to assure accuracy in their program cost analysis.

Source of Funding: Delta Dental of Minnesota Foundation. Centers for Disease Control and Prevention USDP001579 (DP08-802) and USDP004899 (DP13-1307). Health Resources and Services Administration T12HP14659.

32. BEST IN CLASS
Mark J. Doherty, DMD, MPH, DentaQuest Institute

This roundtable presents lessons learned from eight years of practice management technical assistance to over 200 safety net dental practices. What operations, systems, and strategies do public health safety net dental practices utilize to achieve documented oral health improvement in patients, assure quality care and quality improvement, maximize access and maintain financial sustainability? Come to this roundtable to learn how those safety net dental practices that are “best in class” have organized their operations for maximum success.

Source of Funding: None

33. DEFINING CAPACITY AND PRODUCTIVITY: BALANCING OUTCOMES AND SUSTAINABILITY
Dori Bingham, BA, DentaQuest Institute

Often our dental programs are stretched too thin trying to meet an overwhelming demand for care from patients. However, there are also times when “we build it, and they don’t come.” Both situations present operational challenges that need to be addressed. Every safety-net program needs to know its maximum capacity and manage to that capacity. In addition to understanding capacity, safety-net dental programs need to have goals designed to achieve strategic clinical, financial, and access outcomes. This roundtable will help participants understand how to define maximum dental program capacity, learn strategies for maximizing and managing program capacity, and what outcome measures should be tracked, and how to establish provider goals.

Source of Funding: None

34. CUSTOMER SERVICE BASICS
Caroline Darcy, BA, DentaQuest Institute

The quality of the dentistry we provide is extremely important. However, without good customer service, we wouldn’t have any patients to care for. Customer Service is just as important as the quality of our dental care. In this roundtable we will discuss seven basic tenets of good customer service skills, as well as tips and scripts.

Source of Funding: None

35. MARKETING BASICS FOR SAFETY NET DENTAL PROGRAMS
Laura Skaret, BS, RDH, DentaQuest Institute

Sometimes safety-net dental programs struggle to reach their maximum operating efficiency. They simply do not have a sufficient number of patients to fill their chairs each day. Not only is this frustrating for the dental providers who want to provide care to their community, it also causes strain on the entire program’s financial sustainability. This roundtable will help participants understand basic marketing best practices. They will learn how to convey the value of their dental clinic to the community. Because there is no “one size fits all” solution, various strategies for marketing will be discussed. A “FOCUS PSDA” approach to marketing techniques will be explained and encouraged.

This marketing roundtable complements the roundtable presentation titled “Understanding Your Capacity.” Knowing/understanding what your true capacity can be is a prerequisite to beginning any marketing endeavor. Participants will be encouraged to attend both presentations.

Source of Funding: None

36. CONDUCTING ORAL HEALTH SURVEILLANCE UTILIZING DIRECT DATA ENTRY
Donna Solovan-Gleason, PhD, Florida Department of Health

In 2013, the Florida Department of Health in collaboration with the Florida Dental Hygiene Association completed the Third Grade Surveillance survey utilizing direct data entry for recording screening results. Teams of dental hygienists and recorders conducted screenings in forty-one schools across nineteen counties following the Basic Screening Survey protocols and entering data on laptop computers. Screening teams were queried to determine advantages and disadvantages of using direct data entry for conducting surveillance. This roundtable will present the methodology used for data entry and discuss how the process enhanced data collection and analysis. The presentation will include a focused discussion on the benefits and shortcomings of using direct data entry and will share lessons learned and provide recommendations for improving the process.

Source of Funding: Health Resources and Services Administration (HRSA) Grant
WHO IS THE DPH WORKFORCE?
Donald Marianos, DDS, MPH, Association of State and Territorial Dental Directors

The dental public health (DPH) infrastructure is needed to prevent and control oral diseases and promote oral health through organized community efforts. While infrastructure encompasses organizational, informational, legal, policy, and fiscal resources – our immediate focus is on the human infrastructure or “workforce.” In particular, we are interested in discussing the people who are needed to provide the core essential DPH functions, i.e. the DPH workforce.

Public health agencies vary in size, structure, resources, and function. A complement of staff, consultants, and partners are needed to attain the skill sets necessary to provide the core essential DPH functions. The DPH workforce includes people who may or may not have formal training in public health and people who may or may not have oral health training and expertise. The DPH specialist has formal training in public health, oral health, and their intersection.

How are core essential DPH functions being provided? Who has the necessary skill sets? Where are the strengths? Where are the gaps? Who do we need? Does everyone need to be board-certified in DPH to be part of this infrastructure? How are existing DPH specialists best utilized? Do we need DPH specialists or can we just muddle through? How do the diverse aspects of the DPH infrastructure challenge finding the DPH workforce that best meets your needs? Does one size fit all?

Source of Funding: None

DEVELOPING ORAL HEALTH LEADERS THROUGH SUCCESSFUL PARTNERSHIPS AND COMMUNITY-BASED LEARNING
Michelle L. Gross-Panico, RDH, DHSc, A.T. Still University Arizona School of Dentistry & Oral Health

During this round table presentation, the role of community agencies in developing oral health leaders will be described and community agencies will be provided with resources to engage students in community-based service-learning. Partnerships with community agencies are key to enhancing student education and enriching communities through community based service-learning experiences. Successful community-based service-learning is dependent upon partnerships between the educational institution, student learner, and community agency.

Community agencies can partner with educational institutions to engage dental and dental hygiene students in providing clinical and non-clinical services directly to the population served by the agency. Clinical services that can be provided by students in non-traditional and community-based settings include oral screenings, fluoride varnish application, referrals, sports mouthguards, and sealants. Non-clinical services that can be provided by students include oral health education, train-the-trainer sessions, grant writing, and advocating for policy change.

Learning from community agencies encourages students to look to agencies for collaboration when addressing public health issues. Students learn to care for and develop a sense of social responsibility toward the population the agency serves. Community engagement fosters cultural awareness, a desire to become an advocate, and the ability to be involved in the health policy process.

Community agencies play a key role in developing future oral health leaders and graduating clinicians who are clinically competent, culturally competent, socially responsible, and informed about community health. Involvement in community based service-learning is a win-win-win for students, community agencies, and community members as each benefits from the experience.

Source of Funding: None

2014 National Oral Health Conference®
We hope you will find this useful for notes on speakers and session for the online evaluation process.
AMERICAN ACADEMY OF PEDIATRICS AND CAMPAIGN FOR DENTAL HEALTH
Lauren F. Barone, MPH, Manager, Oral Health, American Academy of Pediatrics

The American Academy of Pediatrics focuses on educating pediatricians about oral health as well as advocating for improved oral health services for children and collaboration between the medical and dental homes. The AAP achieves these goals by providing a robust web site (www.aap.org/oralhealth) with practice tools and resources and educational offerings. Each of the AAP State Chapters has a Chapter Oral Health Advocate who works to train others in his state and advocates for oral health at the local level. In addition to this main goal, the AAP also administers the Campaign for Dental Health, an effort to preserve and support community water fluoridation. The web site for this effort (www.likemyteeth.org) strives to provide positive information online and in general about the practice of water fluoridation.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY.
ORAL HEALTH IN PRIMARY CARE: LEARNING FROM THE EARLY ADOPTORS
Jan C. Silverman, MS, MSW, American Academy of Pediatric Dentistry

The AAPD, along with the American Academy of Pediatrics, American Academy of Family Physicians, and other partners has been exploring oral health promotion in primary care over the past year. Through a series of focus groups and practice observations, investigators have learned information on how successful programs have overcome barriers to implementation, various staffing options, and ways to integrate oral health into the medical record. Findings will be discussed and case studies presented that illustrate comprehensive oral health promotion in primary care, including risk assessment, fluoride varnish, anticipatory guidance and instruction, and referral to the dental home. The AAPD has also developed additional resources on Dental Case Management, Caries Risk Assessment, Patient Centered Care, and others, as well as an analysis of state EPSDT schedules. These resources will be available at the roundtable, as well as contact information for our state Public Policy Advocates, who work in each state with stakeholders to improve children's oral health at the state level.

AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY: AN OVERVIEW
Frances M. Kim, DDS, MPH, DrPH, Executive Council Member, American Association of Public Health Dentistry

Founded in 1937, the American Association of Public Health Dentistry (AAPHD) provides a focus for meeting the challenge to improve oral health among the public. AAPHD membership is open to all individuals concerned with improving the oral health of the public. AAPHD is the sponsoring organization for the American Board of Dental Public Health. To meet the challenge of improved oral health for all, the AAPHD is committed to:

- Defining and promoting competency in public health dentistry and developing education and training programs to increase knowledge and improve skills.
- Developing and sustaining diversity in the practice of public health dentistry.
- Advocating for evidence-based policies and practices that increase access for the dentally underserved and achieve optimal oral health for the population.
- Foster growth and development of leaders in dental public health and encourage engaged leadership that promotes DPH at the local, state, and national levels.

This Roundtable will provide an overview of the mission and activities of AAPHD.

AMERICAN DENTAL ASSOCIATION: CALL TO ACTION FOR ORAL HEALTH
Kathleen O’Loughlin, DMD, MPH, Executive Director, American Dental Association

Improving oral health is a top priority for the ADA and our members. In fact, for years, many of our members—through their own efforts or through their state dental associations—have been committed to working with their local leaders to identify and advance solutions that improve oral health. Following the lead of our members, the ADA is working to refocus the discussion on access to oral health care through promotion of a suite of active policy initiatives, which aim to prevent disease, provide oral care to underserved populations, use the safety-net effectively, and increase oral health literacy. The ADA is launching this effort with a Call to Action for Oral Health.

We have identified eight initiatives that offer real answers to real problems. They are evidence-based, affordable, and measurable solutions to improve access. There are success stories to share. The Initiatives address: long-term care, emergency room diversion, expanding Medicaid coverage for children and adults, community water fluoridation, involving elected officials with Give Kids A Smile and Mission of Mercy programs, expanding the use of community dental health coordinators, encouraging Federally Qualified Health Centers to contract with private dentists, and increasing collaboration with non-dental (medical) professionals.

AMERICAN DENTAL HYGIENISTS’ ASSOCIATION: TRANSFORMING THE DENTAL HYGIENE PROFESSION
Ann Lynch, Director of Government Affairs, American Dental Hygienists’ Association

In June 2013 the American Dental Hygienists’ Association (ADHA) celebrated the 100th anniversary of the dental hygiene profession. ADHA President, Denise Bowers, RDH, PhD will share how ADHA is
prepared to lead the transformation of the profession into the next 100 years. President Bowers will highlight the recent dental hygiene education symposium, “Transforming Dental Hygiene Education: Proud Past, Unlimited Future” co-hosted by ADHA and the ADHA Institute for Oral Health in conjunction with The Santa Fe Group. She will show how the ADHA Board has aligned its strategic plan to meet the needs of the public and the profession. Her presentation will outline ADHA’s goals and objectives which include education, alliances, and advocacy.

AMERICAN NETWORK OF ORAL HEALTH COALITIONS. STATE ORAL HEALTH COALITIONS: THE COLLECTIVE VOICE FOR POLICY CHANGE
Karlene Ketola, MHSA, CAE, American Network of Oral Health Coalitions

The American Network of Oral Health Coalitions (ANOHC) exists to create a reliable place for state oral health coalitions to share information, ask questions, and leverage time and resources. ANOHC members are statewide oral health coalitions that promote lifelong oral health by shaping policy, promoting prevention, and educating the public. With 33 member states, ANOHC has developed into an important voice in national oral health policy. The relationship between state oral health programs and coalitions is an important one. Because of tight budgets and restrictions on state agencies, public health professionals must now get creative to make a measurable impact on oral health. As a result, state coalitions have become an integral part of oral health infrastructure. With access to traditional and non-traditional stakeholders and the ability to leverage outside funding, state coalitions are now more important than ever in promoting oral health. For instance, with the abundance of anti-fluoridation activity across the country, state coalitions are serving as the first line of defense against the removal of fluoride from community water systems. With upcoming ACA implementation, state coalitions are acting as important advocates for oral health services. The goal of this session is to educate NOHC attendees on the importance of state coalitions and the role they serve in dental public health. We are looking to engage oral health stakeholders with common goals and identify potential coalition partners. Attendees will walk away with a better understanding of how to utilize and maximize the resources of their own state oral health coalition.

AMERICAN PUBLIC HEALTH ASSOCIATION, ORAL HEALTH SECTION: POLICY IN ACTION
Kathy M. Lituri, RDH, MPH, Chair, American Public Health Association, Oral Health Section

The American Public Health Association (APHA) is a diverse community of public health professionals who have championed the health of all people and communities around the world for more than 140 years. The Oral Health (OH) Section of APHA is comprised of more than 300 members, mostly dentists and dental hygienists, working in public health practice, administration, research, or teaching. The OH Section strives to promote oral health to a large multidisciplinary audience, partners with other health care providers, integrates oral health with overall health, provides input into environmental and health care delivery issues, and disseminates research findings to a diverse audience. This round table will present the policy formulation process within APHA; discuss recent OH Section policy initiatives including amalgam’s phase-down, Community Water Fluoridation, the Alaska Dental Health Aide Therapist, the prophylactic removal of third molars and fluoride varnish; and share policy related activities. The OH Section has two representatives on the APHA Governing Council, the primary mechanism whereby the Section has a voice in this large, multidisciplinary organization and the ability to influence policy development. Through the APHA governing process, the OH Section submits its own resolutions and provides input into other relevant resolutions. APHA staff and lobbyists actively promote APHA resolutions into state and national policies. In an effort to recognize promising new public health professionals, the OH Section sponsors pre and post-professional awards. Through its inter-disciplinary scientific program, the OH section promotes collaboration and fosters advocacy in oral health related issues.

ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS: RESOURCES GALORE
Kimberlie Yineman, RDH, BA, President, Association of State and Territorial Dental Directors

The Association of State and Territorial Dental Directors is a professional association that provides leadership to promote a governmental oral health presence in each state and territory, to formulate and promote sound oral health policy, to increase awareness of oral health issues, and to assist in the development of initiatives for prevention and control of oral diseases. ASTDD’s Members and Associate members are dedicated public health professionals. Through various funding sources, ASTDD committees and consultants have developed competencies, guidelines, best practices, communication plan templates, evaluation tools, policy statements, basic screening surveys for various age groups, and other significant resources. Visit this roundtable to find out how you and your program can access and use these resources. Why not join the organization so you can have access to additional members’ only resources and participate in developing new resources?

CDC DIVISION OF ORAL HEALTH: LEADERSHIP IN ORAL PUBLIC HEALTH
William Bailey, DDS, MPH, Chief Dental Officer, USPHS

Located in the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC), the Division of Oral Health (DOH) works to prevent and control oral diseases and conditions by building the knowledge, tools, and networks that promote healthy behaviors and effective public health practices and programs. DOH core functions are: Monitor/Surveillance; Research; Communications; Preventive strategies; State infrastructure; Evaluation; Investigate and diagnose; Partnerships; and Policy development. This roundtable will focus on current and future DOH activities related to surveillance and prevention programs. Surveillance topics to be discussed include advances related to the National Oral Health Surveillance System, Healthy People 2020, the National Health and Nutrition Examination Survey, and the Behavioral Risk Factor Surveillance System. Prevention topics will include advances related to state oral health program infrastructure and prevention programs. Community-based preventive programs to be addressed are community water fluoridation and school-based/school-linked sealant programs. Collaborations with national partner organizations that enhance national and state surveillance efforts and support for state infrastructure and prevention programs will also be discussed.
CHILDREN INTERNATIONAL. GLOBAL DENTAL SERVICES: PROMOTING ORAL HEALTH ACROSS 11 NATIONS
Andrea M. Dunne-Sosa, MPH, Program Officer for Health and Nutrition, Children International

Children International (CI) makes basic dental services available to nearly 340,000 impoverished children and youth throughout 11 countries in Latin America, Asia, Africa, and the United States. CI provides services through established medical and dental clinics in our community centers, offering curative services to the full sponsored population and preventive services to targeted age groups. Preventive services include provision of fluoride, sealants, and other prophylactic measures. We utilize ASTDD’s Basic Screening Survey (BSS) to prioritize needs and develop a treatment plan for every child screened. Furthermore, we provide needed medications and offer referrals to treat more involved cases. In Little Rock, Arkansas, CI operates the only school-based dental clinic in the state. Finally, these oral health services are provided in conjunction with other child and youth programs with the vision that every child graduates from our program as a healthy, educated, self-reliant adult with the ability and drive to break free from poverty while improving their own communities.

CHILDREN’S DENTAL HEALTH PROJECT: SUPPORTING YOUR SUCCESS
Patrice Pascual, MA, Executive Director, Children’s Dental Health Project

The Children’s Dental Health Project develops tools, resources, and training to help state oral health programs build capacity and infrastructure, and to help state oral health advocates achieve their goals. What does that mean for you? That’s the focus of this roundtable. Bring your programmatic challenges and let’s talk about how CDHP can help. Maybe you need to set priorities among a diverse group of stakeholders. Start a conversation with other chronic disease programs. Identify resources that can help you preserve or expand community water fluoridation in your state. Help local FQHCs contract with private practice dentists. Or develop an “elevator speech” to explain why your work matters. You get the idea. We’re here to support your success in the important work of improving oral health.

THE INDIAN HEALTH SERVICE (IHS): DENTAL CLINICAL AND PREVENTIVE SUPPORT CENTER INITIATIVE
Patrick Blahut, DDS, MPH, Deputy Director, Division of Oral Health, Indian Health Service, HHS

The IHS Dental Support Centers are profiled by their Project Officer, who will provide a brief history of this initiative to open the discussion, and comments concerning the likely future directions of the Centers to conclude this session. Eight regional dental support centers provide a variety of services to the IHS dental field programs and dental personnel they serve. These Centers were created as a way of preserving essential services during a time of organizational downsizing. Services offered by individual Centers are customized to meet the perceived needs of each IHS region. Examples of services include the provision of accredited continuing education, coordination of annual regional dental meetings, on-site clinical reviews, the provision of risk management or malpractice avoidance information, and coordination of regional preventive initiatives. In addition to providing regional services, the Support Centers contribute to national programs such as the current ECC initiative, the ongoing IHS oral health surveillance effort, and the annual health promotion / disease prevention awards program.

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
John Robitscher, MPH, CEO, NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

The National Association of Chronic Disease Directors (NACDD) is a non-profit public health organization committed to serve the chronic disease program directors of each state and U.S. jurisdiction. Founded in 1988, NACDD connects more than 3,000 chronic disease practitioners to advocate for preventive policies and programs, encourage knowledge sharing, and develop partnerships for health promotion. Since its founding, NACDD has been a national leader in mobilizing efforts to reduce chronic diseases and their associated risk factors through state and community-based prevention strategies. We are an entrepreneurial organization that has raised over $3 million in nonfederal revenue to work on new and innovative projects. We are about to launch our newest venture, The ProVention Health Foundation. Come visit this roundtable to learn fundraising basics and to learn more about the ProVention Health Foundation.

NATIONAL CHILDREN’S ORAL HEALTH FOUNDATION: RESOURCES FOR SAVING YOUNG SMILES
Robin Vann, MS, MBA, National Program Manager, National Children’s Oral Health Foundation

Come learn about National Children’s Oral Health Foundation: America’s ToothFairy and the range of financial, product, and technical support the Foundation provides to nonprofit children’s oral health programs throughout North America. NCOHF was formed as a collaborative effort of clinicians, academicians, corporate leaders, and caring individuals in an aggressive response to the #1 chronic childhood illness by providing programs and comprehensive resources to deliver community-based preventive, educational, and treatment services for children of vulnerable populations. NCOHF places a strong emphasis on preventive strategies designed to break the cycle of this preventable disease and change the trajectory of decay in underserved populations. NCOHF is committed to the singular mission of eliminating children’s pain and suffering from preventable oral diseases through a growing Affiliate network of exemplary non-profit community programs and turnkey Signature Programs for students and health professionals. Recognizing that the mouth is the gateway to the body, NCOHF supports the delivery of oral health education and care beginning at the prenatal level. To date, NCOHF has provided over $13 million in support to members of the NCOHF Affiliate Network reaching vulnerable children, teens, pregnant mothers, parents, and caregivers with critical oral health care and education.

NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH’S 2014-2019 STRATEGIC PLAN: DENTAL PUBLIC HEALTH PRIORITIES
Ruth E. Nowjack-Raymer, MPH, PhD, Director, Health Disparities Research Program, National Institute of Dental and Craniofacial Research

Oral health disparities and health inequalities remain in many segments of the U.S. population including low-income racial and ethnic minorities, rural dwellers, immunocompromised persons, people with acquired or intellectual disabilities, the institutionalized, and elders. Dental caries, periodontal disease, and oral and pharyngeal cancer are of particular concern. The National Institute of Dental and Craniofacial Research (NIDCR) has a strong
history of supporting research to understand and intervene upon oral health disparities, and its commitment is unwavering. This roundtable will focus on the NIDCR’s Strategic Plan 2014-2019 goals and objectives of importance to dental public health practitioners, academicians, trainees, and researchers. Research areas include health services and health policy; health communications including health literacy, social media, and social network analysis; social determinants; behavioral science; basic research; and dissemination and implementation research. This research is complex and requires multidisciplinary, multilevel approaches and well as research on individual behaviors and mechanisms of action, and it requires partnerships with communities as well as with sectors beyond the traditional health sector. Essential to achieving the objectives is the purposeful building of a diverse research workforce. Funding Opportunity Announcements (FOAs) that catalyze research areas of the Strategic Plan will be discussed as will mechanisms that support career development and training. Recently cleared concepts that may result in future initiatives will be described. At the conclusion of the roundtable participants will understand: 1) the NIDCR Strategic Plan; 2) funding opportunities for research, career development, and training; and 3) where to get additional information and whom to contact.

NATIONAL NETWORK FOR ORAL HEALTH ACCESS: WORKING TO IMPROVE THE ORAL HEALTH OF UNDERSERVED POPULATIONS WITH A FOCUS ON FQHC

Barbara E. Bailey, RDH, MA, PhD, Executive Director, National Network for Oral Health Access

The National Network for Oral Health Access (NNOHA) is a national organization that works to address the needs of oral health professionals and other staff with a focus on the unique needs of Federally Qualified Health Centers and other safety net programs. Activities of NNOHA include a National Oral Health Training Institute designed to develop excellence in leadership among new Dental Directors; Interprofessional Oral Health Core Competency Program, a pilot that is working to identify core competencies that medical staff can utilize to improve oral health of their patients; project with ASTDD on State Oral Health Program/Primary Care Association collaboration; projects with the Pew Charitable Trusts in the areas of fluoridation, sealants, and workforce models; a joint project with the National Association of Community Health Centers and the DentaQuest Institute to strengthen the oral health network by enhancing the ability of Primary Care Associations to provide oral health assistance to FQHC’s in their states. NNOHA holds an annual conference where oral health professionals from FQHCs and other safety net programs can come together to learn, share experiences, and grow together. Come by our table to learn more.

NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH

Stephanie Hansen, Education and Services Director, National Organization of State Offices of Rural Health

Participants in this roundtable will learn about the National Organization of State Offices of Rural Health (NOSORH), which was established to help State Offices of Rural Health (SORH) in their efforts to improve access to and enhance the quality of health care for America’s 61 million rural citizens. Participants in this session will learn who SORHs are and how to build relationships with them to promote enhanced collaboration around oral health and rural health issues, such as dentist recruitment and retention. The discussion will highlight previous and current SORH and NOSORH partnerships and projects around oral health.

ORAL HEALTH AMERICA’S PROGRAMS ACROSS THE LIFESPAN: WISDOM TOOTH PROJECT & SMILES ACROSS AMERICA

Dora Fisher, MPH, Older Adult Programs Manager, Oral Health America

Oral Health America changes lives by connecting communities with resources to increase access to care, education, and advocacy for all Americans, especially those most vulnerable. At this roundtable, participants will learn about OHA’s older adult and children’s programs and how they can collaborate with us on our initiatives to serve these vulnerable populations. Every day in the U.S., 10,000 adults reach age 65. Only 2% do so with a dental benefit, and Medicare doesn’t help them pay for dental care. The Wisdom Tooth Project™ (WTP) changes the lives of older adults through toothwisdom.org: a web portal of resources that educates on topics relevant to caring for an aging mouth, with health information in plain language and local resources to access affordable care. In addition to connecting older adults to care via toothwisdom.org, the WTP also seeks to connect health professionals in aging and oral health to best facilitate comprehensive care for older adults through national and regional symposia, publications, and health education. Smiles Across America® (SAA) increases access to dental services in school-based or school-linked settings for children most at risk for developing dental caries and oral disease. SAA identifies promising local community efforts and supports these local programs in the development, implementation, promotion, and expansion of programs, with a particular emphasis on disease prevention. Participants will have the opportunity to learn more about OHA’s aging and youth programs and about opportunities to partner with the organization.

ORGANIZATION FOR SAFETY, ASEPSIS AND PREVENTION (OSAP): RISK IS REAL—PATIENT & PROVIDER SAFETY RESOURCES

Therese M. Long, MBA, CAE, Executive Director, Organization for Safety, Asepsis and Prevention

Thirty years ago a group of academicians and corporate representatives incorporated an organization to address truth in advertising. They named the organization OSAP and it has evolved through the decades to become a diverse membership association spanning public health, academia, consulting, clinical practice, and the dental trade. OSAP provides a real focus on infection prevention and safety, and advocates both nationally and internationally for the safe and infection-free delivery of oral healthcare. In dentistry, risk is real and several highly public infection control breaches support the need for an organization that focuses on infection prevention and patient and provider safety. This roundtable is designed to introduce NOHC participants to valuable training and informational resources for dental safety. Participants will be asked to provide their thoughts as to why compliance with infection control remains problematic. Elements of a new program called The Safest Dental Visit™ also will be highlighted.

PEW CHILDREN’S DENTAL CAMPAIGN TO INCREASE ACCESS TO DENTAL SEALANTS

Shelly Gehshan, MPP, Director, Pew Children’s Dental Campaign

Despite strong evidence supporting the use of dental sealants, the children who most need them are least likely to get them. Pew’s Children’s Dental Campaign publishes research, directs advocacy
campaigns, and provides tailored technical assistance that helps states increase access to sealants. In 2013, Pew published *Falling Short: Most States Lag on Dental Sealants*, which graded states on four benchmarks related to dental sealants, and found that many states are not doing enough to make sure children get sealants. Since that report was published, Pew has assisted many states interested in changing their policies to increase access to sealant programs by removing outdated rules that require a dentist’s exam before a dental hygienist can apply sealants in a school-based program. However, many states have not changed their policies: 15 states and the District of Columbia still have outdated rules requiring a prior exam in a sealant program. In this roundtable, the Children’s Dental Campaign will give an overview of our interest in sealants, discuss our research and policy benchmarks, and explain how we continue to work with states to change their policies on sealants.

SAFETY NET SOLUTIONS: CREATING “BANG FOR THE BUCK” IN YOUR SAFETY NET DENTAL PROGRAM

Mark J. Doherty, DMD, MPH, CCHP, Executive Director, Safety Net Solutions

Safety Net Solutions, a program of the DentaQuest Institute, has provided Safety Net Dental Practice Management Technical Assistance to close to 300 practices in 28 states over the last eight years. During that period they have developed a list of criteria, operations and systems that those practices who distinguish themselves as the “Best in Class” utilize to achieve success in four primary areas: 1) Increased Access, 2) Improved Quality, 3) Improved Oral Health Outcomes, and 4) Financial Viability. Learn about SNS national, regional, and state partnerships and collaborations, the SNS process, and results. Learn also what they have learned about TA for practices specializing in the treatment of the underserved and what those challenges are and how to mitigate them. Last, hear what the SNS strategy is moving forward to share with more practices what they need to know to improve their practice efficiency and effectiveness.

2014 National Oral Health Conference®

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Some presenters were unable to attend the NOHC Conference to present their abstracts. Therefore, there is some inconsistency in the numbering of the Posters.

Poster Number: 2  
Serial Number: 20

**INEQUITABLE ACCESS TO DENTAL CARE UNDER THE MANAGED CARE MEDICAID SYSTEM IN OREGON**  
Eli Schwarz (1), DDS, MPH, PhD; Alynn Vienot (2), RDH, MPH  
Oregon Health & Science University, Portland OR, USA (1), Neighborhood Health Center, Oregon City OR, USA (2),  

**Objectives:** By 2014 the health care transformation process in Oregon will integrate dental care into the coordinated care system. The aim of this study was to assess to what extent the dental care needs of the covered Medicaid children population in Multnomah, Clackamas, and Washington counties (Portland Metro) are being met by the present managed care system.

**Background:** Medicaid 2011 data collected as part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program was analyzed by age group of enrolled members and by county of residence. Data were analyzed according to enrolling dental care organization (DCO) with a focus on four EPSDT metrics, any dental services, preventive services, treatment services, and sealants (12 a,b,c,d).

**Results:** Extreme variation was found between levels of services provided by individual DCOS with differences of 30+ percentage points on any dental services and preventive services and 20+ percentage points on sealants. The extent to which an enrollee received any dental service was dependent on which DCO was responsible for the dental care.

**Conclusions:** Considerable inequities exist in the present dental care delivery system. The analysis provides evidence-based information and recommendations that can inform decision making in relation to the ongoing integration of dental care into the CCO structure. It is suggested to 1. Improve the equitable provision of dental care through an evidence based public health approach and 2. Improve the accountability in the dental care system by including additional quality domains, such as cost, health outcomes, and satisfaction with service.

**Source of Funding:** Healthshare of Oregon, the largest Coordinated Care Organization in Oregon, which covers the three counties being analyzed.

Poster Number: 3  
Serial Number: 33

**ACCEPTING NEW MEDICAID CHILDREN PREDICTS HIGHER EVIDENCE-BASED CLINICAL KNOWLEDGE ON USING DENTAL SEALANTS AMONG DENTISTS**  
Vinodh Bhoopathi (1), BDS, MPH, DScD; Sirisha Govindiah (1), BDS, MPH  
Section of Pediatric Dentistry, Nova Southeastern University College of Dental Medicine, Fort Lauderdale, Florida, USA (1)  

**Objective:** To determine the level of evidence-based clinical knowledge among dentists on appropriate use of dental sealants in children. In addition we tested if years since graduation from dental school, and relying on peers/colleagues for regular dental clinical information were associated with clinical knowledge on use of dental sealants.

**Background:** A 25-item pretested, self-administered questionnaire was used to conduct this cross-sectional study at the 2013 Florida National Dental Convention, Kissimmee, Florida. Descriptive, bivariate, and multivariate statistics were performed. A linear regression model predicting evidence-based clinical knowledge on appropriate use of sealants was created.

**Results:** 163 dentists completed the survey. Majority of the respondents were general dentists (98%), males (63%), Whites (73%), and non-Medicaid providers (78%). Dentists answered on average only one question correctly, out of three possible evidence-based clinical knowledge questions. Linear regression showed that male gender (p=0.003) and accepting new Medicaid children (p=0.01) significantly predicted higher evidence-based clinical knowledge.

**Conclusions:** Evidence-based clinical knowledge about appropriate use of dental sealants was low among participating dentists. Years since graduation, and relying on peers/colleagues were not associated with higher knowledge. Interestingly, dentists who accepted new Medicaid children, had higher evidence based clinical knowledge on appropriate use of dental sealants compared to those who did not accept new Medicaid children.

**Source of Funding:** This study was funded by the Nova Southeastern University Health Professions Division Grant

Poster Number: 4  
Serial Number: 54

**DIFFERENTIAL IMPACT OF MEDICAID ADULT DENTAL COVERAGE ELIMINATION IN CALIFORNIA**  
Asthia Singhal (1), BDS, MPH; Peter Damiano (1), DDS, MPH; Christopher Buresh (1), MD, MPH; Daniel Caplan (1), PhD; Mike Jones (1), PhD; Raymond Kuthy (1), DDS, MPH; Elizabeth Momany (1), PhD  
University of iowa, iowa City, iA, USA (1)  

**Objectives:** To examine the impact of eliminating Medicaid adult dental coverage on emergency department (ED) use for dental problems by Medicaid adult enrollees, by patient and visit characteristics.

**Background:** Medicaid adult dental coverage was eliminated in California on July 1, 2009. State Emergency Department Databases (SED) for state of California were acquired from AHRQ for 2006 to 2011 and data use agreement was signed. Interrupted time series study design was utilized to examine the impact of the policy change by various patient and visit characteristics. It was hypothesized that the policy change did not impact Medicaid adult enrollees uniformly across the state. Segmented linear regression analyses were conducted using SAS version 9.3.

**Results:** Elimination of adult dental benefits under Medicaid had a statistically significant immediate increase in the proportion of Medicaid adult enrollees who visited ED for dental problem (beta=0.046, p-value=0.0011). There was a significant time trend, a constant increase in proportion of Medicaid adult enrollees who visited ED for dental problems, throughout the study period (beta=0.0025, p-value<0.0001). However, the policy change did not change this time trend significantly. The impact of policy change was not equal across patient and visit characteristics, with some groups affected more than others.

**Conclusions:** The study provides strong evidence that eliminating Medicaid adult dental benefits leads to an immediate and significant increase in the proportion of Medicaid adult enrollees who visit an ED for dental problems, and the policy decision has a differential effect on various subgroups among the enrollees.

**Source of Funding:** None
VOICES OF A (DISRUPTIVE) INNOVATION: PERSPECTIVES OF DENTAL THERAPY LEADERS

Maureen A. Ohland (1), DDS, MS, MLS
University of Minnesota, Minneapolis, MN, USA (1)

In May of 2009, Minnesota became the first state to establish licensure of the new provider model of dental therapy. Two schools in the metropolitan area trained these professionals and granted degrees on multiple levels in 2011. This research study investigated the programming, the leadership, and aspects of the dental therapy models as a disruptive innovation.

Objectives: The purpose of this study was to establish dental therapy as a disruptive innovation as well as examine and compare the components of the Minnesota dental therapy programs to the existing and proposed models put forth in the literature. A tertiary aim was to investigate the leadership advancing this new workforce model in Minnesota.

Background: An IRB-approved qualitative study investigated the subject matter through participant interviews with dental therapists, employers, and staff. A survey format was utilized to provide adjunctive quantitative data of an “ideal” dental therapy program.

Results: The leaders did not consider dental therapy as a disruptive innovation yet believed this new workforce model provides a cost-effective approach with positive potential to address the access to oral health care issue. Dental therapy programming in Minnesota graduates multiple titles that confuse the definition of the professional in an acrimonious environment.

Conclusions: The leaders in this study put forth recommendations for changes in dental therapy programming that would provide for cohesiveness in the profession moving forward in a positive innovative direction. Instituting these changes would require significant transformational leadership to overcome the challenges and barriers facing the new provider model.

Source of Funding: None

STATE OF DECAY: ARE OLDER AMERICANS COMING OF AGE WITHOUT ORAL HEALTHCARE?

Dora Fisher (1), MPH; Beth Truett (1)
Oral Health America, Chicago, IL, USA (1)

Background: Because of limited access to affordable dental services and lack of awareness, dental problems among older Americans are often ignored or not detected until it is too late, resulting in serious disease. This work reports on the current state of oral health of older adults across fifty states.

Objectives: This report analyzes state data on five variables impacting older adult oral health: edentulism, dental health professional shortage areas (DHPSAs), state oral health plans, Medicaid reimbursements, and water fluoridation (WF). For each state, a four-point scale was assigned to all five variables collected. Each variable was weighted for importance, and then a final numeric grade was calculated out of a percent of the possible top score.

Results: All states demonstrated an overall need for improved access to care, Medicaid reimbursements, WF, decreased edentulism, and greater strategic planning on the issue in State Oral Health Plans. Twenty-two states provide either no dental benefits or only emergency coverage through adult Medicaid Dental. 31 states have high rates of DHPSAs, meeting only 40 percent or less of dental provider needs. Eight states had strikingly high rates of edentulism, most notably West Virginia with 33.8% of the population edentate. 13 states have upwards of 60 percent of their residents living in communities without water fluoridation.

Conclusions: This data and analysis demonstrate the lack of equity with regard to access to oral health care, edentulism, utilization of services, and public policies. These deficiencies are particularly impactful to older adults, who are among the most vulnerable Americans.

Source of Funding: None

SELF REPORTED DRY-MOUTH AMONG GERIATRIC PATIENTS EXAMINED IN A U.S. DENTAL SCHOOL

Susan Roshan (1), DDS, MPH; Kenneth A. Bolin (1), DDS, MPH
Baylor College of Dentistry, Dallas, TX, USA (1)

Objective: Dry-mouth or xerostomia is a self-reported condition affecting millions of Americans and a risk factor for oral disease among elderly patients. 1 It reportedly affects 10%-40% of elderly1,2 and is related to higher number of medications taken.3 Our objective was: To quantify the prevalence of dry-mouth and number of medications taken among a group of ambulatory geriatric patients examined in a dental school setting during a 5 year period.

Background: Dry-mouth is determined by a patient’s positive answer to one of these questions: Does your mouth feel dry when eating a meal? Do you have difficulty swallowing food? Do you have to sip liquids to aid in swallowing? Is the amount of saliva in your mouth too little most of the time? These questions are validated and meet the criteria for a predictive test.1,4-6 From 6/1/2008 to 5/31/2013, students asked these questions from 1,897 geriatric patients (age 65-74, n=1332;
Results: Dry-mouth was reported in 70 patients (17.9%); mostly older-elderly (≥75:24.2%; 65-74:15.1%) and in females (n=49;70%). While our non-xerostomic patients reported taking a mean of 4.5 medications, xerostomic patients took a mean of 6.8 medications.

Conclusions: A majority of dry-mouth patients were older, female, and took more medications. This is comparable with available literature on prevalence of xerostomia among geriatric patients. Further studies are needed to see if these data can be generalized to the entire population.

Source of Funding: None

Poster Number: 9
Serial Number: 28

ORAL HEALTH STATUS AND DENTAL CARE TREATMENT NEEDS OF ADULTS IN CLACKAMAS COUNTY, OREGON

Richie Kohli (1), BDS, MS; Harjit Sehgal (1), BDS, MS; Elena Strahm (2); Zuri Lopez (2); Eli Schwarz (1), DDS, MPH, PhD

Oregon Health & Science University, Portland, OR, USA (1), NorthWest Family Services, Portland, OR, USA (2)

Objectives: Clackamas County is one of the most underserved counties in the State of Oregon, yet the third most populated. The aim of this study was to assess the oral health status and dental care treatment needs of adults in Clackamas County.

Background: In this cross-sectional study, basic screening survey, clinical screening and oral hygiene treatment were performed on adults residing in housing projects. Advanced procedures were done at the mobile dental van or were referred. Data analysis included descriptive analysis and tests of association using SPSS 22.

Results: The study sample consisted of 385 adults (44% males and 56% females) 18 to 91 years old (mean age= 44.7 years, s.d.=14.7). The overall health was rated as “good” to “average” and oral health as “average” to “poor” by 61% adults. The frequency of tooth brushing ranged from once daily (28%), twice daily (39%) to 2-3 times/week (9%). Oral health problems or dentures caused 63% adults to be self-conscious/embarrassed and 25% to have difficulty performing their usual jobs very often/occasionally while 43% reported existing dental pain. Clinical examination revealed that 77% adults had gingival inflammation, 60% had plaque present in two or more teeth and 40% needed referral for further dental care. Besides, females were more likely to have gingival inflammation than males (p=0.03).

Conclusion: There is considerable dental care treatment need for adults in Clackamas County in Oregon. Further, oral health education should be reinforced. This pilot project can be utilized to guide larger state-wide surveys of oral health among adults.

Source of Funding: DentaQuest Foundation and United Way of Oregon.

Poster Number: 10
Serial Number: 51

PREVALENCE OF DECAYED, MISSING, FILLED AND TREATED TEETH BY GENDER, AGE AND EDUCATIONAL LEVELS AMONG RURAL DOMINICANS IN DOMINICAN REPUBLIC

Payal Kahan (1), BDS, MPH; Christine Tisone (1), MPH, PhD

Texas A&M University, College Station, Texas, USA (1)

Background: Latino population is one of the fastest growing populations in the US. Oral health among these populations is neglected leading to chronic oro-facial pain and premature loss of teeth. Although clinical populations have been studied in the Dominican Republic (DR), there is paucity of information on oral health conditions in rural communities. The purpose of the study was to determine the prevalence of decayed, missing, filled and treated teeth (DMFT) among 102 participants in rural DR.

Methodology: Cross-sectional study was conducted in La Esquina community, Province Maria Trinidad Sanchez in July-August 2013 using face-to-face interviews and oral examinations.

Results: Mean age of participants was 42.26±17.90 years; 52.9% females and 47.1% males. 52.9% had some form of elementary education, 20.2% had either partial or full high school education and only 14.4% had higher than high school education. DMFT index of 14.05 was higher among older female individuals (≥51 years) in comparison to age groups 36-50 years (DMFT: 7.58) and 18-35 years (DMFT: 6.86). Similarly the indices were higher for males ≥51 years with DMFT of 13.83. Males of age group 18-35 years and 36-50 years had DMFT indices of 6.30 and 10.13 respectively. DMFT index was lower among individuals who had higher than high school education (6.07) than individuals who either elementary (8.81) or high school (7.0). 85.6% of respondents reported going to the dentist with only 28% in the past one year.

Conclusions: There is a need for oral health programs by gender, age and educational levels.

Source of Funding: This project was funded by College of Education and Human Development, Texas A&M University, College Station, Texas.

Poster Number: 11
Serial Number: 85

ORGANIZING AN ORAL HEALTH NEEDS ASSESSMENT AT AN OUTPATIENT HIV CLINIC

Kari Hexem (1,2), MPH; Sarah Smith (2), MHS, PA-C; Jane Shull (2), MSW; Kristi Katuran (2), MSW; Joan Gluch (1), PhD; Karam Mounzer (2), MD

University of Pennsylvania School of Dental Medicine, Philadelphia, PA, USA (1), Philadelphia FIGHT, Philadelphia, PA, USA (2)

Objectives: Because low income individuals living with HIV/AIDS face many barriers to obtaining oral health care, a collaboration between a University dental school and outpatient HIV/AIDS clinic was established. As a first step, a baseline oral health needs assessment was completed in order to determine need for care and to shape program development.

Background: Three instruments: Oral Health Assessment Tool, Short Dental Fear Survey and a modified version of Perceived Discrimination in Clinical Care Survey, were used by clinic medical providers during all new and well patient visits over a month long interval in February 2013.

Results: Two hundred and fifty patients were screened, with a mean age of 46 years (SD: 10). 62% of patients were African American and 76% of patients were male. One in four presented with dental pain, 83% had at least 1 broken tooth or root, and 43% were in need of denture repair. More than half (54%) of patients said they felt “totally relaxed” during their last dental treatment, and 86% reported that they had not experienced any discrimination. Neither dental anxiety nor discrimination were associated with oral health status in a multivariable model.

Conclusions: Baseline oral health assessment revealed a need for emergency and surgical care as well as prosthodontics services. Need for care was not related to dental anxiety or past experiences of discrimination in dental settings.

Source of Funding: HRSA grant D8SHP20034
Abstracts for Poster and Student Award Presentations

Poster Number: 13
Serial Number: 26

**ORAL CAVITY AND PHARYNGEAL CANCER TRENDS AND DISPARITIES IN DELAWARE: 1999-2010**

Darien Weatherspoon (1), DDS, MPH; Amit Chattopadhyay (1), BDS, MPH, PhD; Gregory McClure (2), DMD, MPH

National Institutes of Health, National Institute of Dental and Craniofacial Research, Bethesda, Maryland, USA (1), Delaware Division of Public Health, Bureau of Oral Health and Dental Services, Dover, Delaware, USA (2)

Oropharyngeal and pharyngeal cancers (OCPC) have poor prognoses due to late detection. Delaware (DE) OCPC statistics have not been published.

**Objective:** To assess OCPC incidence and mortality rates, trends, racial/ethnic, and gender disparities in DE compared to national data.

**Methods:** The United States Cancer Statistics and Delaware Cancer Registry data (from CDC Wonder) were used to assess OCPC rates and to analyze time trends and disparities.

**Results:** In DE, cumulative age-adjusted rates (per 100,000 [95% CI]) were as follows: **Incidence** (1999-2010): [Overall 11.3 [10.7-12.0]]; [Men 17.6 [16.4-18.8]]; [Women 6.0 [5.4-6.7]]; [Whites 11.4 [10.7-12.6]]; [African-Americans 10.6 [9.1-12.7]]. **Mortality** (1999-2009): [Overall 2.5 [2.2-2.8]]; [Men 3.8 [3.2-4.4]]; [Women 1.4 [1.1-1.7]]; [Whites 2.4 [2.1-3.4]]; [African-Americans 2.6 [1.8-4.2]]. In the US, cumulative age-adjusted rates for the same time periods were as follows: **Incidence:** (Overall 10.9 [10.9-10.9]); [Men 16.4 [16.3-16.5]]; [Women 6.2 [6.2-6.2]]; [Whites 11.0 [11.0-11.0]]; [African-Americans 10.2 [10.1-10.3]]. **Mortality:** (Overall: 2.6 [2.6-2.6]); [Men 3.9 [3.9-4.0]]; [Women 1.5 [1.4-1.5]]; [Whites 2.5 [2.4-2.5]]; [African-Americans 3.6 [3.5-3.6]].

**Conclusion:** Overall, Delaware and national OCPC cumulative incidence and mortality rates are similar. Significant gender-based disparities in incidence and mortality are evident in both Delaware and nationally. Acknowledgement: This study is supported by NIH/NIDCR.

**Source of Funding:** National Institutes of Health/National Institute of Dental and Craniofacial Research

Poster Number: 15
Serial Number: 36

**IS SELF-REPORTED DIABETES A DETERMINANT OF MISSING TEETH? FINDINGS FROM THE 2010 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)**

Ariel Port (1,2), DMD, MPH; Victor Badner (1), DMD, MPH; Mark Moss (3), DDS, MS, PhD; Mary E. Northridge (2), PhD, MPH

Jacobi Medical Center, Bronx, NY, USA (1), New York University College of Dentistry, New York, NY, USA (2), New York State Department of Health, Albany, NY, USA (3)

**Objective:** Previous research has demonstrated a relationship between diabetes and missing teeth. We sought to investigate this linkage using available data from a US national surveillance system.

**Methods:** BRFSS is telephone-based surveillance system (N ~ 450,000) with standardized core modules that are administered by states. The relationship between self-reported diabetes (SRD) and missing teeth was assessed by logistic regression.

**Results:** Compared to adults without any teeth extracted (third molars excluded), respondents with 1-5 teeth extracted were more than twice as likely to have SRD (odds ratio (OR) = 2.3, 95% confidence interval (CI) 2.2-2.4); this relationship strengthened with increasing numbers of missing teeth (OR = 5.0, 95% CI 4.8-5.3 for adults with 6-27 teeth extracted and OR = 6.4, 95% CI 6.1-6.8 for adults with all 28 teeth extracted). Moreover, the longer the interval between dental visits, the greater the likelihood of SRD (OR = 2.1, 95% CI 2.0-2.2 for adults with dental visits >5 years ago vs. dental visits in the past year).

**Conclusions:** Consistent with previous research, as the number of missing teeth and the interval between dental visits increases, the likelihood of SRD increases in the BRFSS dataset. Dental providers ought to be aware of the diabetes status of their patients, in order to provide them with quality dental care and primary care referrals where warranted.

**Source of Funding:** None

Poster Number: 16
Serial Number: 37

**STOMATITIS PREVENTION DURING EVEROLIMUS/EXEMESTANE TREATMENT FOR METASTATIC BREAST CANCER: A PHASE 2 STUDY OF STEROID-BASED MOUTHWASH**

Mark Chambers (1), DMD, MS; Hope Rugo (2), MD; Jennifer Litton (1), MD; Ingrid Mayer (3), MD; Jacqueline Rogerio (4); Lisa DeMars (4); Jose Geromimo (4); Ghalum Warsi (4), DDS

The University of Texas MD Anderson Cancer Center, Houston, TX, USA (1), UCSF Helen Diller Family Comprehensive Cancer Center, San Francisco, CA, USA (2), Vanderbilt University, Nashville, TN, USA (3), Novartis Pharmaceuticals Corporation, East Hanover, NJ, USA (4), University of Maryland Medical System, Baltimore, MD, USA (5)

**Objective:** Stomatitis-inflammation of mucous membranes lining the mouth-has been observed in approximately 44-86% of cancer patients treated with everolimus. Anecdotally, clinicians report that steroid-based mouthwashes can prevent and manage stomatitis in patients with advanced breast cancer treated with everolimus. However, no clinical trial data are available.

**Methods:** This phase 2, single-arm study will evaluate the effectiveness of 0.5 mg/5 mL dexamethasone oral solution in preventing stomatitis during treatment of HR+/HER2- breast cancer with everolimus 10 mg/day plus exemestane 25 mg/day. Eligible patients will receive a steroid-based mouthwash (alcohol-free 0.5 mg/5 mL dexamethasone solution) prophylactically. Patients will be instructed to perform the mouthwash regimen 4 times per day and swish the mouthwash in the mouth for a minimum of 120 seconds before spitting it out. Patients will be instructed to abstain from eating or drinking for at least 1 hour after using the mouthwash. The mouthwash regimen will begin on the first day of everolimus administration, after dosing, and patients will continue the regimen for 2 months, with an additional 2 months at the physician's discretion. Primary end point is incidence of stomatitis (grade ≥2) at 2 months.

**Results:** Enrollment for this in-progress study is planned for 97 patients. The definition of grade ≥2 stomatitis will be strictly defined using physical examination, the Normalcy of Diet Subscale, and patient-reported visual analog scale scores to ensure objective and consistent grading.

**Conclusion:** This study is expected to reveal specific treatment strategies to prevent everolimus-associated stomatitis or ameliorate the severity.

**Source of Funding:** Novartis Pharmaceuticals Corporation

Poster Number: 17
Serial Number: 73

**PERCEIVED BARRIERS AND FACILITATORS TO DENTAL TREATMENT AMONG CAREGIVERS OF CHILDREN WITH CANCER**

Sahar Alrayyes (1), DDS, MS; Denise Maniakouras (1), DDS, MS; Anne Koerber (1), DDS, PhD; William Frese (1), MD

University of Illinois at Chicago, Chicago, Illinois, USA (1)

**Objective:** To explore parental perception surrounding select, hypothesized modifiers that may impact their child's initiating and continuing with dental care during cancer treatment.

**Methods:** A qualitative study consisted of a semi-structured interviews of parents of child oncology patients conducted at the University of Illinois, Chicago Outpatient Care Clinic.
Abstracts for Poster and Student Award Presentations

### DIABETES SCREENING IN DENTISTRY

**Eric Levine (1), DDS; Gary Hack (1), DDS**

**University of Maryland School of Dentistry, Baltimore, MD, USA (1)**

**Objectives:** Many patients receiving care at the University of Maryland School of Dentistry present with risk factors associated with chronic diseases, such as diabetes, that adversely affects oral health. The curriculum at the University of Maryland School of Dentistry has been sensitive to the issue of diabetes awareness with the goal of early detection and prevention.

**Methods:** Today’s dental curriculum includes inter-professional education that prepares students to practice a collaborative approach to health care, including acquiring the skills necessary to communicate effectively with other primary care providers. Dental students currently provide information to help their patients develop healthy dietary behaviors. Comprehensive exams, including both a thorough medical and dental history, identify patients at risk for a number of chronic diseases. The next phase of the intervention is for these dental visits to provide patients with an opportunistic setting for diabetes screening and monitoring.

**Results:** Dentists have begun to take a greater role in caring for their patients’ overall health. Understanding the comorbidity of oral disease with other chronic diseases has led to a better appreciation for strategies aimed to prevent the onset of diabetes. Current strategies have been focused on diet and lifestyle changes.

**Conclusions:** The impact and reciprocal nature of chronic health conditions, such as diabetes, on oral health requires the coordination of care between dentists and other health professionals. Through interprofessional education and collaborative intervention, dentistry can become a critical component of the primary care system.

**Source of Funding:** None

### SUGAR SWEETENED BEVERAGE (SSB) CONSUMPTION AND CARIES EXPERIENCE: ANALYSIS OF 2009-2012 NEW YORK STATE THIRD GRADE ORAL HEALTH SURVEY

**Priyanka Kandhari (1), DDS, MPH; Jayanth Kumar (1), DDS, MPH; Mark Moss (1), DDS, MPH, PhD; Vinicius Tavares (1), DDS, MPH**

**Bureau of Dental Health, Albany, NY, USA (1)**

**Objective:** To evaluate the association between SSB and caries experience in New York state third grade children.

**Methods:** We analyzed the Third Grade Oral Health Survey data (2009-2012) obtained from 6758 children in New York State. Parental responses to questions about SSB consumption were categorized as none, one to three times and more than four times in the past week. Descriptive and multivariate logistic regression analyses were performed to assess the association between caries experience and SSB consumption. Results were adjusted for potential confounders such as socioeconomic status, race and last dental visit.

**Results:** Overall, 82% of parents reported their child had one or more SSB consumption in the past week. The prevalence of caries increased with increased consumption of SSB from none (38%), one to three times in the past week (46%) to more than four times in the past week (54%). The adjusted odds ratios (and 95% confidence intervals) for caries experience were: 1.6 (1.4-1.9); and 1.3 (1.1-1.5) for SSB consumption more than four times in the past week (54%). The prevalence of caries experience was increasing with increased consumption of SSB and has a dose related response. Caries risk assessment tools should consider consumption of SSB as an important risk factor for caries experience. Future interventions need to focus on educating parents and children on negative oral health effect of SSB.

**Source of Funding:** None
Abstracts for Poster and Student Award Presentations

**Poster Number: 21**

Serial Number: 15

**CHANGES IN ORAL HEALTH STATUS OF THIRD GRADE CHILDREN: NEW YORK STATE ORAL HEALTH SURVEILLANCE SYSTEM, 2002 - 2004 AND 2009 - 2012**

Jayanth Kumar (1), DDS, MPH; Ismaila Sooso (2), BDS, MPh; Vinicius Tavares (1), DDS, MPH; Mark Moss (1), DDS, MS, PhD

**Bureau of Dental Health, New York State Department of Health, Albany, NY, USA (1), Department of Dentistry, Berkshire Medical Center, Pittsfield, Massachusetts, USA (2)**

**Objective:** We assessed the changes in the oral health status of third grade children in New York State.

**Methods:** We analyzed data obtained from two cross sectional oral health surveys of third grade school children in New York State. Using a standard protocol, 10,895 and 6,758 children drawn from stratified clusters of schools were screened in the 2002-2004 and 2009-2012 surveys, respectively. Weighted estimates of proportions and the respective standard errors were obtained by methods appropriate for stratified cluster sampling.

**Results:** The percent of children with caries experience declined from 54.1% (SE 1.3) in 2002 - 2004 to 44.2% (SE 3.3) in 2009 - 2012. This decline occurred primarily in the high income group (48% to 31.5%) but not in the low income group (59.6% to 57.5%). The percent of children with untreated caries decreased from 33.1% (SE 1.8) in 2002 - 2004 to 22.1% (SE 2.2) in 2009 - 2012. The percent with a dental sealant on a permanent molar, increased from 27% (SE 2.9) in 2002 - 2004 to 40.3% (SE 1.6) in 2009 - 2012.

**Conclusions:** Children in New York State continue to show progress toward New York State Oral Health Objectives. However, disparities between high and low income children widened. These data support the current efforts to promote targeted interventions in high risk and underserved school children.

**Source of Funding:** CDC State-Based Oral Disease Prevention Grant and the NYS Maternal and Child Health Services Block Grant.

**Poster Number: 22**

Serial Number: 32

**CARIRES RISK ASSESSMENT IN PRE-ORTHODONTIC MIDDLE SCHOOL CHILDREN IN WASHINGTON HEIGHTS, NEW YORK**

Claudia L. Cruz (1), DDS, MPH; Athanasios I. Zavras (1), DDS, MS, DrMSc; Stephen E. Marshall (1), DDS, MPH

**Columbia University, New York, USA (1)**

**Objective:** To evaluate the caries risk in a group of middle school kids in Washington Heights who are actively seeking orthodontic treatment, through implementation of a caries risk assessment protocol.

**Methods:** This is an ongoing study that is expected to include included 80 male and female subjects 11-14 years old. Biofilm activity is measured using an adenosine tri-phosphate (ATP) bioluminescence biometric test. We are examining clinically each child’s dentition and their current caries experience is recorded. Data on general health, diet, oral hygiene and use of fluorides are also obtained.

**Results:** Most of the minority, low-income children who seek orthodontic treatment are not receiving caries risk assessment or appropriate management of caries. Approx. 50% of 11-14 year olds in this group are at high risk for developing dental caries.

**Conclusions:** We identified a need for caries risk assessment and management in a group of urban underserved youth. Multiple risk factors cause a compounding effect in an orthodontic patient. The management of caries prior to starting active orthodontic treatment is essential to the patient.

**Acknowledgement:** This project was supported in part by HRSA grant D88HP20109

**Source of Funding:** None

**Poster Number: 23**

Serial Number: 39

**ORAL HEALTH STATUS OF CHILDREN SEEN IN A SCHOOL-BASED ORAL DISEASE PREVENTION PROGRAM IN LAREDO, TX**

David Cappelli (1), DMD, MPH, PhD; Anniellieg Cothron (1), BS, MS; Juan Steffensen (1), RDH, MCHES; Carolina Diaz De Guillory (1), DDS; Andrea Longoria (1), MS; Magda De La Torre (0), RDH, BS, MPH

**University of Texas Health Science Center at San Antonio, San Antonio, TX, USA (1)**

**Objective:** The University of Texas Health Science Center at San Antonio, Dental School provides preventive dental services to high risk, underinsured/underinsured elementary school children in Webb County, TX, along the Texas-Mexico border. Miles of Smiles-Laredo tracked changes throughout their program participation to measure, thereby improving oral health.

**Methods:** Miles of Smiles provided limited oral evaluations and fluoride varnish to kindergarten, second, and third graders in the Texas-Mexico border region. Second grade students receive dental sealants on first permanent molars and third graders had program sealants replaced if sealants were not retained. Basic Screening Survey data is collected during the limited oral evaluations. Children are tracked and charted longitudinally so that changes in oral health are examined and more specific interventions may be implemented.

**Results:** The oral disease burden among children participating in the Miles of Smiles-Laredo program is greater than national comparison with 65.8% identified as having caries experience and 28.2% of children having untreated tooth decay. Of the children screened, 21% needed some form of dental care with 500 children having urgent oral health issues. Among second grade children entering the program to be evaluated for sealant viability, 8% already had at least one decayed first permanent molar (FPM). When looking at the same group of children with at least one FPM decayed or filled, this increases to 21.5%.

**Conclusions:** The disease burden among high-risk children along the Texas-Mexico border is significant. Prevention through the Miles of Smiles-Laredo program will help decrease disease and identify disease at early stages.

**Source of Funding:** Supported by the DentaQuest Foundation and HRSA T12HP19338

**Poster Number: 24**

Serial Number: 47

**BREASTFEEDING DURATION AND EARLY CHILDHOOD CARIES IN US CHILDREN**

Solafa Ayoub (1), BDS; Woosung Sohn (1), DDS, PhD, DrPH

**Division of Dental Public Health, Department of Health Policy and Health Services Research, Boston University School of Dental Medicine, Boston, Massachusetts, USA (1)**

**Objectives:** The American Academy of Pediatrics recommends breastfeeding for one year or longer. However, the literature about its influence on children’s oral health is controversial. The aim of this study is to investigate the association between breastfeeding duration and early childhood caries (ECC) among young children in the United States.

**Methods:** Data from the National Health and Nutrition Examination Survey (NHANES)1999–2004 was analyzed for children aged 2-4 years old (N=2,042). Information regarding breastfeeding was obtained from the diet behavior and nutrition questionnaire. Children’s dental caries data were obtained from the oral health examination at mobile examination center (MEC). Bivariate and multivariate analyses to account for potential confounding were conducted. All analysis was conducted using SAS (version 9.1) Survey Procedures to account for the complex sampling design from NHANES.

**Results:** 63.4% of children were breastfed. Children breastfed for 6-12 months (36.5%) had lowest mean dft (0.3) compared to those...
Abstracts for Poster and Student Award Presentations

DENTAL CARIES IN SCHOOL AGED CHILDREN – RESULTS FROM NHANES 2009-2010
Swati Sakhuja (1), BDS; Ankit Sakhuja (2), MBBS; Alan Carr (3), DMD, MS
Maharana Pratap Dental College, Kanpur, Uttar Pradesh, India (1), Mayo Clinic, Rochester, MN, USA (2), Mayo Clinic, Rochester, MN, USA (3)

Objectives: Dental caries are an important cause of tooth loss in young. In this study we looked at the prevalence and risk factors for caries in school aged children.

Methods: Using NHANES 2009-2010 survey we evaluated the prevalence and risk factors for caries in children aged 6-19 years. Multivariable logistic regression including demographics and intake of sugary foods & drinks (>30 times a month vs less) was used to assess risk factors. We also evaluated protective effect of dental sealant use.

Results: Study included 2467 participants aged 6-19 years, that were representative of 55,885,813 US children. 14.3% had dental caries. Those with caries were more often males, Hispanic or Black and below poverty line. Caries were higher in those with high ice cream (35.9% vs 13.2%; p=0.004) and high soda intake (24.2% vs 13.5%; p<0.001). Those with dental restorations still had more caries. Those with sealant use were age group 11-15 (OR 1.97; 95% CI 1.59-2.44) and female (OR 1.47; 95% CI 1.28-1.69). Blacks had lower odds of sealant use (OR 0.64; 95% CI 0.50-0.82). Odds of sealant use were not different based on frequency of or intake of sugary foods and sodas.

Conclusion: Use of dental sealants in children is protective against caries but the overall prevalence of use is less than 50%. Those at higher risk of caries due to higher intake of sugary foods and sodas have no higher use of sealants than those with lower intake of these foods.

Source of Funding: None

USE OF DENTAL SEALANT IN CHILDREN – RESULTS FROM NHANES 2009-2010
Swati Sakhuja (1), BDS; Ankit Sakhuja (2), MBBS; Alan Carr (2), DMD, MS
Maharana Pratap Dental College, Kanpur, Uttar Pradesh, India (1), Mayo Clinic, Rochester, MN, USA (2)

Objectives: Use of dental sealant for prevention of caries though recommended, has been low. In this study we looked at the use of dental sealants in populations at high risk for caries - those with increased intake of sugary foods and sodas.

Methods: Using NHANES 2009-2010 database we evaluated the prevalence of dental sealant use in children aged 6-15 years and especially among those with high intake of sugary foods and sodas (>30 times a month vs less) using multivariable logistic regression.

Results: Of total 1,839 children aged 6-15 included in the study that represented estimated 40,656,938 US children, only 42% had dental sealant present. Sealant use was higher in girls, Whites and those above poverty line. Existing dental decay was more prevalent in those without sealant (19.4% vs 5.4%; p<0.001). Sealant use was not different based on intake of sugary foods and sodas. On adjusted analysis, predictors for sealant use were age group 11-15 (OR 1.97; 95% CI 1.59-2.44) and female sex (OR 1.47; 95% CI 1.28-1.69). Blacks had lower odds of sealant use (OR 0.64; 95% CI 0.50-0.82). Odds of sealant use were not different based on frequency of or intake of sugary foods and sodas.

Conclusion: Use of dental sealants in children is protective against caries but the overall prevalence of use is less than 50%. Those at higher risk of caries due to higher intake of sugary foods and sodas have no higher use of sealants than those with lower intake of these foods.

Source of Funding: None

PREVALENCE OF DENTAL CARIES IN VERY YOUNG CHILDREN AT A HOSPITAL-BASED PEDIATRIC DENTAL CLINIC
Homa Amini (1,2), DDS, MPH, MS; Beth Noel (1), RDH
Nationwide Children’s Hospital, Columbus, Ohio, USA (1), Ohio State University, Columbus, Ohio, USA (2)

Objective: To assess prevalence of early childhood caries among children ages 0-42 months seen in the baby dental clinic at Nationwide Children’s Hospital in Columbus, Ohio.

Methods: 2500 children ages 0-42 months were evaluated from January 2011 to June 2012. Demographic information, caries risk

Source of Funding: None
assessments and clinical findings were documented. For those children deemed to be at high risk for dental disease, we recorded patient’s plan of care including 1) three months recall for disease management of non-cavitated white spots, 2) emergency treatment, 3) referral for non-pharmacologic restorative visit, 3) referral for sedation, and 5) referral for general anesthesia.

Results: Majority of patients had Medicaid as source of payment. 30% of patients were deemed to have a high caries risk based on presence of non-cavitated demineralized enamel surface and/or cavitated lesions. Of those high risk patients, 32% required a 3 month recall (disease management visit to monitor and manage incipient caries or white spot lesions), 30% for non-pharmacologic restorative visit, 6% sedation, and 26% general anesthesia, and 6% other.

Conclusion: Prevalence of early childhood caries is high in low-income young children. Prevention and outreach must begin early to alleviate the burden of disease for this population.

Source of Funding: None

Poster Number: 29
Serial Number: 76
THE ELECTRONIC HEALTH RECORD AS A TOOL TO CORRELATE FRUIT AND VEGETABLE INTAKE AND THE DMFS INDEX OF PEDIATRIC PATIENTS AT BELLEVUE HOSPITAL CENTER IN NEW YORK CITY
Douglas Pollack (1,2), DDS; Athanasios I. Zavras (1), DDS, MSc, ScD; Courtney Chinn (1), DDS, MPH; Emily Alpector (1), LMSW
Columbia University, New York, NY, USA (1), Bellevue Hospital Center, New York, NY, USA (2)

Objective: This ongoing study seeks to compare the incidence of dental caries among pediatric patients receiving nutritional counseling at a New York City public hospital.

Method: This study is expected to include 200 participants. The DMFS values of patients receiving nutritional counseling are being tabulated. The number of documented servings of fruits and vegetables are being recorded. This data will be analyzed for correlations (p<.05).

Results: There is a difference in DMFS score between pediatric patients with a high intake of fruits and vegetables when compared to those with a low intake.

Conclusion: We expect to find that greater intake of fruits and vegetables could offer a protective effect against dental caries. Possible confounding variables will be identified and discussed.

Source of Funding: This project was supported in part by HRSA grant T17MC06359

Poster Number: 31
Serial Number: 90
WHY ARE CARIES RISK ASSESSMENT TESTS ON CHILDREN UNDER-UTILIZED BY PEDIATRIC DENTISTS?
Renuka Bijoor (1,2), DDS, MDS, FDSRCS, FFDRCS; Athanasios Zavra (1,2), DDS, MSc, ScD; Agelina Paek (1)
Columbia College of Dental Medicine, New York, New York, USA (1), Columbia Mailman School of Public Health, New Yrk, New York, USA (2)

Objective: The aim of this on-going study is to identify the barriers to the clinical implementation of caries risk assessment tools by pediatric dentists.

Method: A random sampling of approximately 30-40 pediatric dentists from the Tri-state area will be selected for the survey. Participants will be sent a questionnaire through direct mail and/or via email to assess if they use caries risk assessment and to provide reasons for not utilizing caries susceptibility test/caries risk assessment (CAT/CAMBRA). Additional questions will be given to those that do perform these diagnostic services, whether insurance claims are submitted and reasons why they are not submitted. Responses will be collected from each dentist and an average response determined. After analysis of the results of the first survey, a second survey will be sent to the same subjects with inclusion of the results and subjects will be asked to complete and submit the second survey.

Results and Conclusions: This is an on-going study and the results and conclusions will be available at the time of the 2014 conference.

Source of Funding: This project was supported in part by HRSA grant D88HP20109

Poster Number: 32
Serial Number: 29

GEOGRAPHIC DIFFERENCES IN DENTAL CARE AND UNMET ORAL HEALTH NEEDS AMONG CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)
Esther Kim (1), DMD, MPH; Jayanth Kumar (1), DDS, MPH; Mark Moss (1), DDS, MS, PhD
Bureau of Dental Health, New York State Department of Health, Albany, NY, USA (1)

Objective: To identify geographic differences in oral health indicators for CSHCN, and compare them to that of children without Special Health Care Needs (SHCN).

Methods: The 2011-2012 National Survey of Children’s Health was used to assess responses to five oral health indicators with respect to ten Health Resources and Services Administration (HRSA) regions. The five indicators include the child’s dental condition; and whether the child experienced any oral health problems, received any dental and/or preventive care, and had delayed or no dental care. Ten HRSA regions received a grade of “A” if they performed at or better than the national average for at least 4 out of 5 indicators, “B” for 3 out of 5, “C” for 2 out of 5, “D” for 1 out of 5, and “F” for 0 out of 5.

Results: Three HRSA regions consistently received an A for both CSHCN and children without SHCN. While one region received an F for CSHCN, no region scored lower than a D for children without SHCN. For CSHCN, one region received a B, four received a C, and one received a D. For children without SHCN, three received a B, two received a C, and one received a D.

Conclusion: There are geographic differences in dental care and unmet oral health needs identified among both CSHCN and children without SHCN. Additional studies are needed to explain why certain regions consistently perform well for both groups, while others do not. Further policy initiatives should be explored to ensure equity.

Source of Funding: HRSA Maternal and Child Health Block Grant.

Poster Number: 33
Serial Number: 78

ACCESS TO DENTAL SERVICES AMONG CHILDREN WITH SPECIAL HEALTH CARE NEEDS IN THE U.S
Ismail Jolaoso (1), DDS, MPH; Eziafa Oduah (2), MD, MPH
Berkshire Medical Center, Pittsfield, MA, USA (1), University at Albany, Albany, NY, USA (2)

Objective: To evaluate the use of dental services among children with special health care needs in the United States.

Methods: We analyzed data obtained from the 2011 - 2012 National Survey of Children’s Health to determine the prevalence of dental caries and assess the use of dental services among children with special health care needs. The analysis included 19,403 children with special health care needs aged 0 - 17 years. Statistical analysis was done using SAS 9.4 and results were weighted to represent the population of non-institutionalized children aged 0 - 17 years in the United States.

Results: One out of every five children in the U.S has special health care needs. Twenty-two percent (21.6 - 23.3) of children with special health care needs had one or more oral health problems within the past
Abstracts for Poster and Student Award Presentations

Poster Number: 34
Serial Number: 9
WIC ORAL HEALTH PROGRAM EVALUATION
Jaana Gold (1,2), DDS, PhD; Elizabeth Lense (2), DDS, MSHA; Scott Tomar (2), DMD, MPH; Frank Catalanotto (2), DMD
A T Still University, Kirksville MO, USA (1), University of Florida, Gainesville FL, USA (2)

Objective: Integrating preventive oral health services into WIC programs may reduce the burden of disease among women and children at high-risk. The objective of this project was to conduct an interim evaluation of newly implemented WIC Oral Health Program.

Methods: Axium Dental Software was used to collect and analyze patient demographic and clinical data for WIC clients.

Results: We conducted 248 oral evaluations during the first 6 months (1-2 days/week). Most (68.5%) oral evaluations were for children aged 0-6 years. Forty seven (19%) pregnant mothers and caregivers were screened. A total of 210 oral hygiene instructions and 191 fluoride varnish treatments were provided.

Cavitated lesions were found in 48 of 192 children (25%) aged 0-5 years and 21 of 72 children (29%) aged 3-5. Twenty-five (32%) children aged 0-3 years were referred to the University of Florida College of Dentistry Infant Oral Health Clinic. Others in need of dental treatment were assisted in finding a local Medicaid provider.

Conclusions: A preventive oral health program was successfully implemented in a local WIC clinic. Cavities prevalence in these children is high compared with national estimates. Preventive and restorative dental services are greatly needed in this population. The UF WIC Oral Health Program may serve as a model for interdiciplinary health programs to improve the health of at-risk populations.

Source of Funding: None

Poster Number: 35
Serial Number: 21
THE DIET AND EARLY CHILDHOOD CARIES (DECC) STUDY: FEASIBILITY, ACCEPTABILITY, AND SHORT-TERM IMPACT OF A NOVEL ECC INTERVENTION
Christie Custodio-Lumsden (1,2), PhD, MS, RD, CDN; Randi Wolf (2), PhD, MPH; Isabel Contento (2), PhD, MA; Charles Basch (2), PhD, MS; Pamela Koch (2), PhD; Patricia Zybert (2), PhD, MPH; Burton Edelstein (1), DDS, MPH Columbia University College of Dental Medicine, New York, NY, USA (1), Teachers College Columbia University, New York, NY, USA (2)

Objectives: To determine the feasibility, acceptability, and short-term impact of “MySmileBuddy” (MSB), an innovative Early Childhood Caries (ECC) risk assessment tool and educational platform for behavior change in predominantly Hispanic low-income children attending the Columbia University Pediatric Dental Clinic in New York City.

Methods: The Diet and Early Childhood Caries study (DECC) evaluated MSB among 108 parent/young child (2-6 years old) dyads. Using MSB, we delivered targeted risk-based behavior change messages via interactive iPad-based technology and assessed feasibility of delivery and acceptability immediately following a routine dental examination. At one month, impact of the intervention was assessed as parental recollection of, and progress toward, behavior change goals.

Results: Of the 113 parents/caregivers approached, 108 (95.6%) accepted invitations to participate and all completed MSB in its entirety. Over 96% of the participants reached for the one-month follow-up recalled MSB and most (63.3%) recalled setting a specific behavior change goal. Four-fifths of participants reached for follow-up (79.7%) reported taking some action to change ECC-related behavior post intervention.

Conclusions: The exceptionally high recruitment and intervention completion rates suggest that there is a recognized need and interest among low-income Hispanic parents/caregivers to learn more about caries risk reduction. Although longer-term studies are needed, the follow-up survey findings suggest that MSB is a valuable tool for initiating behavior changes to reduce ECC risk. The MSB intervention was determined to be feasible to implement in a busy clinic setting and acceptable to this high-risk population.

Source of Funding: None
Abstracts for Poster and Student Award Presentations

**IMPROVEMENT IN CLINICAL ORAL HEALTH FOLLOWING RECEIPT OF THE CENTERINGPREGNANCY® ORAL HEALTH PROMOTION (CPOP) PILOT INTERVENTION DELIVERED IN THE GROUP PRENATAL CARE SETTING: RESULTS OF A PILOT STUDY**

Sally Adams (1), PhD, RN; Steven Gregorich (1), PhD; Lisa Chung (1), DDS, MPH

**Objective:** National and professional organizations recommend including oral health (OH) promotion in prenatal care to improve women’s OH. However, few prenatal programs include this. The objective was to determine if women receiving an OH intervention within CenteringPregnancy® (CP) group prenatal care had greater clinical OH improvement than women receiving standard CP care.

**Method:** Women were recruited from 4 Northern California CP sites to pilot test the CPOP Intervention (Intervention n=49; Control n=52). Intervention groups received two 15-minute OH modules (maternal and infant), delivered by trained CP prenatal care providers. The maternal module included facilitated discussions and skills-building activities including proper tooth brushing practice. Intervention and control groups completed dental examinations at the pre- and post-intervention periods approximately 8-10 weeks apart (n=78). Clinical outcomes included participant-specific mean periodontal probing depth in mm (PD), mean Plaque index (Pl; range 0-3), and probing location-specific binary indicators of gingival bleeding on probing (BOP). Generalized linear mixed models, which included random intercepts for CP site, CP provider, CP group, and participants, tested effects of intervention groups, time (pre v post), and groups-by-time interaction.

**Results:** Tests of group-by-time interaction showed that the Intervention versus the Control group had significantly greater pre-post change (d) in mean PD (d=-.07mm v d=+.05mm, respectively, p<.0001), mean Pl (d=+.17 v d=+.03, p<.0001), and absolute probability of BOP (d=-.07 v d=0, p=.004), indicating significant improvement in the Intervention group.

**Conclusion:** Providing brief OH education and skills-building activities within prenatal care visits may be effective in improving women’s OH during pregnancy.

**Source of Funding:** NIH/NIDCR R21-DE019211 and US5 DE019285; Dental Trade Alliance Foundation

**HEALTHY WEIGHT INTERVENTION IN THE DENTAL SETTING FOR CHILDREN AGE 2.5-6 YEARS OLD**

Lisa Lian (1), DMD; Mary Tavares (1,2), DMD, MPH; Anna O’Keefe (3), DMD

**Objective:** For children under 6, the caregiver is critical for HWI; the child is rarely engaged. This paradigm can lead to challenges that are not encountered when HWI is used with older children.

**Results:** Feedback from clinician and parent interviews was utilized to enhance survey, which addresses diet, physical activity, and eating behaviors. Motivational interviewing with hygienists, parents completed the HWi intervention group.

**Conclusions:** Some challenges were addressed in improvements of questionnaire implementation, so that dental professionals may be better prepared to advise pediatric patients and their parents in healthy weight habits. For children under 6, the caregiver is critical for HWI; the child is rarely engaged. This paradigm can lead to challenges that are not encountered when HWI is used with older children.

**Source of Funding:** Harvard Medical School, Scholars in Medicine Department, Bingham Trust, Colgate Palmolive

**PROMOTORAS AND CHILDREN’S ORAL HEALTH: AN INNOVATIVE PROGRAM TO IMPROVE ACCESS TO CARE**

Baharak Amanzadeh (1), DDS, MPH; Vanessa Bohm (2), MFA; Sharon Rose (1), MPH

**Objectives:** To create a sustainable program that empowers promotoras (community health workers in Spanish) to address Latino children’s oral health disparities in San Francisco by improving children’s oral health and access to dental services.

**Method:** This program is designed through an authentic university-community partnership. Promotoras are trained in children’s oral health concepts, preventive strategies, basic screening and Fluoride Varnish application. They then disseminate the intervention, which is a combination of oral health education, fluoride varnish application, and case management services to link to community resources. The program evaluation tools examine the effectiveness of the training, families’ access to care barriers and acceptance of the program, as well as the effectiveness in connecting the families to dental care.

**Results:** Promotoras educate parents, intervene in children’s oral health and link families with dental services by engaging in effective, culturally appropriate oral health education and practices for a community that trusts in them.

**Conclusions:** This Community Health Worker (CHW) model can be an effective approach to address access to dental care barriers for children of minority populations in the US. Further policies to support and reimburse CHWs’ health education, Fluoride Varnish application and case management work will assure the sustainability of this model.

**Source of Funding:** San Francisco Health Improvement collaboration grant funding, ADA Harris Fund Grant

**ENERGIZING THE DENTAL PUBLIC HEALTH PIPELINE AT THE GRASSROOTS LEVEL?**

Eugen Kim (1); Yoonah Danskin (1); Jessica Richards (1); Kathryn Atchison (1), DDS, MPH

**Objectives:** To understand student interest in and perceptions of DPH.

**Methods:** An online survey was distributed to first- and second-year dental students via the American Student Dental Association (ASDA) leadership at 8 selected dental schools. Student interest was measured by their interest in participating in a predoctoral DPH...
certificate program; four topics were offered to see how students perceived DPH functions. Participants were provided a $5 gift card upon survey completion. Analysis was done using chi-square and t-tests.

**Results:** A total of 140 dental students completed the survey. Overall, 69% of respondents plan on continuing their dental education in a specialty (55%) or advanced degree program (military, AEGD/GPR, graduate degrees) (14%); none planned to pursue a DPH specialty. 63% indicated interest in a pre-doctoral DPH certificate program and 67% indicated they would ‘likely or definitely’ participate in such a program. Furthermore, 79% indicated that it was important for dentists to have knowledge of DPH, however only 34% expressed interest in the DPH specialty. Regarding the student perception of DPH, over 70% related ‘preventing disease and promoting health’ and ‘addressing the oral health needs of the community’ with DPH; 54% chose ‘providing free or subsidized dental services’ and 39%, included ‘collecting oral health data’ in their definition. Differences by gender and future career plans in how DPH is defined were present.

**Conclusions:** Offering a pre-doctoral DPH certificate program, which could provide leadership opportunities in oral health promotion, may foster interest in the specialty of Dental Public Health.

**Source of Funding:** NIH/National Center for Advancing Translational Science (NCATS) UCLA CTSI Grant Number TL1TR000121, UCLA/DREW Project EXPORT, NIMHD, P20MD000182

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**EVALUATION OF A COMMUNITY BASED DENTAL EDUCATION PROGRAM: STUDENT SELF-RATED COMPETENCIES**

Kimberly McFarland (1), DDS, MHSA; Preethy Nayar (1), MD, PhD; Brian Lange (1), PhD; Diptee Ojha (1), BDS, MBA; Aastha Chandak (1), BS University of Nebraska Medical Center, Omaha, NE, USA (1)

**Objective:** The objective of this study was to evaluate the impact of a rural Community Based Dental Education (CBDE) program on the self-rated competencies of dental students.

**Background:** Fourth year dental students in the College of Dentistry, University of Nebraska Medical Center participate in a CBDE program that includes a four week rotation in rural dental practices.

**Methods:** A paper-based retrospective post-test survey was administered to the dental students who participated in the CBDE program in academic year 2011-2012. The survey questionnaire included closed-ended questions on demographic information, and self-rated ADEA competencies (on a Likert scale from 1 to 5); before and after participation in the program. The pre to post program change in competencies was examined using Wilcoxon rank sum test.

**Results:** The mean pre-program student self-rated competencies of the participants ranged from 3.36 (Practice Management and Informatics) to 4.03 (Professionalism). The mean post-program self-rated competencies of the students ranged from 3.9 (Practice Management and Patient Care: Establishment and Maintenance of Oral Health) to 4.43 (Professionalism). There was a significant increase in self-rated competencies for all of the six domains of ADEA competencies. The improvement was greatest in the domain of Patient Care: Establishment and Maintenance of Oral Health) to 4.43 (Professionalism). There was a significant increase in self-rated competencies for all of the six domains of ADEA competencies. The improvement was greatest in the domain of Professionalism.

**Conclusion:** The results signify that the CBDE program was effective in improving the students’ dental competencies in addition to preparing them to better serve the oral health needs of rural, underserved populations, and highlight the value of rural CBDE programs in the dental curriculum.

**Source of Funding:** Health Resources and Services Administration
Abstracts for Poster and Student Award Presentations

**Poster Number: 44**
**Serial Number: 45**

**ATTITUDES, BELIEFS AND READINESS FOR TELEDENTISTRY**

**Objective:** The objective of this study was to examine the attitudes, beliefs and readiness for teledentistry among health professionals who participated in a statewide teledentistry training program in Nebraska.

**Methods:** Ninety-six respondents who participated in a teledentistry training program conducted at eight sites across Nebraska responded to a self-administered, paper-based, retrospective post-test survey. The survey assessed the participants' beliefs about attitudes towards and readiness for teledentistry.

**Results:** The participants included 20 (20.8%) dentists; 37 (38.54%) dental students; 6 (6.34%) dental hygienists and other health professionals (public health nurses and social workers). Of the participants, 51 (54.3%) believed that increasing access to the dental services was very important in strengthening health services in the community. About two thirds, (64: 66.7 %) had never participated in teledentistry consultations. However, the majority were willing to: refer patients (73; 76%); to participate in teledentistry consults (76; 80%); and training (74; 77%); to acquire teledentistry equipment (63; 65.6%); and to become a teledentistry provider (59; 61%). The most common barrier to teledentistry identified by participants was attitudes of employer (37%).

**Conclusions:** While a significant proportion of the health professionals were aware of the benefits of and willing to participate in teledentistry, few actually had the resources including equipment or clinical support needed to participate in teledentistry programs, indicating that significant challenges exist in developing a successful teledentistry program.

**Source of Funding:** Health Resources and Services Administration

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**Poster Number: 46**
**Serial Number: 50**

**IMPLEMENTING CLINICAL DECISION SUPPORT TOOLS IN A LARGE GROUP DENTAL PRACTICE: BASELINE DATA**

Elizabeth Mertz (1), PhD, MA; Olumide Bolarinwa (1), BDS, MSc; Ram Vaderhobhi (1), BDS, MS; Joel White (1), DDS, MA

**Objective:** The objective of this study is to assess the baseline conditions relative to acceptability of implementation of clinical decision support tools within the electronic health record of a large group dental practice.

**Methods:** A baseline electronic survey of all Willamette Dental Group employees (n=1166, 54 sites, 3 states) examined predisposing factors for acceptance of the tools, including: comfort with dental and information technology, employee satisfaction, demographics, and attitudes, knowledge and training on caries and periodontal disease management by risk assessment and use of a Proactive Dental Care Plan.

**Results:** They surveyed was conducted from 7/22/13 to 11/11/13 and received a 79.8% response rate (n=930) with an 83.1% response rate (n=567) from clinicians (80.2% dentists (n=172), 92.1% hygienists (n=164), and 80.3% assistants (n=346). Clinicians reported being satisfied in their jobs (74.8%), confidence in their own (89.4%) and their team's (76.1%) ability to adapt to change, being experienced with computers (65.1%) and EHRs (76.9%), and satisfaction with the newly implemented EHR (73.6%). Less than half of clinicians reported formal training in risk assessment for caries & periodontal disease (46.1% & 43.5% respectively), while a majority of providers agreed that these tools were supported by evidence (64.8% & 64.4%), likely to improve quality (71.8% & 70.5%), productivity (53.5% & 52.9%) and be cost-effective (53.0% & 52.4%).

**Conclusions:** Baseline conditions are amenable to implementation of CDST. Clinicians report good knowledge of the concepts and rationale underpinning the tools yet they report higher expectations of improved patient care and quality than of business processes.

**Source of Funding:** THE SKOURTES INSTITUTE
**Methods:** This study tracks POST-BAC participants who completed the program from 2003-2007 and were admitted to dental school from 2004-2008. The study compares dental school GPA's, national board dental examination (NBDE) results, graduation rate, and evidence of practicing in underserved areas. An independent t-test of POST-BACs versus non-POST-BACs pre-matriculation/matrículation statistical data was completed. The chi-square test was used to analyze the post-baccalaureate and non-post-baccalaureate graduation and attrition rates.

**Results:** Eighty-nine percent of the POST-BAC students in 2003-2007 were admitted to the Meharry dental school, comprising 21% of its total dental school enrollment. Significant differences between POST-BAC and non-POST-BAC students existed in 1st, 3rd, and 4th-year dental school GPA's and NBDE Part I performance. No significant difference existed in NBDE Part II performance, graduation rate, attrition rate, and practicing in underserved areas.

**Conclusion:** The POST-BAC program serves as a vehicle for increasing the number of minority dentists, and increasing the number of minorities who serve the underserved. Increased federal funding and/or identifying financial resources to support HCOP type programs can serve to increase the number of minority dentists and improve access to oral health care for underserved areas.

**Source of Funding:** None

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**Poster Number:** 49  
**Serial Number:** 13  
**VOLUNTEERISM AMONG DENTISTS IN A MOBILE DENTAL PROGRAM: MOTIVATIONS AND BARRIERS**

Lori Woods (1), PhD; Eli Schwarz (1), DDS, MPH; Matthew Stiller (2), BS; Byung Park (1), PhD; William Lambert (1), PhD  
Oregon Health & Science University, Portland, OR, USA (1), Medical Teams International, Tigard, OR, USA (2)

**Objectives:** Many low income people rely on volunteer dentists in nonprofit organizations for urgent care. The purpose of this study was to determine the motivations for and barriers to volunteerism among dentists in a mobile dental program.

**Methods:** Using a mixed-methods design, we conducted focus groups with program staff, and current and former volunteer dentists who contributed time to one non-profit mobile dental program in Oregon. This qualitative information was used to design a web-based survey to quantify the relative importance of potential motivators and barriers.

**Results:** 117 dentists completed the on-line survey. “Making a difference” in patients’ lives and a sense of professional responsibility ranked highest as motivators. Volunteerism in alternative programs was the #1 barrier (48.8% of respondents). Facilities and/or equipment were ranked #2; and a preference for working only with patients of a particular age was ranked #3. Respondents indicating that they “strongly agreed” or “agreed” that a factor limited their service was as follows: not having time (34.2%), personal financial commitments (27.0%), volunteering elsewhere (24.3%), preference not to do certain procedures (14.4%), need to pay off school loans (12.6%), patient age or other demographics (12.6%), patient needs not urgent (12.5%), facilities (10.8%), and other factors (<6%).

**Conclusions:** The most important factors affecting volunteerism appear to be external to the program itself and not directly under the control of the organization. Even so, organizations relying on volunteer dentists should be aware of these motivating factors and barriers that may affect their ability to recruit and retain volunteers.

**Source of Funding:** None

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**Poster Number:** 50  
**Serial Number:** 23  
**FACTORS PREDICTING DENTISTS’ CONFIDENCE IN TREATING TOBACCO DEPENDENCE AMONG THEIR PATIENTS**

Pradeep Bhagavatula (1), BDS, MPH, MS; Vinodh Bhoopathi (2), BDS, MPH, DScD  
Marquette University School of Dentistry, Milwaukee, WI, USA (1), Nova Southeastern University College of Dental Medicine, Fort Lauderdale, FL, USA (2)

**Objective:** To identify the factors which best predict dentists’ confidence in provision of tobacco cessation treatment and counselling to their patients.

**Methods:** For this cross-sectional study, we used a 39-item pretested online survey to target all active dentists in the State of Wisconsin who were members of Wisconsin Dental Association. Univariate, and bivariate analyses were performed. A multivariable linear regression model was used to predict dentists’ confidence in providing tobacco dependence treatment.

**Results:** 243 dentists completed the survey (Response rate = 28%). Majority of the respondents were males (80%), Whites (96%), non-Hispanics (98%), and had graduated more than 15 years ago from a dental school (70%). 22% reported that tobacco cessation training was a part of their dental school curriculum and 14% reported receiving training outside dental school. 54% reported that tobacco cessation counseling was part of preventive care in their clinic. Linear regression model (R²=29.0%) showed that male dentists (p<0.0001), dentists who...
received tobacco cessation training outside dental school curriculum (p=0.02), and who perceived that he/she together with the dental team can effectively help someone quit tobacco addiction (p<0.0001), were more confident in providing tobacco dependence treatment.

**Conclusion:** Gender, receiving training outside dental curriculum, and having a positive attitude towards the efficacy of dental team in helping patients quit tobacco use are associated with higher level of confidence in providing tobacco dependence treatment.

**Source of Funding:** None

Poster Number: 51
Serial Number: 34

**PRE-DOCTORAL STUDENT PREFERENCES FOR AN ELECTIVE DENTAL PUBLIC HEALTH (DPH) EDUCATION PROGRAM**

Yoonah Danskin (1); Eugen Kim (1); Jessica Richards (1); Kathryn Atchison (1) DDS, MPH

UCLA, School of Dentistry, Los Angeles, California, USA (1)

**Objective:** This study presents the results of a survey on the design preferences of dental students for a DPH elective education program.

**Method:** 1st and 2nd year students at 8 dental schools were invited through their ASDA leadership to participate in an online survey about the structure, presentation, and evaluation of a possible design of the DPH certificate program.

**Results:** 120 students completed the items and 94 students (32 Males & 62 Females) indicated interest in participating in an elective DPH certificate program. In terms of program structure, 68% of the White, 49% of the Asian, and 81% of the other students preferred an in-person presentation format (lecture, small group discussions, and/or an opportunity to work with DPH specialists), over self-paced programs. Group settings were preferred both by students planning to specialize (62%) and enter general practice (56%). No significant differences were found. Students expressed greatest interest in learning about basic principles of dental public health (85%), oral health promotion (83%), and preventive treatments (78%). The majority of the students preferred evaluation by written exams (44%) or reflection papers (62%) rather than research projects (33%) or poster presentations (28%).

**Conclusion:** Encouraging students elect DPH education programs may require careful consideration of the preference of students towards education topics and delivery modes to design a program that best attracts dental students.

**Source of Funding:** Clinical and Translational Science Institute

Poster Number: 52
Serial Number: 35

**UTILIZING THE THEORY OF DISRUPTIVE INNOVATION TO EXAMINE AND EXPLAIN THE ATTITUDES OF DENTAL PROFESSIONALS AT COLUMBIA UNIVERSITY COLLEGE OF DENTAL MEDICINE REGARDING DENTAL HEALTH AIDE THERAPISTS**

Charles Wei (1); Joseph McManus (1), DMD, MS, MHA, MBA, MS

Columbia University College of New York, New York, NY, USA (1)

**Objectives:** The goal of this project is to determine whether the theory of disruptive innovation played a significant role in the development of a dental professional's attitude toward Alaska's Dental Health Aide Therapist model, as well as the potential expansion of this model to other underserved, rural regions in the United States.

**Method:** A comprehensive review of the literature was conducted on the DHAT model. Emails with an embedded link to a secured, online survey were sent to students, residents, and clinical faculty members at Columbia University College of Dental Medicine (CUCDM). The purpose of the survey is to assess their attitudes on the DHAT model currently in Alaska, as well as the expansion of this model to other underserved, rural regions of the United States.

**Results:** There were 73 valid responses, with the majority supporting the implementation of Alaska’s DHAT model, and holding positive attitudes toward the expansion of this model to other underserved, rural area of the United States.

**Conclusions:** Dental professionals at CUCDM believe that the DHATs have been beneficial to the underserved Alaskan population and may be a part of the solution to address the access to care issue in the rest of the underserved, rural regions of the United States. Most of the respondents are specialty oriented and do not find the DHATs to be in direct competition with them. It may be inferred that the theory of disruption innovation explains the respondents' positive attitudes toward the expansion of the DHAT model.

**Source of Funding:** None

Poster Number: 53
Serial Number: 60

**DENTISTS’ ATTITUDES TOWARDS MEDICAID AND LOW INCOME PATIENTS IN IOWA**

Susan McKernan (1,2), DMD, MS, PhD; Julie Reynolds (1,2), DDS; Raymond Kuthy (1), DDS, MPH; Nancy Adranie (3), BSDH; Elham Kateeb (2), BDS, MPH, PhD; Peter Damiano (1,2), DDS, MPH

University of Iowa College of Dentistry Department of Preventive & Community Dentistry, Iowa City, IA, USA (1), University of Iowa Public Policy Center, Iowa City, IA, USA (2), Iowa Primary Care Association, Urbandale, IA, USA (3)

**Objective:** We surveyed private practitioners in Iowa about participation in Medicaid along with attitudes towards the program. Our goal was to assess current safety net capacity in preparation for Medicaid expansion associated with implementation of the ACA.

**Methods:** A mixed mode survey (mail and online) was sent to all active 1,341 dentists in spring 2013 (n=1,341). We asked dentists about acceptance of new Medicaid patients, along with attitudes towards the Medicaid program and patients.

**Results:** Surveys were returned by 58% of dentists (N=776). Sixteen percent of dentists accept all new Medicaid patients; 42% accept some new patients—for example, patients of their own who become Medicaid enrolled. Additionally, over half of the dentists who accept new Medicaid patients had moderately or extremely seriously considered discontinuing this. Low reimbursement rates, broken appointments, and complicated paperwork were the most important issues for dentists in deciding how much to participate in the Medicaid program. Dentists who accept Medicaid were more likely to have favorable attitudes towards the program and to report more altruistic attitudes.

**Conclusions:** Compared with previous surveys of Iowa dentists in the 1990s, fewer dentists are accepting new Medicaid patients. The ACA-related expansion of Medicaid in states with adult dental coverage will provide pressure to have adequate provider panels. Developing or modifying Medicaid programs to encourage provider participation will be critical to successfully improving access to dental care. Addressing the unique concerns of dentists who do not currently participate in the program will be an important step in this direction.

**Source of Funding:** DentaQuest Foundation (Boston, MA)

Poster Number: 54
Serial Number: 83

**UNDERSTANDING ORAL HEALTH INEQUITY THROUGH CULTURAL HUMILITY**

Maria Dolce (1), PhD, RN, CNE; Brian Swann (2), DDS, MPH; Pamela Ring (1), JD, MPA

Northeastern University, Boston, MA, USA (1), Harvard School of Dental Medicine, Boston, MA, USA (2)

**Objectives:** To address oral health inequities, health professionals need to understand the important connection between oral health
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and overall health, and underlying determinants of poor oral health for different population groups. The aim of this presentation is to describe the experiences of allied health students and faculty collaborating with dental students and faculty in a community outreach program to better understand the oral-systemic health needs of a local American Indian population.

Methods: Faculty and students from Bouvé College of Health Sciences at Northeastern University participated in Harvard School of Dental Medicine's community outreach to the Wampanoag Tribe of Gay Head on Martha's Vineyard, Massachusetts. Allied health students including nursing, pharmacy, and behavioral health, collaborated with dental students in a community outreach to the tribal community. Allied health students teamed with dental students in conducting oral health screenings, risk assessments, and health histories. Students interacted with tribal community members, including children, adolescents, adults and older adults, providing oral-systemic health information and counseling about healthy personal behaviors.

Results: The community outreach program enhanced students' understanding about oral-systemic health, diverse barriers to achieving optimal oral health, and the importance of cultural humility in addressing oral health inequities for American Indians. Building trusting relationships with the community and team members was foundational to this program's success.

Conclusion: Bringing together students and faculty across health professions to engage in a community outreach is an effective interprofessional education strategy to promote cultural humility in improving oral-systemic health for vulnerable and underserved individuals, communities, and populations.

Source of Funding: This presentation is made possible as a result of funding from the DentaQuest Foundation. The DentaQuest Foundation is committed to optimal oral health for all Americans through its support of prevention and access to affordable care, and the

Poster Number: 55
Serial Number: 14

THE PUBLIC HEALTH SAFETY NET: IOWA'S COMMUNITY HEALTH CENTER CAPACITY TO MEET THE ANTICIPATED DENTAL DEMAND IN 2014 AND BEYOND
Raymond Kuthy (1), DDS, MPH; Susan McKernan (1), DMD, MS, PhD; Julie Reynolds (1), DDS, MS; Nancy Adrianse (2), BS; Peter Damiano (1), DDS, MPH
University of Iowa Public Policy Center, Iowa City, Iowa, USA (1), Iowa Primary Care Association, Urbandale, Iowa, USA (2)

Objective: Little is known about the preparedness of community health centers (CHCs) in addressing demand for dental services that are associated with full implementation of the Affordable Care Act (ACA). Although the national emphasis has been directed at increasing the eligibility of children, several states, including Iowa, must also plan for the sharp increase in adults now eligible for comprehensive dental services within their Medicaid programs. This study assesses the dental capacity of Iowa's safety net providers.

Methods: Fifteen Iowa CHCs were sent a survey in Fall 2013 to determine current and anticipated capacity for providing dental care. The survey included questions relating to structural and personnel capacity and preparedness in anticipation of changes brought about by the ACA.

Results: Of 11 returned surveys, 5 had at least one satellite in addition to its main facility. Although all centers expected the number of child patients to either remain the same or increase somewhat, eight expected the number of adult patients to increase. Centers felt that dental treatment needs for both children and adults was commensurate, on average, with the expected number of new patients. Slightly more than half anticipated a need for additional dental clinic space to address patient needs. There were mixed results about the ability of these dental clinics to meet some challenges that health reform will bring.

Conclusion: This study indicates that centers anticipate and are willing to accept the ACA changes, but that considerably more effort is required to adequately address an increased demand for services.

Source of Funding: DentaQuest Foundation

Poster Number: 56
Serial Number: 18

JPS COMMUNITY HEALTH DENTAL SERVICES COMMUNITY PARTNERSHIPS
Bill Devine (1), DMD; Huda Al-Hafidh (1), DDS
JPS Health Network, Fort Worth, Texas, USA (1)

Introduction: Untreated oral disease goes far beyond pain and discomfort. Oral disease can lead to poor nutritional health, serious systemic problems and diminished quality of life. Too many of the sick, poor, homeless and underserved children are falling through the cracks of present dental programs.

Objectives: The JPS Dental Health Services decided, through community partnerships, to improve access of dental care and make dental education and prevention the center of patient care for the underserved. Our goals are to reduce the barriers to quality oral care and provide outreach programs to schools, homeless shelters and immigration centers.

Methods: School outreach teams (JPS Healthy Smiles) consisting of a dentist, dental hygienist, and dental assistant were assigned designated schools in underserved areas to perform dental evaluations, apply preventive services and present visual dental educational programs. These teams also visited homeless shelters, immigration centers and presented staff dental training programs to several groups in our hospital.

Results: The JPS Dental Health Services reduced the barriers to oral care for the underserved by getting the community involved in our outreach programs. The JPS outreach teams evaluate and provide dental preventive services to over 25,000 students a year and our clinics have over 16,000 dental visits a year.

Conclusion: Poor oral health exists in our community. Forming partnerships with the community enables us to reach a lot of people in need of dental services. It is going to take a TEAM to fight dental disease and we are proud to do our part!

Source of Funding: JPS HEALTH NETWORK

Poster Number: 58
Serial Number: 56

FACTORS AFFECTING PATIENT RETENTION BEHAVIOR AT VCU DENTAL SCHOOL CLINIC: A PRELIMINARY ANALYSIS
Julie Coe (1), DDS,MS,MBA; Suzanne Makarem (1), PhD
Virginia Commonwealth University, Richmond, VA, USA (1)

Objectives: The purpose of this investigation is to identify baseline factors related to patient retention behavior at VCU School of Dentistry (SoD) where many low income or uninsured patients receive affordable and comprehensive oral care from disease control to maintenance.

Methods: An analysis of characteristics of VCU SoD patients screened between August 2010 and July 2011 (N=3604) was done. The data were obtained from SoD's electronic health record: axiUm® and included birthdate, gender, race, type of insurance, zipcode, date of completion of initial oral exam(IOE) and oral disease control completion(ODCT), and the current status of the patient (active or inactive/discontinued).

Results: Out of 3,604 patients, only 672 (16%) completed ODCT and 2,093(58.1%) became inactive/discontinued. Older age, having insurance, and living within 60 miles radius were found to be associated with patient retention (P<0.001). Primary reasons for becoming inactive
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were no response to communication effort (20.5%) and financial problems (15.8%). Those who completed ODCT were more likely to stay active (p<0.001).

Conclusion: The results strongly suggest the need to address continuum of care which is critical to the outcome of the disease control and prevention. Oral health care providers may want to educate patients of the importance of continuing treatment until completion. Future research should address more details of what influenced the retention behavior to develop strategies to improve it.

Source of Funding: None.

Poster Number: 59
Serial Number: 86
USE OF QUALITY MEASUREMENT ACROSS US DENTAL DELIVERY SYSTEMS: A QUALITATIVE ANALYSIS
Hosam Alrqiq (1), BDS, MS; Athanasios Zavras (1), DDS, MPH; Burton Edelstein (1), DDS, MS, DrMSc
Columbia University, New York, USA (1)

Objective: While there is some literature describing quality measurement activities of various US oral health care sectors, little attention has been paid to how these activates began, how they are being used, and their overall impact on oral health care organizations. Specific aims are to examine factors in developing, adopting, and implementing quality measures and related programs among various types of US oral health organizations and to assess how specific characteristics of those organizations influence these activities.

Methods: A conceptual model to understand use of quality measures in dental practice was created and used to develop a structured interview guide. 18 types of oral health care organizations were identified in the literature and associated organizations were purposively selected as examples. Quality measurement experts from these organizations were interviewed by telephone. The interviews were transcribed and the findings analyzed qualitatively.

Results: Motivation for quality measurement was reported to be more internally than externally riven. Data management and information technology systems were cited as both barriers and facilitators. Leadership was reported to be the most influential part of an organization’s commitment to measuring quality. Reported impacts of quality measurement efforts on organizations varied from simple operational improvement to revisions in the philosophy and associated practice guidelines of the organization. Organizational characteristics, especially those related to type and size appear to influence quality programs.

Conclusion: The current status of quality measurement is highly variable across dental organizations because organizational leadership, needs, and requirements vary according to mission and structure.

Source of Funding: None.

Poster Number: 60
Serial Number: 17
ORAL HEALTH CARE REFORM: POLICY CONSIDERATIONS FOR VERMONT
Craig Stevens (1), MPH
John Snow Inc, Burlington, VT, USA (1)

Objectives: To develop a set of policy considerations addressing access, quality and cost for the Green Mountain Care Board, Vermont’s health care and health care reform regulatory body.

Method: A literature review of innovative and cutting edge policy reforms was conducted to identify emerging issues in oral health care reform. With the assistance of the Vermont Oral Health Coalition and national stakeholders, these emerging issues were discussed and vetted to develop a set of policy considerations to shape a vision of oral health care reform.

Results: Recommendations in the areas of Quality, Alternative Workforce, Adult Essential Benefits, Increased Reimbursement and Medical/Dental Collaboration provided a landscape of the necessary changes for the future of oral health and the direction of oral health care reform.

Conclusions: The literature, local and national stakeholder analysis provided clear direction on the necessary oral health care reform initiatives to improve access, quality and cost as well as to bring oral health to the forefront of health care reform. While there is significant gaps in the body of knowledge and understanding of the operationalization of oral health reform initiatives, there is a great opportunity to test these initiatives in states with progressive health care environments.

Source of Funding: State of Vermont, Green Mountain Care Board

Poster Number: 61
Serial Number: 40
BEST PRACTICE APPROACH FOR IMPROVING ORAL HEALTH THROUGH STATE ORAL HEALTH PROGRAM CAPACITY DEVELOPMENT
Samantha Jordan (1)
Harvard School of Dental Medicine, Boston, MA, USA (1)

Objectives: To meet the oral health needs of the United States population and provide the core essential dental public health (DPH) functions, the DPH infrastructure must be strengthened. Infrastructure encompasses human, organizational, informational, legal, policy, and fiscal resources. DPH infrastructure includes many diverse stakeholders. State Oral Health Programs (SOHPs) are an important part of the DPH infrastructure. Our focus is on how SOHPs can increase their capacity to provide the core essential DPH functions by developing their human infrastructure to be a sufficient, competent, and effective complement of people.

Methods: The Association of State and Territorial Dental Directors (ASTDD) Best Practice Approach was used to conduct literature search, interviews and information gathering of best practice concepts, principles, guidelines, initiatives, coordinated efforts and grant programs in oral health and other disciplines.

Results: SOHPs vary in size, structure, resources, and focus. A successful SOHP needs a complement of staff, consultants and partners with variable levels of public health and/or oral health training and expertise to establish an adequate and competent workforce to achieve the SOHP’s core essential DPH functions. The ASTDD Competencies delineates the various and diverse skills necessary for a robust SOHP.

Conclusions: An adequate and competent workforce is crucial for a strong DPH infrastructure and the success of an SOHP in achieving the core essential DPH functions. However, workforce is only one aspect of the DPH infrastructure. Workforce strategies to improve oral health through SOHP capacity development must ultimately consider the organizational, informational, legal, policy, and fiscal aspects of infrastructure.

Source of Funding: None

Poster Number: 62
Serial Number: 46
THE U.S. NATIONAL ORAL HEALTH ALLIANCE AND CRACKING THE NETWORK CODE
Michael Monopoly (1), DMD, MPH; Steven Geiermann (2), DDS; Matthew Bond (1)
Dentaquest Foundation, Boston, MA, USA (1), American Dental Association, Chicago, IL, USA (2)

The U.S. National Oral Health Alliance (Alliance) provides a platform for a diverse network of stakeholders to forge common ground in order
to harness opportunities and create viable solutions for improved oral health through prevention and treatment for vulnerable populations across our country. The Alliance welcomes partners to focus and align efforts to assure optimal oral health for all and build on collective strengths for more effective impact.

The Alliance embodies the spirit of collaboration by its convening of leadership colloquia organized around each of the six priority areas identified at the 2009 Access to Dental Care Summit. Over the course of these two-day colloquia, participants begin to lay a foundation in areas of common ground. Through their discussions, which were built on trust and openness, a range of unifying messages emerged.

With these six sets of unifying messages in hand, the Alliance is looking to build upon the blossoming networking relationships that were an additional product of the colloquia. By banding together, partnering organizations and individuals can accomplish far more than an equal number of top-notch organizations could by working in isolation. The Alliance is ready to step out into a new phase of implementation of its work. Come and see how you can be a part of this “common ground” movement.

Source of Funding: none

Poster Number: 63
Serial Number: 19/59

ADDRESSING HEALTH LITERACY CHALLENGES TO TARGET AN EDUCATIONAL MESSAGE FOR HIV POSITIVE DENTAL PATIENTS
Elana Lowell-Shlansky (1); Safiya Smith (1), DDS; Carol Kunzel (1), PhD; MA: Ryan Lemke (1); Liza Kasmara (2); Moussa Sanogo (1), MD, MPH; K. Akuwuala (1), DDS, MPH; Noreen Myers-Wright (1), RDH, MEd; Burton Edelstein (1), DDS, MPH
College of Dental Medicine, Columbia University, NY, USA (1)
Harlem United Community AIDS Center, NY, USA (2)

Objectives: We aimed to develop an educational pamphlet on HIV and oral health that targets the needs of the HIV positive dental patients at Harlem United (HU), a non-profit, community-based healthcare organization.

Method: To develop our pamphlet we assessed feedback from HU patients on existing HIV and oral health educational materials gathered through a structured interview. We also developed evidence-based recommendations from literature reviews on health literacy and readability, and from the expert advice of oral pathologists and HIV specialists. We then evaluated the oral health literacy levels of HU patients using TOFHLiD and test them against an earlier version of our pamphlet using focus groups.

Results: During our initial interview 22 percent of participants said they sometimes or often have problems learning about medical conditions because of difficulty understanding written materials. Evidence-based recommendations from the literature included using sentences with eight to ten words, bright colors, and sans serif fonts. Expert advice suggested focusing on only five diseases: oral hairy leukoplakia, oral warts, candidiasis, aphthous ulcers, and xerostomia. Our pamphlet was modified to minimize discrepancies between HU patients’ oral health literacy levels and our pamphlet’s readability.

Conclusions: The newly developed pamphlet was based on qualitative and quantitative methods that involved all stakeholders, key informant interviews of HIV and dental specialists, and literature. The final pamphlet more specifically meets the needs of the HU dental patient population as compared to existing educational materials.

Source of Funding: This project was supported in part by HRSA grant 5 H65 HA00014 (CK, MS, KA, NMW, BE)
TOOTHBRUSHING HABIT FORMATION IN CHILDREN OF LATINO FAMILIES: A QUALITATIVE STUDY
Dafna Benadof (1), DDS, MPH, PhD candidate
University of Pittsburgh, Pittsburgh, PA, USA (1)

Oral diseases can produce pain, disabilities, and affect people’s social life. The Latino population has higher risk of developing caries and of having untreated caries, and gingivitis. These diseases can be prevented by implementing oral hygiene behaviors such as toothbrushing. For this behavior to be effective, it is adamant that it evolves into a habit.

Objectives: The purpose of this study is to describe efforts Latino parents make to teach their children to brush their teeth, and to identify habits components present during this process.

Methods: Personal interviews were conducted with 20 parents (Mexicans or Puerto Ricans) to understand the process by which parents are able to successfully develop toothbrushing habits in their children. Interviews were recorded, transcribed verbatim and are being coded for thematic analysis.

Results: Some of the topics that have been identified on preliminary analyses are: use of verbal reminders, importance of oral health, and barriers to good oral hygiene (bad attitude, and time). The relationship of these topics to habit components such as automaticity, contextual cues, social norms, frequency, and knowledge is being evaluated. It is expected to have final results by February, 2014.

Conclusion: This study will help develop new knowledge in the formation of oral hygiene habits in children. It will provide us with a range of topics and experiences that occur during the early stages of the toothbrushing process in children. This information can be used as the base for future quantitative research studies intended to evaluate toothbrushing habit formation in larger groups.

Source of Funding: None

FIRST TOOTH: PREVENTING EARLY CHILDHOOD CARIES THROUGH MEDICAL AND DENTAL EDUCATION AND COLLABORATION
Karen Hall (1), EPDH
Oregon Oral Health Coalition, Wilsonville, Oregon, USA (1)

Tooth decay remains the most common chronic disease of childhood despite being preventable. The "First Tooth" project was developed by the State Oral Health Program in collaboration with the Oregon Oral Health Coalition (OROH C) to reduce early childhood tooth decay.

Objectives: First Tooth is to expand the oral health workforce in Oregon and the reach of prevention into rural and frontier locations; to assist pediatric providers to provide culturally appropriate early childhood caries prevention; and facilitate referrals between medical and dental providers to ensure all children a dental home; to reduce childhood caries rates among Oregonian children by 30-69%.

Method: First Tooth comprises in-person training and continued technical assistance. All staff are involved in evidence-based preventive oral health services for infants and toddlers under age 3, foremost by clinical intervention by fluoride varnish applications and education of parents.

Results: More than 2,000 providers have been trained since 2010 with a 98% overall satisfaction rating.

Conclusion: The study concluded that there is need to focus on control of SLT as it is a major alternative to tobacco smoking among indigenous African population.

Source of Funding: NONE

CAN HYPOTHETICAL SCENARIOS BE USED TO PREDICT REAL-LIFE DENTAL TREATMENT DECISIONS?
C. Shao (1), BS; M.R. McQuistan (1), DDS, MS; T. Chen (1); C.F. Espanto (1)
The University of Iowa College of Dentistry, Iowa City, IA, USA (1)

Objective: To determine if associations exist between making hypothetical dental treatment and general economic decisions with real-life dental treatment decisions.

Methods: Adult patients seeking care at the University of Iowa College of Dentistry were recruited for the study. Participants completed a survey to assess how they would respond to hypothetical dental scenarios pertaining to retaining or extracting teeth and economic questions modeling temporal discounting and risk aversion concepts. Participants’ records were then reviewed to determine the actual treatment they selected at their dental appointment (i.e., extraction, “keep tooth”=root canal or restorative, or “other treatment”=reference group). Chi-Square and Fisher’s Exact Tests were used to determine associations (p<0.05).

Results: N=66. Record reviews revealed that 44% of participants opted for extraction, 26% opted to keep their teeth, and 30% had other treatment needs. Participants in pain were more likely to select an extraction (64%) than to keep their teeth (20%; other=16%; p=0.04). Participants who chose to keep their teeth in the hypothetical dental situations were also more likely to choose to keep their teeth during their dental appointment compared to the extraction and reference groups (p<0.05). Sex, age, economic decisions, time of travel to the dentist, and past dental treatment were not associated with real-life treatment decisions (p>0.05).

Conclusion: Hypothetical dental scenarios, but not economic decisions, were associated with participants’ real-life dental treatment choices suggesting that people may use different thought processes when making dental versus economic decisions. Dentists may be able to predict patients’ real-life treatment preferences based on hypothetical dental scenarios.

Source of Funding: The University of Iowa Dows Dental Research Grant

UTILIZING A CASE MANAGER TO LINK CHILDREN SEEN IN A SCHOOL-BASED PREVENTION PROGRAM TO A DENTAL HOME
Josefine Wolfe (1), PhD (abd), MSPH, RDH, CHES; Jennifer Bankler (2), DDS; Annaliese Cothron (1), MS; Jane Steffensen (1), MPH, MCHES; David Cappelli (1), DMD, MPH, PhD
University of Texas Health Science Center San Antonio, San Antonio, TX, USA (1), San Antonio Metropolitan Health District, San Anotnio, TX, USA (2)

Objective: To determine if a case manager is effective in linking families whose children have been identified as having urgent oral health needs to a dental home. Dental professionals working in a school-based prevention program have a responsibility to refer children identified as needing urgent dental care.

Source of Funding: The Ford Family Foundation, DentaQuest Foundation

Funding beginning in 2014: Northwest Health Foundation, Kaiser Gives Program
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**Northeastern University, Boston, MA, USA (1)**

**Objectives:** The purpose of this session is to present an interprofessional education faculty toolkit for developing a collaborative health care workforce with team-based competencies to improve oral and systemic health in primary care. At the completion of this session, participants will be able to apply interactive, interprofessional teaching-learning strategies that enhance teamwork and oral health competencies to promote the integration of oral health promotion and prevention in primary care practice.

**Methods:** A train-the-trainer approach will be described for faculty development and student learning. Strategies in interprofessional education will be described for integration in health professions curricula including e-learning, case study, and simulation using standardized patient cases.

**Results:** The result is an interprofessional education faculty toolkit designed to advance oral health and teamwork in primary care settings, and expand the capacity of all health professionals to incorporate oral health in primary care practice. The toolkit can be adapted for training all primary care health professionals including dental hygienists, dentists, nurses, nurse practitioners, nutritionists, pharmacists, physicians, physician assistants, public health professionals and others.

**Conclusions:** All primary care health professionals have the opportunity to address oral health in every primary care visit and across a variety of primary care settings, with appropriate education and training.

**Source of Funding:** This presentation is made possible as a result of funding from the DentaQuest Foundation. The DentaQuest Foundation is committed to optimal oral health for all Americans through its support of prevention and access to affordable care, and through its partnerships with funders, policymakers and community leaders.

**Posters**

**Poster Number: 73**

**Serial Number: 38**

**BARRIERS TO ACCESSING DENTAL CARE ALONG THE TEXAS/MEXICO BORDER**

Magda De La Torre (1), RDH, BS, MPH; Annaliese Cothron (1), BS, MS; Jane Steffensen (1), MPH, MCHES; Carolina Diaz De Guillory (1), DDS; Andrea Longoria (1), MS; David Cappelli (1), DMD, MPH, PhD

University of Texas Health Science Center at San Antonio, San Antonio, TX, USA (1)

**Objective:** The Miles of Smiles-Laredo program provides preventive services to elementary school children in Webb County along the Texas-Mexico border. Access to dental services remains a challenge both geographically and financially for many people living in this region. The objective of the Miles of Smiles-Laredo program is to provide preventive oral health care to children who experience limited access to dental care and to identify children with urgent oral health care needs and create a plan for their care.

**Methods:** Miles of Smiles-Laredo provides limited oral evaluations for kindergarten, second, and third grade children. Children with urgent dental needs are identified and dental case managers follow-up by addressing barriers to accessing oral health care.

**Results:** Nearly 16% of children screened in 2012/2013 needed to see a dentist within the previous year and were unable to access dental care compared to 3.2% nationally, and 5% of low-income children in Texas. Twenty seven percent, (27%) of children participating in the Miles of Smiles-Laredo program indicated they did not currently have a dental home. Dental case managers successfully linked children to dental homes for treatment of urgent needs in 73% of referred cases.

**Conclusions:** Miles of Smiles-Laredo has identified and addressed the significant barriers to accessing care experienced by children along the Texas-Mexico border region through effective dental case management.

**Source of Funding:** Supported by the DentaQuest Foundation and HRSA T12HP19338

**Poster Number: 74**

**Serial Number: 42**

**NEED AND ACCESS TO DENTAL CARE AMONG 3rd GRADE SCHOOL CHILDREN, GEORGIA 2011**

Hyacinthe Kabore (1), DDS, MPH; Chinelo Ogbuaniu (1), MD, MPH, PhD; Carol Smith (1), RDH, MSHA

Georgia Department of Public Health, Atlanta, GA, USA (1)

**Objective:** To assess the needs and barriers to dental care among 3rd graders.

**Methods:** The Georgia Department of Health, Oral Health Program conducted a statewide survey of third grade school children in 63 randomly selected schools in school year 2010-2011 (31 rural and 32 urban). Dental screenings were performed on the children, and parents were asked to complete a questionnaire. SAS-callable SUDAAN 11.0.1 was used for data analysis.

**Results:** Children who had toothaches within 6 months before the survey, children on free lunch and children with untreated tooth decay were significantly more likely to have not been able to get dental care when they needed it (OR=4.5, 95% CI: 3.3 - 6.1, OR=3.9, 95% CI: 2.7 - 5.8, and OR=3.3, 95% CI: 2.5 - 4.1 respectively). Black children (OR=1.9, 95% CI: 1.4 - 2.6) and Hispanic children (OR=1.6, 95% CI: 1.2 - 2.3) were significantly more likely to have not been able to get dental care when they needed it compared to white children and non-Hispanic children respectively. There was no significant difference among children who needed and could not get dental care in urban areas and rural areas. The most common cited reason for not getting dental care when needed was the lack of insurance (30.7%, 95% CI: 26.9% - 34.9%).
Conclusions: Access to dental care is a multifaceted public health issue. This study provides an insight that can help shape the oral health program prevention strategy to prevent dental decay among children.

Source of Funding: Centers for Disease Control and Prevention, Cooperative Agreement 5U58DP001587-03

Poster Number: 75  
Serial Number: 77

PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS) - USING THIS DATA SOURCE TO EXPLORE THE RELATIONSHIP BETWEEN MATERNAL CHARACTERISTICS AND ORAL HEALTH CARE BEFORE AND DURING PREGNANCY

Bilquis Khan Jiwani (1), MSc., MBA, MSc; Cheryl Barber (1), MS, MPH; Merry Jo Thoele (1), MPH, RDH
Minnesota Department of Health, St. Paul, MN, USA (1)

Objectives: To describe the relationship between maternal characteristics and oral health care prior to and during pregnancy using PRAMS data. To discuss the use of PRAMS data to inform and evaluate oral health strategies outlined in the State Oral Health Plan.

Methods: Stratified prevalence estimates for oral health indicators adjusted models to assess the relationship between maternal characteristics and oral health care prior to and during pregnancy were generated using SUDAAN (Survey Data Analysis) using 2009-2010 Minnesota PRAMS data.

Results: Recent studies have found that maintaining good oral health during and after pregnancy is beneficial for both mother and child. Overall, PRAMS data show good oral health and access to care for the surveyed women but further analyses reveal significant disparities. Compared to White women, African-American, American Indian, and Hispanic women were significantly less likely to have their teeth cleaned 12 months prior to pregnancy. African-American and American Indian women were twice as likely to report they needed to see a dentist for a problem during pregnancy. Women from poor families (<185% poverty level), with lower educational attainment (high school and lower), without insurance or Medicaid, had less oral care and more dental problems compared to women with higher economic status prior to and during pregnancy.

Conclusions: To improve oral health of women, particularly women of color, women with lower educational and income levels; oral health programs need to extend collaboration and partnerships with health professionals, Maternal and Child Health programs, Early Head Start and Head Start.

Source of Funding: Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS), Minnesota Department of Health, Division of Community and Family Health, Maternal and Child Health.

This data was made possible by grant number IU01DP003117-01 from the Centers for Disease Control and Prevention and Grants to States to Support Oral Health Infrastructure US58DP004899 (DP13-1307).

Poster Number: 76  
Serial Number: 69

DO MORE PREGNANCIES INCREASE CARIES RISK?

Hebah Hamdan (1), BDS; Woosung Sohn (1), DDS, PhD, DrPH
Boston University Henry M. Goldman School of Dental Medicine, Boston, MA, USA (1)

Objective: During pregnancy several factors can predispose pregnant women to dental caries such as neglected oral hygiene, frequent snacking and morning sickness. This study aims to investigate the association between pregnancy and dental caries.

Methods: National Health and Nutrition Examination Survey (NHANES 1999-2004) data for parous women aged 20-45 years were used for our analysis. The association between parity (number of live births) and DMFT was analyzed in bivariate and multivariate regression analyses. Sample weights were used to account for oversampling and nonresponse. All analysis was conducted using SAS (ver9.1) Survey Procedures to account for the complex sampling design from NHANES.

Results: The bivariate analysis showed a trend of increase of dental caries among parous women as the number of live births increased. The mean DMFT of women who gave live birth one-time (33.60%), two-times (32.43%), three-times (21.24%) and four-times or more (12.72%) was 4.82, 5.36, 5.57, and 7.74, respectively (p=0.06). However, after adjusting for confounding such as age, race/ethnicity, poverty income ratio (PIR) and level of education, no association was found between increased parity level and dental caries (P=0.9). Age was the most significant predictor for DMFT (P <0.0001).

Conclusion: The results provide no evidence to suggest that women with repeated pregnancies are at higher risk for dental caries. However, clinicians are encouraged to continue providing special oral health education and care to pregnant women, as their own oral health is one of the important determinants to the oral health of their children.

Source of Funding: None

Poster Number: 77  
Serial Number: 84

OPTIMIZING COMMUNITY WATER FLUORIDATION THROUGH STATEWIDE FLUORIDE ANALYSIS DEVICE AWARDS

David Rindal (1), PE; Merry Jo Thoele (2), MPH, RDH
Minnesota Department of Health, St. Paul, MN, USA (1), Minnesota Department of Health, St. Paul, MN, USA (2)

Objectives: To increase the number of Minnesotans receiving the oral health benefits of optimally fluoridated drinking water by assisting community public water systems (PWSs) with fluoridation process optimization through field analysis improvements.

Methods: The Minnesota Department of Health (MDH), through collaboration between its Oral Health Program and Drinking Water Protection Section, awarded 14 pre-purchased analysis devices to municipal community PWSs through a competitive process. Criteria used to select the analysis devices included analytical interferences, National Water Fluoridation Training Course Laboratory Practice Session performance observations, purchase and operational costs, and ease of use. Three types of devices were selected: a fluoride ion-selective electrode, a fluoride colorimeter, and a multiple-analyte colorimeter. Device recipient selection was determined by source water fluoride concentrations, numbers of fluoridation treatment points, analysis device age, phosphate treatment, and additional chemical analysis necessity. Because phosphate treatment is prevalent in Minnesota and interferes with colorimetric fluoride measurements, half of the selected devices were of the electrode type. Accuracy comparisons were performed between awarded and replaced devices through collection of at least 20 consecutive field fluoride analysis result pairs per recipient.

Results: Community PWSs expressed greater interest in analysis devices than infrastructure improvements offered through previous grants. An abbreviated 26 day submission period resulted in 57 applications from 617 fluoridating PWSs. Awardees performed usability, accuracy, precision, and operational comparisons within 60 days of device receipt. Colorimetric phosphate interference was eliminated at seven fluoridating PWSs.

Conclusion: Analysis device awards allowed improved field tests and fluoridation process control affecting 126,000 people.

Source of Funding: Health Resources and Services Administration (HRSA) T12HP14659
LOADING PROTOCOLS FOR UNSPLINTED IMPLANT-SUPPORTED MANDIBULAR OVERDENTURES: A SYSTEMATIC REVIEW
Rufus Caine (1), DDS, MPH; Khyati Mehta (1), BDS; Neha Kumarley (1), BDS; Niyatiben Patel (1), DDS; Jeannine Stephenson-Buffong (1), DMD
Rutgers School of Public Health, Newark, NJ, USA (1)

Objective: To determine treatment effectiveness for early and conventional loading protocols with 2-implant supported unsplinted mandibular overdenture.

Methods: An electronic search using Pubmed, Ovid Medline, Cochrane database of systematic review, Cochrane controlled trial register and several professional scientific journals was done. The articles on RCTs, systematic review, meta-analysis, and controlled clinical trials with key characteristics, implant survival rates, age 18-85 years, early and conventional loading protocols, unsplinted implants, mandibular overdenture and 2-year follow-ups were included. Five out of 24 articles meeting the criteria were included. Statistical hypothesis was that there was no statistically significant difference between early and conventional loading protocols for unsplinted implant-supported mandibular overdentures. Heterogeneity with $I^2$ and Cochrane Q test; and pooling effect size with Tau squared test were measured. The hypothesis testing was done by student $t$-test at $p<0.05$ significance level. A random effect size model was used to determine 95% CI and point estimate of survival rates.

Results: Five clinical trials had 132 implants. Fixed model had $Z$-value -1.729 with $p$-value of 0.084. Random model had $Z$-value -1.658 with $p$-value 0.097. For fixed and random models, point estimate of effect size was 0.034 and 0.036; and 95% CI was (0.097–1.158) and (0.039–1.220), respectively. Test for heterogeneity had $Q$-value of 4.263 with 4 df($Q$) and $I^2$ test value of 6.166 with $p$-value of 0.372. Tau squared value was 0.137 with standard error of 1.566, variance of 2.452 and tau value 0.369.

Conclusion: There was no statistically significant difference found between loading protocols for mandibular implant-supported overdentures.

Source of Funding: None

THE MINAMATA CONVENTION ON MERCURY: A UNEP GLOBAL TREATY TO PROTECT HUMAN HEALTH AND THE ENVIRONMENT MAY BRING UNINTENDED CONSEQUENCES TO DENTAL PUBLIC HEALTH AND COMMUNITY DENTISTRY
Linda Kaste (1), DDS, MS, PhD; Helene Bednarsh (2), RDH, MPH; Kathy Lituri (3), RDH, MPH; Howard Pollick (4), BDS, MPH; Scott Tomar (5), DMD, MPH, DrPH
University of Illinois at Chicago, Chicago, IL, USA (1), Boston Public Health Commission, Boston, MA, USA (2), Boston University Goldman School of Dental Medicine, Boston, MA, USA (3), UCSF School of Dentistry, San Francisco, CA, USA (4), University of Florida, Gainesville, FL, USA (5)

Objectives: In October 2013, at the Conference of Plenipotentiaries held in Japan under the auspices of the United Nations Environment Program, a global treaty on mercury pollution (The Minamata Convention on Mercury) achieved the signatory step in adoption by 92 countries. Subsequently, the USA became the first country to ratify. This presentation reviews the history of this act, special provisions for dentistry, and potential implications for dental public health and community dentistry.

Methods: Documentation of the Minamata Convention on Mercury is located at: http://www.mercuryconvention.org/ which includes text of the Convention, description of negotiations over five sessions between June 2010 and January 2013, identification of the countries who are signatories and ratification parties, associated publications from UNEP, and associated news articles.

Results: The Minamata Convention on Mercury includes a ban on new mercury mines, phase-out of existing ones, control measures on air emissions, and international regulation of the informal sector for artisanal and small-scale gold mining. One provision calls for “[m]easures to be taken by a Party to phase down the use of dental amalgam shall take into account the Party’s domestic circumstances and relevant international guidance...”

Conclusions: Global health concerns around mercury have rapidly increased, putting pressure on dentistry to eliminate use of dental amalgam. A decline in the availability of amalgam in the absence of suitable replacement materials may have negative impacts on population oral health, particularly in low-income nations and some subpopulations. Dental public health must help achieve a balance among occupational, environmental, and oral health considerations.

Source of Funding: None
PERINATAL AND WELL-CHILD COMMUNITY ORAL HEALTH EDUCATION PROGRAM
Laura Hettinger, RDH (1)
Dental Hygiene Degree Completion Program University of Michigan School of Dentistry (1)

Background: Over 40% of the United States population does not receive dental care. A large percentage of this population is from uninsured and low income families. This places children at risk for the number one chronic childhood illness, dental caries. Pregnant women are at risk for early preterm birth due to the possible systemic link from periodontal inflammation. Even though this percentage of the population does not seek dental care, a majority of this population of pregnant women and young children are seen by medical providers through perinatal and well-child care. The Frances Nelson Health Center, Champaign, IL, is a Federally Qualified Health Center that houses both a medical and dental clinic.

Objectives: Deliver oral health education at perinatal and well-child appointments. Assist patients without a current dental home in scheduling dental appointments. Develop and deliver in-service presentation for the perinatal and well-child medical staff.

Procedures: Over the six week period oral health education was given by a registered dental hygienist, in a degree completion program, to the participants of perinatal and well-child appointments. Participants were also questioned on the status of a current dental home and, if had none, were assisted in making an appointment with dental clinic. During the same six week period an oral health education in-service was delivered to the perinatal and well-child medical staff.

Results: One hundred percent of the well-child and perinatal patients agreed to receive oral health education and accepted education materials. In the well-child visit population fifty-five percent of patients seen did not have a dental home. Forty-five percent of well-child patients seen scheduled appointments at the dental clinic. Seventy-five percent of perinatal patients seen did not have a dental home. Forty-five percent of well-child appointments were scheduled appointments at the dental clinic. Seventy-five percent of perinatal patients seen did not have a dental home. Forty-five percent of well-child patients seen did not have a dental home. With thirty-five percent of perinatal patients seen did not have a dental home. Thirty-five percent scheduling appointments with the dental clinic. The Medical staff demonstrated an increase in knowledge from pre-test to post-test on all nine test questions related to the in-service presentation. Conclusion: The programs outcomes indicate that dental education and interprofessional communication/collaboration can improve access to oral health education and care.

Funding source: None

Poster Number: 82
ORAL HEALTH CARE IN THE LGBT POPULATION: ACCESS, PERCEPTIONS, BARRIERS, AND POTENTIAL SOLUTIONS
William A. Jacobson, (1)
School of Dental Medicine, Case Western Reserve University (1)

Background: Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals in addition to having the same basic health care needs as the general population, face health disparities. Poor oral health leads to a multitude of negative effects in an individual’s quality of life. The literature on the oral health of the LGBT population is sparse. The purpose of the study was to investigate the access to dental care for LGBT people, the actual and perceived barriers for their dental care, and potential solutions to improve their access to dental care.

Methods: The questionnaire was administered at five locations in Northeast Ohio to 355 subjects. Data were collected by a self-administered questionnaire of 37 items, with 32 pre-coded and five open ended. Quantitative data were analyzed by SPSS (Version 20), and qualitative by Microsoft Excel.

Results: Among the 355 participants, 315 self-identified as LGBT or other sexual minority status. The LGBT participants visited the dentist slightly more often, (65.8% vs. 61.6%), than the general population. Nearly 8.0% of the study subjects had experienced discrimination in dental offices. Lack of finances was the primary barrier for not seeking dental care among LGBT. A majority of LGBT subjects preferred a dentist to be knowledgeable of STIs, HIV/AIDS, and to be trained in the needs of the LGBT community.

Conclusion: Primary reason for LGBT population not seeking dental care was financial. Study participants preferred a dentist to be an ally of the LGBT community. Transgender subjects were especially vulnerable when compared to LGBT-less dental visits and being discriminated by the dentist. Efforts should be made to include LGBT cultural sensitivity and oral manifestations of STIs and HIV/AIDS in dental school curriculum.

Funding source: None

ORAL HEALTH STATUS, KNOWLEDGE, AND PRACTICES AMONG 12 YEAR OLD KENYAN CHILDREN- A GLOBAL HEALTH STUDY
Amelia Stoker, BS (1); Sydney Stoker, BA (1); Caroline DeVincenzi, BA (1); Eli Schwarz, DDS, MPH, PhD (1)
Oregon Health & Science University, School of Dentistry, Portland, Oregon (1)

Objectives: Information about children oral health in Kenya is scanty. This study aimed to assess the oral hygiene level and prevalence of dental caries in 12 year olds in Chwele, Kenya; to investigate the fluoride content in the drinking water in the community; and to assess the oral health knowledge, attitudes, and practices in the study population, and their access to dental care.

Methods: Four primary schools were selected from which 11-13 year-old children participated in an epidemiologic survey and a brief questionnaire survey. Oral hygiene was assessed by Visible Plaque Index and dental examinations used the World Health Organization's criteria for DMFT and Dean's fluorosis index. Dental hygiene, eating habits, and knowledge about dental decay were surveyed by questionnaires. Water samples were tested by fluoride meter.

Results: The study comprised 105 students. The caries prevalence was 88% and average DMFT was 4.75 (sd.3.44) mostly appearing on the occlusal surfaces of permanent molars. Most children had visible plaque on all six sites examined, but there was no correlation between plaque and caries prevalence. The level of fluorosis in Chwele was very low consistent with water samples below 0.8 ppm. The chewing stick was the most frequent oral hygiene aid and most children reported they knew what causes tooth decay. Almost 100% of the population reported eating sugarcane. There was no relationship between the use of sugarcane and caries rate.

Conclusions: Dental caries is widespread in this population. A case is made for developing a school based program focusing on oral hygiene, fissure sealants and atrumatic restorative restorations.

Funding source: None

ORAL HEALTH CARE IN THE LGBT POPULATION: ACCESS, PERCEPTIONS, BARRIERS, AND POTENTIAL SOLUTIONS
William A. Jacobson, (1)
School of Dental Medicine, Case Western Reserve University (1)

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Conclusion: Primary reason for LGBT population not seeking dental care was financial. Study participants preferred a dentist to be an ally of the LGBT community. Transgender subjects were especially vulnerable when compared to LGBT-less dental visits and being discriminated by the dentist. Efforts should be made to include LGBT cultural sensitivity and oral manifestations of STIs and HIV/AIDS in dental school curriculum.

Funding source: None
USE OF SPATIAL ANALYSIS TO INFORM COMMUNITY OUTREACH ACTIVITIES
Adam Fitzgerald (1)
Southern Illinois University School of Dental Medicine (1)

The issues facing dental public health care are very complex and require effective means for analyzing outcomes. The use of Geographic Information Systems (GIS) technologies has provided means to analyze and incorporate different forms of data into an easy to read map. In this study a newly designed index: Normalized Oral Health Index (NOHI) was used to effectively measure and correlate caries rates in children with other parameters. The study data was collected from school exam forms for children entering kindergarten, 2nd, and 6th grade in Southern Illinois. A spatial analysis was conducted to determine if federally qualified health centers (FQHC) in Southern Illinois were optimally situated in relation to each other. A stepwise regression analysis was conducted to examine trends between NOHI and socioeconomic status (SES), distance from and the time since the establishment of an FQHC. The results indicate that the FQHC’s are optimally situated and there was an increase in NOHI when distance and time since establishment increased. Clinic utilization increased as time since establishment increased. The results would suggest that distance from and time since establishment of an FQHC influenced the caries rates and clinic utilization for the population. Additionally the use of GIS and NOHI appear to be valuable tools with regards to effectively analyzing issues facing dental public health care.

Source of funding: SIU School of Dental Medicine Dean’s Summer Student Research Fellowship

ELIMINATING THE ORAL HEALTH DISPARITY IN LOW SOCIO-ECONOMIC COMMUNITIES THROUGH DENTAL EDUCATION AND PREVENTATIVE CARE
Linda Sepideh Borna (1)
The Ostrow School of Dentistry of USC

Introduction: The aim of this project was to evaluate the impact of prevention and oral health care education on populations residing in underserved communities. One of the main contributing factors of lack of access to dental care and poor oral health is the level of income per capita. Through dental education and preventative procedures, the USC dental student volunteers, dental hygiene volunteers, and pre-dental student volunteers, were able to utilize their knowledge in providing the less fortunate in an opportunity to improve their lives and the lives of their children.

Procedures: Data and analyses were obtained from three sources: The Ostrow School of Dentistry Screening results form various health fairs, the volume of patients comprehensively diagnosed and treated at the USC Mobile Dental Clinic and JWCH Clinic, and interviews from parents, adolescents, and children. My roles included organizing and coordinating the health fairs and student volunteers, and corresponding with sponsors, while maintaining a positive, motivational attitude.

Results: From a sample of 6,000 patients, the results of this project were used to define the level of dental urgency in low socioeconomic and minority communities, the contributing factors to poor oral health, and the advantages of providing preventative services to these populations. Research shows that over 65% of the patients assessed and treated at the USC Mobile Dental Clinic and JWCH Clinic, and Dental Health Fairs, the reduction in oral health disparities are unprecedented volume of urgent dental needs that was observed in this project. With promising programs such as the USC Mobile Dental Clinic and Dental Health Fairs, the reduction in oral health disparities are promising, yet the need for a more permanent outlet for dental care in low socio-economic and minority populations evidently remains.

Source of Funding: Funding for this project was gratefully accepted in conjunction with Community Hospitals (not-for-profit), Hospitals (private, for-profit), Blue Cross (California Endowment), Queen of Angels Hospital (QueensCare), The American Dental Association, Access to Care, St. Vincent’s Hospital, and other private foundations. We these graciously donations, we have been able to create a nurturing and collaborative environment to help those in need.

TRENDS IN AMBULATORY CARE SENSITIVE DENTAL RELATED VISITS TO HOSPITAL EMERGENCY DEPARTMENTS IN NEW YORK STATE, 2007 TO 2011
Vinicius N Tavares, DDS, MPH (1)
Bureau of Dental Health, New York State Department of Health (1)

Background: This study assessed the trends in visits to Emergency Departments (ED) and the associated charges for ambulatory care sensitive (ACS) dental conditions in New York State.

Methods: We used data from the 2007 to 2011 New York State Statewide Planning and Research Cooperative System (SPARCS). ACS related diagnoses were included in the analysis. Descriptive statistics and multiple logistic regressions by selected indicators were calculated along with the total and mean treatment charges.

Results: For the 5-year period there were over 455,000 ACS dental related visits to emergency departments in New York State. Individuals 21 to 43 years of age accounted for 213,295 visits (46%) to EDs. The total charges per year increased from $44.7 to $70.9 million.

Conclusions: ACS related visits to EDs and associated charges increased from 2007 to 2011 in New York State. Designated Dental Health Professional Shortage Areas had the highest rate of visits.

Practice Implications: Dental professional and policy makers should be aware of this growing problem. Effective strategies should be adopted to reduce the number of preventable dental visits to EDs.

Source of Funding: HRSA Residency Training in Dental Public Health Grant (1D5GHP160760100)

IMPACT OF A PREVENTIVE DENTAL PROGRAM IN MEDICAL OFFICES ON STATEWIDE TRENDS IN DENTAL CARIES
Leo Ndiangang Achembong, BDS, MPHc (1)
University of North Carolina Gillings School of Global Public Health (1)

Objectives: The objectives of this study are to evaluate the impact of a North Carolina Medicaid preventive dentistry program in primary care medical offices (Into the Mouths of Babes Program; IMBP) on decayed, missing and filled primary teeth (dmft) of kindergarten students statewide and in schools with a large proportion of students from low-income families.

Methods: An ecologic study using panel data of 920,505 kindergarten students with 11,694 school-year observations examined the effect of the IMBP on dmft scores from 1998 to 2009. Ordinary least squares regression with fixed effects determined the association between IMBP visits per child 0-4 years of age per county and mean dmft scores per kindergarten student per school, controlling for school-level poverty and ethnicity, and county-level Medicaid enrollment and supply of dentists and physicians.

Results: Mean dmft per kindergarten student per school increased from 1.53 in 1998 to 1.84 in 2004, then decreased to 1.59 in 2009. The mean number of IMBP visits per child 0-4 years of age per county increased from 0.01 in 2000 to 0.22 in 2009. A one-unit increase in
Abstracts for Student Poster and AAPHD Foundation Grant Presentations

IMBP visits per county was associated with a 0.248 (95% CI: -0.40, -0.10) decrease in dmft per kindergarten student per school. For schools with more students at high-risk for dental disease, a one-unit increase in IMBP visits was associated with a 0.320 (95% CI: -0.55, -0.09) decrease in dmft.

Conclusions: IMBP reduced dental caries among targeted vulnerable children, which helped to reduce oral health disparities among preschool-aged children in North Carolina.

Acknowledgment: This work was completed under the direction of my thesis committee composed of R. Gary Rozier, DDS, MPH; Rebecca S King, DDS, MPH; Ashley M Kranz, PhD

Funding Source: This study was funded by a Dental Public Health Training Grant from the Health Resources and Services Administration (Grant# D13HP15295). The content is solely the responsibility of the authors and does not necessarily represent the official views of the authors and does not necessarily represent the official views of the Health Resources and Services Administration.

Poster Number: 87

NEIGHBORHOOD AND FAMILY SOCIAL CAPITAL AND THE ORAL HEALTH OF CHILDREN IN IOWA
Julie C. Reynolds, DDS, MS (1)
University of Iowa College of Dentistry (1)

Objectives: A growing body of evidence supports the impact of social factors on oral health disparities in children in the United States. The goal of this study is to examine the relationship between two components of social capital – family and neighborhood – and oral health in Iowa’s children.

Methods: A statewide representative data source was analyzed cross-sectionally for parent-reported oral health status of children as the outcome. An index of neighborhood social capital and four separate indicators for family social capital formed the independent variables. Data were analyzed using a mixed linear regression with a random effect for zip code.

Results: Significant positive associations were found between oral health status and neighborhood social capital (p=0.005) and family frequency of eating meals together (p=0.02) after adjusting for covariates.

Conclusions: Neighborhood social capital and family function, a component of family social capital, may influence child oral health outcomes. This is the first study to assess the relationships between family and neighborhood social capital and oral health at the state level in the USA.

Source of Funding: This project was not funded specifically, however J. Reynolds was funded consecutively through the Herschel S. Horowitz Scholarship through the American Association of Public Health Dentistry Foundation and a HRSA training grant throughout the course of her graduate studies.

Poster Number: 88

PREVALENCE, INCIDENCE AND RISK FACTORS ASSOCIATED WITH EARLY CHILDHOOD CARIES AMONG AFRICAN-AMERICAN CHILDREN IN ALABAMA
Go Matsuo, DDS, MPH (1)
University of Maryland School of Public Health (1)

Objectives: To investigate Maryland dentists’ knowledge and use of caries preventive regimens in children and detect dentists’ characteristics associated with knowledge.

Methods: Cross-sectional data from questionnaires sent to 1,562 Maryland pediatric and general dentists in 2010 were analyzed. Statistical analyses included chi-square tests and logistic regression.

Results: Response rate was 28%. Overall pediatric dentists (PDs) were more knowledgeable than general dentists (GDs) (p< 0.01 to 0.05). Less than half of GDs or GDs and PDs have correct knowledge on four out of six items regarding fluoride. Although both groups have better knowledge regarding dental sealants than fluoride, only 64.1% of GDs knew placing sealants on noncavitated teeth does not pose a risk for decay. About 50% of GDs do not provide fluoride for young children. The most commonly used fluoride application time for fluoride gel and foam was 1 minute. The opinion of effectiveness of fluoride application varies depend on procedure and child age. GDs who had taken a course on caries prevention other than that in dental school than those who had not and who graduated recently had better knowledge.

Conclusions: Maryland dentists’ knowledge and use of caries preventive regimens is only moderate. Dentists’ lack of understanding of caries prevention will impede the appropriate use of preventive regimens and education for their patients to improve their oral health status and oral health literacy. Dental schools are in prime position to provide current, caries prevention curriculum for their students and continuing education for dental practitioners.

Source of Funding: This study was supported by a grant from the DentaQuest Foundation.

Poster Number: 89

ASSOCIATION BETWEEN SLEEP PROBLEMS AND PERIODONTAL DISEASE AMONG US ADULTS
Tarek Elmajie, BDS (1)
Boston University Henry M. Goldman School of Dental Medicine (1)

Objectives: Periodontitis is becoming a highly prevalent disease among adults in the United States. Sleep problems including sleep disorders, sleep disturbances, and sleep insufficiency have also increasingly been recognized as serious public health problems in United States. Untreated sleep problems may have negative effects on health. While it is also plausible that these conditions may negatively influence periodontal tissues, there is paucity of research on this topic. Therefore, we aim to investigate the association between sleep problems and periodontitis in a representative sample of US adults.

Method: This study analyzed data of 3,743 participants, representing over 137 million US adults aged 30 years and older, who were surveyed between 2009 and 2010 as part of the National Health and Nutrition Examination Survey (NHANES). Participants who underwent periodontal examinations and had a completed sleep habits questionnaire were included. Subjects were first categorized based on sleep hours at night into short sleepers (≤ 6 hrs.), average sleepers (7-8 hrs.), and long sleepers (≥ 9 hrs.), and into three sleep disorders groups based on the answers to two self-reported sleep disorders questions: diagnosed sleep disorders, sleep disturbance and no sleep problems. To assess the associations for combined sleep problems on prevalence of periodontitis, 6 mutually exclusive categories were created based on sleep disorders status and sleep duration. We followed the Centers for Disease Control and Prevention (CDC) and the American Academy of Periodontology (AAP) case definition of periodontitis. Other covariates included were age, gender, race/ethnicity, education, SES, BMI, alcohol consumption, diabetes, hypertension, depression and C-reactive protein (CRP).

Results: Overall, 38.5% of subjects had periodontitis, 35.7% were short sleepers, 7.8% reported having diagnosed sleep disorders and 18.8% reported sleep disturbance. Using multiple logistic regression models adjusting for covariates, the odds ratio (OR, 95% CI) of having periodontitis among short sleepers was 1.19 (CI 95 %; 1.02, 1.40) compared to average sleepers. Having sleep disorders (considered individually) was not significantly associated with periodontitis (OR, 1.23; 95% CI, 1.00-1.51), however, having sleep disorders was associated with an increased likelihood of having periodontitis (OR = 1.44; 95% CI = 1.11–1.89) among subjects ≥ 50 years, but not among adults < 50 years. Additionally, a significant association was observed when sleep disorders were combined with short sleep (OR, 1.50; 95% CI, 1.03-
IS PERIODONTAL HEALTH IN THE ELDERLY MORE SENSITIVE TO THE EFFECTS OF CHRONIC DISEASES, MEDICATIONS AND SMOKING?
Zuhair Natto, BDS, MDA, MPH (1)
Tufts University School of Dental Medicine (1)

The objective of this research was to evaluate whether or not there is an interaction in the sample of the elderly between the clinical attachment level (CAL) or probing depth (PD) of teeth with the number of medications, smoking or major causes of death, such as cardiovascular disease (CVD) and diabetes mellitus. Dental examinations were conducted on 284 patients by one examiner. Periodontal assessments were performed by probing with a manual UNC-15 periodontal probe to measure PD and CAL at 6 sites. Complete lists of the patients’ medications were obtained during the examination and causes of death of some of these patients were abstracted from death certificates. Statistical analyses involved ANOVA, Kruskal Wallis, Chi square and multivariate logistic regression analysis. Our results demonstrated that patients in our sample who died of CVD had higher CAL than the group still living (OR=2.16, 95% CI: 1.47–3.17) and this effect persisted even after controlling several variables (OR=2.03, 95% CI: 1.35–3.03). The number of medications had a greater effect on CAL and the attachment loss increased after 4 medications; it did not have any effect on periodontal PD. In multivariate logistic regression analyses, 6 or more medications led to a higher risk of attachment loss (> 3 mm) compared with no medication in crude odds ratio (OR=1.20, 95% CI: 0.22–6.64), and age-adjusted (OR=1.16, 95% CI: 0.21–6.45), but not with a multivariate model (OR=0.71, 95% CI: 0.11–4.39). Smoking showed the same dose response pattern on CAL by comparison with PD. We concluded that, when compared with PD, attachment level seemed to be more sensitive to chronic diseases, number of medications and smoking. Among those factors, CVD and smoking had the strongest effects. However, it was not possible to discriminate exactly what number of combined drugs led to the breakdown in CAL.

Source of Funding: USDA Human Nutrition Research Center on Aging (HNRCA) and Educational foundation of America

TRENDS IN ACCESS TO DENTAL CARE AND DENTAL INSURANCE STATUS AMONG CHILDREN AND ADOLESCENTS
Liny Cheean, BDS (1)
Case Western Reserve University School of Dental Medicine (2)

Objectives: To explore the trends in access to dental care and dental insurance among Hispanic and African American children and adolescents in the U.S. from 2002 to 2010.

Methods: Medical Expenditure Panel Survey (MEPS) data was used for analyses from 2002-2010. Dental care access and dental insurance for children and adolescents who were 0 to 17 years old was the dependent variable and the time period from 2002-2010 was used as independent variable. Descriptive, bivariate and multiple regression analyses estimated the trends, adjusting for age, gender, family income and parent education.

Results: Among 0-6 year old children, 50% were less likely to have delayed and/or unable to get dental care compared to 12-17 years old. African Americans were 37.6% and Hispanics were 22.6% less likely to have delayed and/or unable dental care compared to Whites. Of the 0-6 years, 23.9% and among 7–11 years 10.2% more likely to have public dental insurance compared to the 12-17 years old. African Americans were 44.6% and Hispanics were 35.6% more likely to have public dental insurance compared to Whites. Among 0-6 years old 18.6% and among 7-12 years old 8.1% were less likely to have no dental insurance compared to 12-17 years old. African Americans were 34.2% less likely to have no dental insurance compared to White.

Conclusion: Although dental care access is improving efforts to create dental home, utilization of promotoras, and integration of oral health in primary care setting should be emphasized.

Source of Funding: HRSA
IMPLEMENTING A PREGNANCY FOCUSED ORAL HEALTH PROGRAM THROUGH INTERPROFESSIONAL COLLABORATION

Jeffrey Jackson (1), BS; Rocio B. Quinonez (2), DMD, MS, MPH; Amanda Kerns (1), BS; Alice Chuang (3), MD; R. Scott Eidson (4), DDS; Kim Boggess (3), MD; Jane A. Weintraub (1), DDS, MPH
School of Dentistry, University of North Carolina, Chapel Hill, NC, USA (1), Department of Pediatric Dentistry, School of Dentistry, University of North Carolina, Chapel Hill, NC, USA (2), Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina, Chapel Hill, NC, USA (3), Department of Operative Dentistry, School of Dentistry, University of North Carolina, Chapel Hill, NC, USA (4)

Objectives: To report on the implementation of a prenatal oral health program (pOHP) in an academic setting that addresses coordinated care, educational accreditation standards and new clinical practice guidelines for medical and dental students and providers.

Methods: pOHP was an educational intervention for third year medical students, residents and faculty to deliver preventive oral health information and referral to a dental home for pregnant women. On the dental side, pOHP was used to educate senior dental students and faculty on similar principles and provided comprehensive oral health care to pregnant women. A systems-based approach was used to guide the pOHP implementation during the 2012-2013 academic year.

Results: Fifty percent (n=96) of third year medical students and 100% (n=80) of the fourth year dental students participated in the prenatal oral health education at UNC. One hundred and twenty six referrals dental were made to the School of Dentistry during the 2012-2013 academic year. Fifty five pregnant women presented for care, resulting in 50% (n=40) of dental students participating in the clinical experience and delivery of simple and complex oral health procedures.

Conclusion: The prenatal period is a frequently missed opportunity to address oral health care. pOHP is an interprofessional collaboration model to educate dental and medical providers in an academic setting and provides a system of referral for comprehensive clinical care of pregnant patients, including educating women about their oral health and that of their children. Such programs can help meet interprofessional accreditation standards and encourage implementation of practice guidelines.

Source of Funding: This work was supported by an Albert Schweitzer Fellowship to JJ, AK, RQ, AC, and JW and by an American Academy of Public Health Dentistry Small Grant to JJ, AK, RQ, AC, and JW.

2014 National Oral Health Conference®
We hope you will find this useful for notes on speakers and session for the online evaluation process.
AAPHD Student Merit Awards Program

**Leverett Graduate Student Merit Award for Outstanding Achievement in Dental Public Health**

**First Place**

Vinicius Tavares, DDS, MPH  
New York State Department of Health  
Title: TRENDS IN AMBULATORY CARE SENSITIVE DENTAL RELATED VISITS TO HOSPITAL EMERGENCY DEPARTMENTS IN NEW YORK STATE, 2007 TO 2011  
Sponsor: Dr. Jay Kumar

**Second Place**

Leo Achemborg, BDS, MPHc  
University of North Carolina Gillings School of Global Public Health  
Title: IMPACT OF A PREVENTIVE DENTAL PROGRAM IN MEDICAL OFFICES ON STATEWIDE TRENDS IN DENTAL CARIES  
Sponsor: Dr. R Gary Rozier

**Third Place**

Julie Reynolds, DDS, MS  
University of Iowa College of Dentistry  
Title: NEIGHBORHOOD AND FAMILY SOCIAL CAPITAL AND THE ORAL HEALTH OF CHILDREN IN IOWA  
Sponsor: Dr. John J. Warren

**Honorable Mention**

Go Matsuo, DDS, MPH  
University of Maryland School of Public Health  
Title: WHAT MARYLAND DENTISTS KNOW AND DO ABOUT PREVENTING DENTAL CARIES IN CHILDREN  
Sponsor: Alice Horowitz, PhD

Tarek Elmajie, BDS  
Boston University Henry M Goldman School of Dental Medicine  
Title: ASSOCIATION BETWEEN SLEEP PROBLEMS AND PERIODONTITIS AMONG US ADULTS  
Sponsor: Dr. Woosung Sohn

Tariq Ghazal, BDS, MS  
University of Iowa College of Dentistry  
Title: PREVALENCE, INCIDENCE AND RISK FACTORS ASSOCIATED WITH EARLY CHILDHOOD CARIES AMONG AFRICAN-AMERICAN CHILDREN IN ALABAMA  
Sponsor: Dr. John J. Warren

Zuhair Natto, BDS, MDA, MPH  
Tufts University School of Dental Medicine  
Title: IS PERIODONTAL HEALTH IN THE ELDERLY MORE SENSITIVE TO THE EFFECTS OF CHRONIC DISEASES, MEDICATIONS AND SMOKING?  
Sponsor: Dr. Athena Papas

Shillpa Naavall, BDS, MPH, MS  
Department of Health & Human Services Centers for Disease Control and Prevention  
Title: FACTORS ASSOCIATED WITH PARENT-REPORTED DENTAL CARE UTILIZATION FOR A DENTAL PROBLEM AMONG U.S. CHILDREN AGED 2–17 YEARS—NATIONAL HEALTH INTERVIEW SURVEY, 2008  
Sponsor: Dr. Barbara Gooch

**Predoctoral Dental Student Merit Award for Outstanding Achievement in Community Dentistry**

**First Place**

Sydney Stoker, BA, Amelia Stoker, BS and Caroline Devincenzi, BA  
Oregon Health & Science University School of Dentistry  
Title: ORAL HEALTH STATUS, KNOWLEDGE, AND PRACTICES AMONG 12 YEAR OLD KENYAN CHILDREN-A GLOBAL HEALTH STUDY  
Sponsor: Dr. Eli Schwarz

**Second Place**

William Jacobson, MPH  
Case Western Reserve University School of Dental Medicine  
Title: ORAL HEALTH CARE IN THE LGBT POPULATION: ACCESS, PERCEPTIONS, BARRIERS, AND POTENTIAL SOLUTIONS  
Sponsor: Dr. Kristin Williams

**Third Place**

Adam Fitzgerald  
Southern Illinois University School of Dental Medicine  
Title: USE OF SPATIAL ANALYSIS TO INFORM COMMUNITY OUTREACH ACTIVITIES  
Sponsor: Dr. Poonam Jain

**Honorable Mention**

Linda Borna  
University of Southern California Ostrow School of Dentistry  
Title: ELIMINATING THE ORAL HEALTH DISPARITY IN LOW SOCIO-ECONOMIC COMMUNITIES THROUGH DENTAL EDUCATION AND PREVENTATIVE CARE  
Sponsor: Dr. Santosh Sundaresan

**Dental Hygiene Student Merit Award for Outstanding Achievement in Community Dentistry**

**First Place**

Laura Hettinger, RDH  
University of Michigan School of Dentistry Dental Hygiene Degree Completion Program  
Title: Perinatal and Well-Child Community Oral Health Education Program  
Sponsor: Janet Kinney, RDH, MS

**Second Place**

Laura Beers, Lydia Diekmann, Erin Herbranson and Erin Kloke  
University of Minnesota Division of Dental Hygiene  
Title: COMMUNITY ORAL HEALTH OUTREACH PROJECT: NATIVE AMERICAN COMMUNITY CLINIC  
Sponsor: Priscilla Flynn, RDH, MPH, DrPH