Government of the District of Columbia

Department of Health

Oral Health Program

First Oral Health Leadership Summit

July 18, 2003

"Rebuilding on a Framework for Improving Oral Health in the District of Columbia"

Table of Contents

Introduction

The District of Columbia held its first Oral Health Leadership Summit on July 18, 2003 at Gallaudet University, Washington DC. The theme of the Summit was *Rebuilding on a Framework for Improving Oral Health in the District of Columbia*. The Summit was planned as one of the District's strategic responses to former U.S Surgeon General, Dr. David Satcher's report on *Oral Health in America* issued in May 2000 and current U.S. Surgeon General, Dr. Richard Carmona's recently released report *The National Call to Action to Promote Oral Health*. This one-day summit addressed issues such as oral health policy development, oral health quality assurance, and initiating linkages with dental and medical providers as well as the dental community. The summit also discussed issues surrounding low Medicaid reimbursement rates, bureaucratic administrative requirements, lack of uniformity and methods to rebuild the dental infrastructure in the District in order to facilitate greater access to dental services. The District of Columbia's unique position to benefit from the knowledge and resources of many local and national organizations committed to improving the oral health needs of children, women, men and families were also addressed. The Oral Health Leadership Summit was the first big step in formalizing the needed integrated oral health delivery system and health plan that will reach children with unmet needs.

Purpose of Summit

Approximately 70 individuals from both the private and public sectors attended the Summit. These individuals had both the experience and desire to make sound policies and propose recommendations on how to improve the oral health of individuals and communities within the District of Columbia (DC). There was representation from the health policy arena, dental and medical providers, insurers, federal and local government representatives, members of academia, dental researchers, local community leaders, health officials, and legislators to name a few.

The Summit aimed to enable stakeholders to learn more about each other and to discuss opportunities to work together in order to better serve the oral health needs of families, women, children and adolescents in the District of Columbia. More specifically, the Summit aimed to:

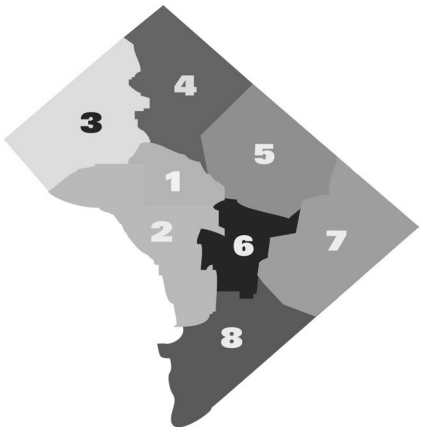
- Broaden the ownership for oral health improvement in the District of Columbia;
- Increase the awareness of the scope of oral health problems in the District of Columbia;

- Discuss and develop oral health prevention, and access strategies particularly for those who are underserved within the District of Columbia;
- Discuss and develop strategies that enhance the coordination, distribution or replication of past successful oral health and treatment services in the District of Columbia.
- Build a network of individuals and organizations committed to finding an effective approach to improving oral health and dental care for District residents by fostering a positive, nonjudgmental, and comfortable environment which allows people the opportunity to think of innovative solutions that go beyond traditional approaches;
- Highlight what is unique about the District of Columbia and its environs; and
- Develop specific plans for next steps for public health in the District of Columbia.

Challenges in Washington, DC

According to the last Census done in 2000, the District of Columbia is home to 572,059 people[1]. Although there are integrated neighborhoods, the District is largely segregated along lines of income and race, resulting in great health disparities. The northeastern and southeastern Wards (see Diagram 1) have the highest concentration of low-income residents and African Americans while the northwestern Wards have the greatest proportion of high-income residents and Caucasians.

Diagram 1: Map Showing the Wards of Washington, DC

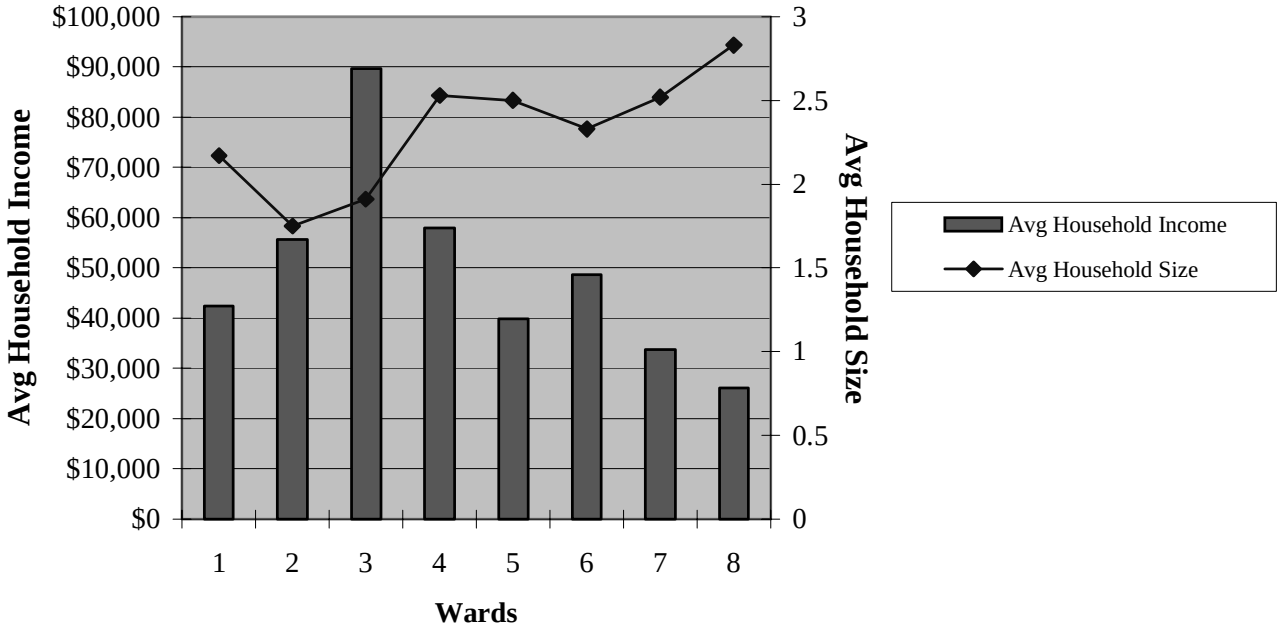


[1]U.S. Census Bureau. United States Census 2000. http://quickfacts.census.gov/qfd/states/11000.html. Retrieved June 2004.

Poverty in Washington, DC

Compared to the United States average of 12.6 percent, 19.7 percent of District residents are disadvantaged and placed at risk of poor oral health as a result of living in poverty. Among children, the rate is even more alarming with over 30 percent younger than five years living in poverty. Poverty rates vary significantly in DC by Ward[2]. The median household income of DC residents in 1998 was $43,011, with the median incomes in Ward 3 and Ward 8 being $89,675 and $26,145, respectively, as indicated in Graph 1 below. The average annual income for the poorest fifth of DC families declined 17 percent in the last decade while families in the middle fifth experienced a decline of 14 percent. These disturbing facts denote that twenty percent of the District population receives 62 percent of the income while the bottom 20 percent receives only 2 percent.

Graph 1: The Average Household Income & Size Per Ward in Washington, DC



As indicated by Graph 1 above, Wards 1, 5, 6, 7, and 8 contain most of the District's poor families and are overwhelmingly African American. The census tracts also classify these Wards as medically underserved areas.

[2] U.S. Census Bureau. http://www.census.gov. Retrieved 2001.

How Poverty Impacts Oral Health

As stated in the Surgeon General's Report on Oral Health (2003)[3], there are severe disparities in the incidence and prevalence of dental disease according to income. In fact, low-income children are two times more at risk than more affluent children to be affected by dental diseases and are more likely to remain untreated. These untreated diseases may result in pain and suffering that affects the child's self-esteem, ability to eat, attend school and communicate among other things. Sadly these disparities often continue into adolescence and perhaps even adulthood since good oral habits were not instilled at an early age.

Oral Health in Washington, DC

The District's high rate of poverty (approximately 10.6 percent of the District's population are living below the Federal Poverty Level[4]) combined with its large minority population (approximately 75 percent of the population are African Americans and Hispanics) results in very low oral health indicators. According to the 2000 Behavioral Risk Factors Surveillance System survey:

- Almost 30% of African Americans in DC indicated that they had lost six or more teeth due to decay or gum disease compared to 12 percent of Hispanics.
- About 33% of Hispanics and African Americans had not visited a dentist in the past year.
- Males in the District have the highest incidence (25.4) and mortality rate (11.4) per 100,000 of oral cancer in the country.

Unfortunately, the last major specific District Needs Assessment on Oral Health was in 1985 and focused on children in school. However, the District of Columbia, Oral Health Program was able to conduct a limited Oral Health Needs Assessment through funding from the W. Kellogg Foundation supported Community Voices Collaborative. This limited Oral Health Needs Assessment was carried out in the summer of 2002. District residents were asked to respond to nine questions in order to collect basic information about their oral health needs and practices.

[3] U.S. Department of Health and Human Services. *A National Call to Action to Promote Oral Health.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, May 2003

[4] U.S. Census Bureau. Washington QuickFacts. http://quickfacts.census.gov/qfd/states/53000.html. Retrieved August 2004.

The survey captured information on oral hygiene practices, number of dental visits, methods of payments, and barriers to services. Some of the significant findings from the survey were:

- Approximately 52% of those surveyed (respondents were individuals and parents of children older than 2 years of age) had an oral health visit in 2001
- 55.3% of those surveyed said that access problems resulted in their inability to visit an oral health care provider. More specifically:
  - 27% were unable to afford the high dental costs
  - 17.5% did not know a dentist or have access to one
  - 7.8% were unable to obtain an appointment at a convenient time
  - 3% were unable to get to the dentist's office
- 43.8% of those surveyed had lost at least one tooth due to dental caries or periodontal disease (which was slightly better than the Year 2010 target of 42% and better than the 1999 national baseline of 31%). Of those surveyed:
  - 39% had lost 1 to 5 teeth
  - Approximately 14% had lost 6 or more teeth
  - 3.2% had lost all their teeth
- 67.4% of those surveyed reported having insurance that paid some or all of their dental expenses while 31.3% had no such insurance.

Oral Health Leadership in Washington, DC

A major challenge faced by the District of Columbia was the absence of a dental directive for more than a decade and a half. Additionally, the school-based dental program, which acted as the main source of primary and preventative dental care to children, folded in 1981. Both of these events made it difficult for the District to develop neighborhood-specific baseline data by which a needs assessment could be performed and appropriate programs developed and implemented. They may have also attributed to some of the oral related problems faced within the District.

Nonetheless, the DC DOH's Medical Assistance Administration organized an Oral Health Task Force in August of 2001 upon the request of the Health Care Financing Administration (HCFA) – now known as the Centers for Medicare and Medicaid Services (CMS). Its purpose was to address the oral health needs of children either enrolled in State Children's Health Insurance Program (SCHIP), MCOs, or who used a fee-for-service plan.

Through the work of the Task Force, a 150% increase in Medicaid dental fees went into effect October 2003.

Summit Recommendations

Workshops for the Summit were broken into two sessions. The morning session (Strategy Development Phase I) addressed barriers and resources while the afternoon session (Strategy Development Phase II) aimed to develop strategies for an oral health plan. Attendees were able to choose from the following topics to discuss both development phases:

- Oral Health Needs of Children & Adolescents
- Oral Health Needs of Working Families & the Uninsured
- Oral Health of Special Needs Populations (Disabled, Seniors, MRDDA, HIV/AIDS)
- Dialoguing with Dental and Medical Providers

Oral Health Needs of Children & Adolescents

Facilitator: Dr. John Rossetti, Maternal and Child Health Bureau, Health Resources and Services Administration

Aim: To discuss ways to improve the District's children and adolescents access to oral health care in a timely manner within DC.

Recommendations:

<u>Morning Session</u>

1. DC families should receive more education about the importance of proper oral health.
2. More collaboration is needed between both private and public sectors to address oral health problems in the District.
3. Oral Health programs within the District need to learn from the success stories of other programs.
    a. A volunteer program (similar to the one that exists in Chicago) should be implemented to provide low-income patients with oral health care.
4. The following should be considered to help address dental provider access issues
    a. Dental Schools within DC should be utilized more to help address some of the dental issues faced.

b. Dental providers in the military, VA and public health services that are licensed to practice within the District should be considered as a possible source of inexpensive (or complimentary) care to the underserved within DC.
c. Dentists should be rotated throughout underserved areas within the District.

5. Health care providers from Upward Bound should return to low-income communities in DC to influence and mentor youth to enter similar professions.
6. Medicaid reimbursement rates should be increased.
7. Foreign-trained dentists should be allowed to do the Dental Board exams in Maryland and the District of Columbia in order to help fill the shortage of dentists available to serve DC residents.
8. Head Start and Early Head Start programs should be used as a model to build a system of dental care.
9. Access to quality, timely dental care needs to be improved within the District.
10. More holistic approach to treating patients should be adopted. Patients' mental, physical and dental health should all be evaluated when a patient sees a provider.

Afternoon Session

1. The public-private partnership that eroded as a result of the absence of a DC Department of Health Dental Director for over 20 years should be re-established.
   a. DC DOH should re-establish the position of Oral Health Dental Director
2. Dentists need to be educated about how to treat small children.
   a. Pediatric dentistry needs to be emphasized more on the dental curriculum.

Oral Health Needs of Working Families & The Uninsured

Facilitator: Dr. Steven Price, Health Concepts International and Private Practice Dentist in District of Columbia

Aim: To discuss ways to improve the oral health in the District of Columbia, particularly for Working Families & The Uninsured

Recommendations:

Morning Session

1. Dental insurance coverage should be increased, especially since Medicaid does not provide dental services to adults and DC Healthcare Alliance only provides services to the extremely poor in the District.
2. The position of Oral Health Director should be re-instituted within the DC Department of Health in order to direct focus on the oral health issues faced by the residents within the District.

Afternoon Session

1. Providers should participate in the DC Healthcare Alliance and Safety Net.
2. Oral health dental insurance coverage should be expanded to benefit a wider population.
3. The position of Oral Health Director should be re-instituted within the DC Department of Health.
4. A Dental Advisory group should be established in order to meet with National Policy Makers.
5. Foundations should be engaged to solicit funds to improve Oral Health in the District.
6. Health promotion campaigns should be launched to increase Oral Health awareness in the District.
7. Dentists should be lobbied to consider extending hours of operation to include evenings and/or weekends to accommodate the schedules of working patients.
8. A rotational system for dental providers should be established to give dentists more flexibility to schedule patients during evenings and weekends.
9. Dental vans equipped to treat patients should be scheduled to visit various work sites around the District to facilitate working patients' schedules.
10. Oral Health data that is generated should accurately reflect the District's unique population (particularly its large immigrant community).

Oral Health of Special Needs Populations (Disabled, Seniors, MRDDA, HIV/AIDS)

Facilitator: Mr. William Hunter, Deputy Maternal & Child Health Officer, District of Columbia Department of Health

Aim: To identify needed oral health services not being accessed by Special Needs Populations

Recommendations:

Morning Session

1. Dentists should be rotated in clinics that serve patients with special needs in order to provide them with more experience in treating this special population.
2. Dental schools should place more emphasis on training dental students to treat patients with special health care needs.
3. More business training and community relations courses should be taught in dental schools.
4. Academic, community and religious collaboration is needed in order to receive additional funds and to increase oral health education/awareness.

Afternoon Session

1. Policy makers should be educated/reminded about the oral health issues faced by individuals with special health care needs.
2. A school based oral health program should be re-established within the District on a permanent basis in order to increase access to oral health care to underserved children.
    a. DC Public Schools should be included as a partner to address the oral health needs of individuals with special population meetings.
3. Dental students should get more training to deal with individuals with special health care needs.
4. Telemedicine should be implemented within the District.
5. Community involvement should be fostered by:
    a. Incorporating the community's voice while an oral health plan for the District is created.
    b. Having town-hall meetings.

Dialoguing with Dental and Medical Providers

Facilitator: Dr. Donald Schneider, Dental Consultant in Health Policy and Dental Research

Aim: To discuss ways to initiate standard setting in the dental world, improving quality of care and identifying indicators of care.

Recommendations:

Morning Session

1. Public awareness about the importance of oral health needs to be heightened.
2. Oral Health education needs to begin with younger audiences in order to instill proper oral hygiene habits at an early age.
3. Oral Health education should be targeted to the immigrant population in DC, as they may be from cultures that do not emphasize the need for good oral health.
4. Dentistry should be "demystified" in order to decrease public's apprehension about visiting dentist.

Afternoon Session

1. DC residents need to be made aware of where to go to seek oral health treatment.
2. Medicaid reimbursement rates need to be increased.
3. More outreach needs to be performed to encourage dental providers to enroll into managed care.

Oral Health Leadership Summit Priority Issues

Discussions from the various sessions generated many thought provoking issues. Participants were able to identify and recommend possible solutions to many of these. Some of the more common, reoccurring topics throughout the Summit were:

1. *The public's awareness to the benefits of good Oral Health needs to be increased* - Campaigns, improved health promotion efforts, etc. needs to be developed and/or increased to change District residents' attitude towards oral health.
2. *There is a greater need for community collaboration* – Access to additional resources, knowledgeable advice, creativity, skills and motivation needed to further develop the DC DOH Oral Health program will be facilitated with greater community collaboration.
3. *The position of DC DOH Dental Director should be re-established* - Because the District has been without a Dental Director for over two decades many of its public-private partnership has disappeared and therefore needs to be re-forged.

What the District of Columbia is Currently Doing:

(Post 2003 Oral Health Leadership Summit)

In an attempt to address some of the oral health issues experienced by the District, the Oral Health Program of the DC DOH has begun to develop and implement program based on the recommendations made during the Summit. The following are activities that are currently being carried out by the Oral Health program.

School-Based Dental Sealant Pilot Project

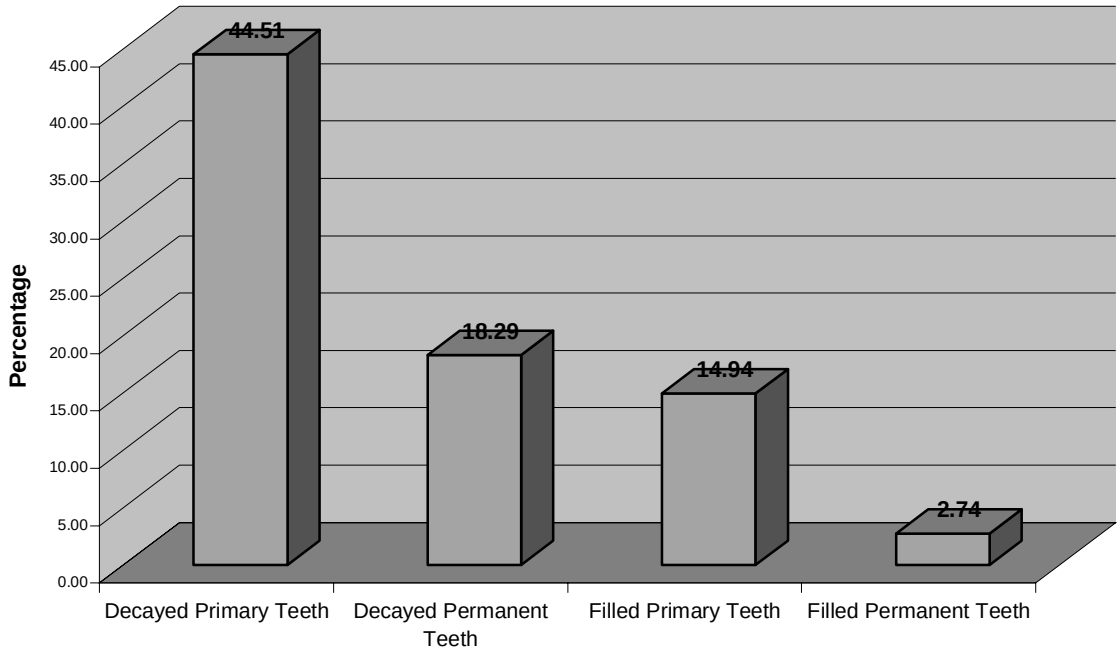
The School Dental Sealant Pilot Project was initiated in seven elementary Transformation Schools (TS) in DC. At this point more than 400 2nd and 3rd graders have been examined and provided oral health treatment including sealants. The provision of dental services also allowed valuable oral health data to be collected from each participating child. This data contributes to the development and implementation of an oral health database surveillance system. The program captures data regarding:

- Decayed, Missing and Filled Surfaces (DMFS) of both primary and permanent dentitions
- Percent student participation in the free/reduced lunch program
- Ward (school location)
- Percentage of parental consent form returned
- Number of students referred for urgent and routine care
- Gender & race/ethnicity
- Sealants (previously and currently placed)
- Cost per child treated

Of the students examined 50% had decayed primary teeth, 20% had decayed permanent teeth, 18% had filled primary teeth and 5% had filled permanent teeth (see Graph 2 on the following page). Consequently, approximately 90% of all students examined received sealants resulting in more than 988 sealants being placed.

In addition to the clinical accomplishments of the School Based Dental Sealant Project, the program also provided an educational component. All 2nd and 3rd graders, whether or not they

Graph 2: History of Caries for 2nd & 3rd Grade Transformation Elementary School Students



had returned a signed parental consent form, were instructed on how to adopt proper oral health behaviors such as the correct way to brush and the effects of proper diet on oral health.

As a result of this program, access to oral health services in these otherwise neglected communities was greatly improved. Additionally, oral health awareness of students, staff, families and other community members was increased. These efforts will play a valuable role in decreasing the incidence of early childhood tooth decay within individual schools as well as the total DC community.

The dental sealant project uses portable dental equipment in the schools. The team comprises of a retired dentist and a dental assistant. The dental assistant is a resident of the community in which some of the TS are located and has a child that attends a TS. She is a former Temporary Assistance to Needy Families (TANF) recipient trained by the dental program to be a dental assistant.

DC Oral Health Coalition

An Oral Health Coalition for the District of Columbia was convened in order to provide a more comprehensive approach to oral health policy, planning and programming. The coalition consists of a voluntary network of individuals and organizations that are committed to finding an effective local approach to improving oral health and decreasing the access barriers within the District of Columbia.

OHA & CHC Forms

Oral Health Assessment (OHA) and Child Health Certificate (CHC) forms were developed in Spring 2004. The OHA replaces the Dental Appraisal Form and should be completed for all children of the age of three years or older. Both the OHA and CHC forms will replace all other enrollment forms for children enrolled in public and private schools, Head Start, and childcare, and may also be used for camp, after school, and athletic programs. The forms aims to improve the efficiency with which the health status of children enrolling in child related educational programs in the District are assessed concurrently making the process more convenient for parents and providers. DC DOH collaborated with governmental and community agencies, as well as health professionals and other stakeholders to develop the new forms. These non-DOH entities are all committed to supporting DOH in their efforts to improve the health and well being of children in the District of Columbia.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCNs) often receive lower levels of health services including dental, than other children and are in dire need of oral health services. The DC Oral Health Program is providing dental care for Children with Special Needs in order to improve the oral health of this unique population within the District. The program is currently housed on two sites, Mamie D. Lee in Northeast DC and Sharpe Health School in Northwest DC

Provision of Dental Care for Children with Special Needs aims to improve the oral health of this unique population residing within DC The program has developed organizational structure, roles, relationships and accountability mechanisms.

Since Children with Special Health Care Needs uniformly receive lower levels of health services including dental, than other children, Special Needs children in the DC are in dire need

of oral health services. In addition to providing clinical services at the two schools using existing but refurbished dental equipment, the oral health program will also be conducting outreach, education and home based monitoring and coaching to assist parents and caregivers of these special needs children to understand the importance of oral health and gain the skills required to implement their child's oral health care plan. The Dental Staff at Children National Center (CNMC) is providing the clinical dental treatment at the two special needs schools.

Forging Partnerships

Presentations discussing the DC DOH Oral Health Program have been made to national oral health conferences. These presentations have facilitated the development, expansion and improvement of relationships between oral health partners in order to promote an integrated oral health system and increase resources within the District. Audiences include the DC Dental Society Leadership Summit, DC Mayor's Health Policy Council Children's Forum, the American Association of Community Dental Programs, the Children's Dental Disease Prevention Program Pre-Conference Symposium National Oral Health Conference, Annual Joint Meeting of American Association of Public Health Dentistry (AAPHD) as well as the Association of State and Territorial Dental Directors (ASTDD).

Conclusion

The first Department of Health Oral Health Leadership Summit held on July 18, 2003 brought together many of the leading figures in Oral Health Care from both the public and private sectors within the District of Columbia. Insightful recommendations were generated from both developmental phases of the Summit where the following topics were discussed:

- Oral Health Needs of Children & Adolescents;
- Oral Health Needs of Working Families & the Uninsured;
- Oral Health of Special Needs Populations (Disabled, Seniors, MRDDA, HIV/AIDS); and
- Dialoguing with Dental and Medical Providers.

The recommendations from the Summit are being used in developing the five-year Oral Health Plan for the District of Columbia. The District of Columbia Oral Health Coalition will also address some of the recommendations proposed by the Summit.

Acknowledgements

The Oral Health Program of the District of Columbia, Department of Health would like to thank the following for their assistance in planning the Oral Health Leadership Summit. The time, creativity and hard work contributed by these individuals resulted in the success of the Summit.

Name	**Organization**
Lelia Abrar	Office of Communications (DC DOH)
Carole Amaning	Data Collection & Analysis, Maternal Family Health Administration (DC DOH)
Brenda Crowder Gaines	HIV/AIDS Administration (DC DOH)
Abe Davis	Maternal Family Health Administration (DC DOH)
Jamie Edwards	Adolescent Health, Maternal Family Health Administration (DC DOH)
Marion Flores	Nutrition Program/ Women, Infants & Children Program (DC DOH)
Dr. Donna Grant- Mills	Robert Wood Johnson Foundation/Howard University College of Dentistry Pipeline, Professions & Practice Initiative, Project Director and Howard University College of Dentistry, Faculty Member
Judith Johnson	Community Voices Collaborative, Project Manager (DC DOH)
Deirdre Jordan	Medical Affairs (DC DOH)
Sally Lawrence	Maternal Family Health Administration (DC DOH)
Felicia Lynch	HIV/AIDS Administration (DC DOH)
Farhia Mussa	Maternal Family Health Administration (DC DOH)
Corey Palmer	Office of Primary Care (DC DOH)
Gwendolyn Petersen	Medical Assistance Administration (DC DOH)
Marilyn Seabrooks Myrdal	Maternal Family Health Administration, Chief Officer (DC DOH)
Colleen Whitmore	Adolescent Health, Officer, Maternal Family Health Administration (DC DOH)

Sponsors

The Oral Health Program of the District of Columbia, Department of Health would like to thank the following for financially supporting the Oral Health Leadership Summit, without which the Summit would have never been a reality:

The Health Resources and Services Administration,

The Association of State and Territorial Dental Directors,

The W. K. Kellogg Foundation funded DCDOH Community Voices Collaborative Project, and

The District of Columbia Department of Health.

Without your support, the Oral Health Leadership Summit would not have been the success it was.

Appendix A

Plenary Speakers

James J. Crall, DDS, ScD
Director, Maternal and Child Health Bureau
National Oral Health Policy Center
Division of Community Health
Columbia University School of Dentistry and Oral Surgery
154 Haven Avenue, 1st Floor
New York, NY, 10032
Phone: (212) 304-5707
Fax: (413) 812-2811
Jjc233@columbia.edu

Caswell Evans Jr. DDS, MPH
Project Director/Editor
Surgeon's General's Report on Oral Health
National Institutes of Dental & Cranial Facial Research
National Institutes of Health
Bldg.31, Room 2C39
31 Center Drive, MSC2290
Bethesda, Md. 20892
Phone: (301)-594-3281
Fax: (301) 402-2185
Evansc@45.nidr.nih.gov

Emanuel Finn, DDS, MS
Oral Health Program Manager
DC Department of Health
825 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 442-9395
Fax: (202) 535-1710
efinn@dchealth.com

Donna Grant-Mills, RDH, M.Ed., DDS
Program Director
RWJF Community Based Dental Education Program
Howard University College of Dentistry
Washington, DC 20059
Phone: (202) 806-0065
Fax: (202) 806-0354
d_grant-mills@howard.edu

William Hunter
Deputy Maternal and Child Health Officer
Maternal and Family Health Administration
DC Department of Health
825 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 442-9340
Fax: (202) 442-4947
whunter@dchealth.com

Phyllis Mayo, PhD
Chief of Staff
DC Department of Health
825 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 442-5999

Steven Price, DDS
Vice President
Health Concepts International
Oral Health Development
2132 Yorktown Road, NW
Washington, DC 20012
drsprice@aol.com

Michael Richardson, MD, FACP
Chief Medical Officer
Primary Care, Prevention and Planning
DC Department of Health
825 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 442-5999

Donald A. Schneider, DDS, MPH
Dental Consultant in Health Policy and Dental Research
donsdds@comcast.net

Bailus Walker, Jr., PhD
Chairman
Mayor's Health Policy Council
441 4th Streeet, NW, 1150 N
Washington, DC 20001
Phone: (202) 727-9239
bwalker@fac.howard.edu

Appendix B

A Leadership Summit Sponsored by DC Department of Health
Gallaudet University Kellogg Conference Center
July 18, 2003
AGENDA

8:00 – 8:30 am	**Registration & Continental Breakfast**
8:30 – 8:40 am	**Welcome & Introductions** Phyllis Mayo, Ph.D. Chief of Staff, DC Department of Health
8:45 – 9:00 am	**Remarks & Greetings** Bailus Walker. Jr., PhD., MPH, Chairman, Mayor's Health Policy Council
9:00 – 9:10 am	**Remarks** Sandra Allen (Invited) Council Member (Ward 8)
9:10 – 9:25am	**Remarks & Greetings** Michael Richardson, MD, FACP Chief Medical Officer Primary Care, Prevention and Planning DC Department of Health
9:30 – 10:00 am	**Oral Health in America: Critical Issues, Trends & Strategies** Caswell Evans, DDS, MPH Editor, Surgeon's General Report on Oral Health Director, National Oral Health Initiatives Surgeon General's Office.
10:00 – 10:15 am	**Status of Oral Health in the District of Columbia** Emanuel Finn, DDS, MS Oral Health Program Manager DC Department of Health
10:15 – 10:45 am	**Financing and Workforce Considerations** James J. Crall, DDS, ScD Maternal and Child Health Bureau National Oral Health Policy Center Division of Community Health Columbia University School of Dental and Oral Surgery New York, NY.
10:45 – 11:00 am	**Break**
11:00 – 12:30 pm	**AM Roundtable Discussions: Strategy Development Phase I - Discussions on barriers and resources** • Addressing the Oral Health Needs of Children & Adolescents. • Addressing the Oral Health Needs of Working Families & the Uninsured.

	• Addressing the Oral Health of Special Needs Populations (Disabled, Seniors, MRDDA, HIV/AIDS) • Dialoguing with Dental and Medical Providers.
12:30 – 1:15 pm	**Lunch and Presentation** **Pipeline Profession and Practice Community Initiative funded by Robert Wood Johnson Foundation** Donna Grant-Mills, RDH, M.Ed., DDS Program Director RWJF Community Based Dental Education Program Howard University College of Dentistry's **Provisions of Oral Health Services to Children with Special Needs Project** Marilyn Seabrooks Mydral, MPA Maternal and Child Health Officer DC Department of Health
1:15 – 2:45 pm	**PM Roundtable Discussions: Strategy Development Phase II - Discussions on barriers and resources** • Addressing the Oral Health Needs of Children & Adolescents. • Addressing the Oral Health Needs of Working Families & the Uninsured. • Addressing the Oral Health of Special Needs Populations (Disabled, Seniors, MRDDA, HIV/AIDS) • Dialoguing with Dental and Medical Providers.
2:45 – 3:45 pm	**Reporting Out**
3:45 – 4:00 pm	**Next Steps and Closing Remarks** Emanuel Finn, DDS, MS. Oral Health Program Manager DC Department of Health.