PROMOTING ORAL HEALTH IN MISSISSIPPI COMMUNITY HEALTH CENTERS

Myrtis Small, MPH
Director of Human Resources
Delta Health Center, Mound Bayou, Mississippi
OVERVIEW

- Importance of Oral Health in Mississippi
- DentaQuest Foundation “Strengthening the Oral Health Safety Net Initiative”
- Partnerships
MS CHCs/DentaQuest Project Participants
MISSISSIPPI CHCs/DENTAL SITES

- **21 COMMUNITY HEALTH CENTERS**
  - 20 out 21 provides dental services
  - 11 have participated in the SOHSN Initiative

- **38 DENTAL SITES (INCLUDES STAND ALONE SITES)**

- **122 OPERATORIES**

- **33.09 FTEs (DENTIST)**
Limited access is the primary reason MS suffers from such poor oral health.

Many health professionals and state policy leaders have a limited understanding of the strong link between oral health and primary health.

According to Kaiser State Health Facts, MS has the 2\textsuperscript{nd} lowest percentage of adults who visited the dentist.

2010 data showed that only 58\% of state adults visited the dentist during the previous year, compared to the national average of 70\%.
PROJECT DESIGN

- Promote interprofessional collaboration among CHC dental and medical programs
- Elevate the importance of oral health within the PCA and the State
- Collaborate with the DentaQuest Foundation and SNS to achieve operational enhancements and greater sustainability within health center dental programs.
- Increase knowledge of state oral health status and advance oral health safety net needs among state leadership.
DENTAL CARE FOR MEDICAID BENEFICIARIES AGE TWENTY-ONE (21) AND OLDER ARE RESTRICTED.
   - TREATMENT ONLY IF DUE TO EMERGENCY/MEDICAL CONDITION
WORKPLAN YEAR 1

- Utilized the web-based Smiles for Life Curriculum
- Hosted 1st Oral Health Summit
- Developed an Oral Health Workgroup
- Incorporated oral health in all PCA meetings and workshops
YEAR 1

- Conducted a face-to-face training with both medical and dental providers on the importance of Fluoride Treatments and Varnish & Tobacco Use and Oral Health Deficits
- Conducted medical and dental integration session at our Annual PCA Conference
- Conducted 1st Oral Health Summit/Keynote Dr. Bobby Russell
- Involve other PCAs/Arizona PCA
YEAR 1 CHALLENGES

- ESTABLISHING AN ORAL HEALTH WORKGROUP
  - Key participants not being able to meet or be fully engaged

- GETTING ALL OF THE PROVIDERS TO COMPLETE THE SMILES FOR LIFE CURRICULUM
Communicated and reviewed the DentaQuest project at every Board meeting
Conducted training on Medical and Dental Integration
Encouraged Health Center Clinicians to utilize the Smiles for Life Curriculum
Developed Referral System
Tri-State Oral Health Summit-MS, TN & GA PCAs
Incorporated MS Dentist Loan Repayment Participants
YEAR 2 CHALLENGES

- INABILITY TO HOST A DENTAL DIRECTORS WORKSHOP - COLLABORATION WITH PCO
  - PCO sponsored Dr. Paul Glassman’s attendance at the 1st Tri-State Oral Health Summit
- Collaborate with the MSDH Office of Tobacco Control to conduct training
- Conduct Dental Billing and Coding Training for Dental Staff
- Host a Medical and Dental Directors Leadership Training Session
- Host Second Annual Tri-State Summit/Atlanta, GA
- Provide Oral Health Educational information in PCA newsletter
- Promote Oral Health Care for Pregnant Women

“LITTLE THINGS CAN MAKE A BIG DIFFERENCE”
CONCERNS WITHIN EACH DENTAL PROGRAM

- IMPROVING PROVIDER PRODUCTIVITY
- DENTAL LEADERSHIP
- CONTINUED CEO/ED SUPPORT
- FINANCIAL
- UTILIZATION OF CURRENT RESOURCES
Partnerships

- MSDH Oral Health Division/Mississippi Oral Health Community Alliance
- MSDH Office of Rural Health and Primary Care
- MSDH Office of Tobacco Control
- Mississippi Office of Rural and Primary Care Dentist Loan Repayment Program
CONTINUE TO DO THE BEST WE CAN

CONTINUE TO EDUCATE MEDICAL AND DENTAL PROVIDERS

CONTINUE TO COLLABORATE AND NETWORK WITH ORAL HEALTH ADVOCATES
THANK YOU
Partnering With State Oral Health Programs

How they can benefit the community and improve oral health

Bob Russell, DDS, MPH
State Health Department: Population Health

- Partnership development and coordination
- Oral health surveillance
- Program evaluation
- Needs assessment
- State oral health plan
- Oral health promotion

State OH Program Leadership and Capacity
Centralized Support Center

Maintaining Basic Community Capacity

Evidence-based Preventive Interventions

- School-based sealants
- Community water fluoridation
- Other best practices targeting underserved
- Local grants and aid
Organization and Coalition Building

- Seeding new community capacity
  - Organize state oral health coalition
  - Complete state environmental scan, burden of disease document, and state oral health plan
  - Complete state program evaluations
The Benefits of Good Data: Internal and Network Use

- Helps in the planning process
- Provides information on the challenges ahead
- Allows for tracking changes and corrections in strategic outlook
- Compliance with federal rules
- Improves quality of care
- *Helps to know the territory!*
Data for Community Health
Needs Assessments

- Health Centers Must Have Data Including:
  1. Estimated of number of users.
  2. Description of existing providers and resources in the community as well as an assessment of unmet need.
  3. Predominant characteristics of service population
  4. Oral health status, prevention, and treatment needs of the population.
  5. Barriers to access/availability to comprehensive oral health care services.
  6. Description of needs and treatment of special populations.
IDPH Sealant Programs – 2013

- 7,321 students served
- 4,523 received sealants
- 24,523 sealants placed
- 915 with untreated decay
- 4,311 with Medicaid or no insurance
IDPH Sealant Programs - 2014

- 9,413 students served
- 5,651 received sealants
- 32,503 sealants placed
- 1,719 with untreated decay
- 5,570 with Medicaid or no insurance
Impact in Iowa

- Growth resulted in 11 new programs – totaling 18 contracted programs that cover 72 counties. 5 additional counties covered by programs not contracted.

- Most of the expansion has been within rural Iowa where dental access is difficult due to limited number of providers and those accepting Medicaid, as well as greater distances to travel to get to a provider.

- **Over 3300 caries averted based on CDC analysis with a $3 million dollar savings to Medicaid**
Triple Aim

- All care delivery strategies should simultaneously accomplish three critical objectives:
  - Improve the health of the population served
  - Improve the experience of each individual
  - Affordability as measured by the total cost of care

- School-Based Sealant Programs are accomplishing these objectives by:
  - Prevention or referral for early decay in a population-based setting
  - Eliminates stigmas and barriers
  - Inexpensive and efficient
AIM
Increase the proportion of children, adolescents, and adults who use oral health care, education, prevention, and treatment.

Goals
- Increase affordability of oral health care for consumers
- Increase availability and use of oral health care based on evidence and disease management
- Prevent diseases of the mouth
- Achieve oral health equity

PRIMARY DRIVERS
- Education about Importance and Urgency
- Broad Access to Preventive Care and Treatment
- Infrastructure and Capacity
- Data Monitoring and Risk Assessment
How to Partner with State Oral Health Programs

- Go to your SOHP website
- Sign up to receive their newsletters and updates
- Seek web resources where public health data is listed
- Be an active member of your state’s oral health coalitions
- Serve on advisory groups that work with SOHPs
Bob Russell, DDS, MPH
NNOHA Board Member
515-281-4916
e-mail: bob.russell@idph.iowa.gov
Meeting the Oral Health Needs of Your Community

NACHC Policy and Issues Forum
Washington, DC

Presented by:
Greg Nycz, Executive Director
Family Health Center of Marshfield, Inc.
March 20, 2015
Oral Health Access is a National Problem

FY 2007 EPSDT Dental Utilization Rates
Percent Receiving a Dental Service

(No data for Hawaii and Maine)
Oral Health Access is a National Problem

FY 2007 EPSDT Dental Utilization Rates
Percent Receiving No Dental Service

(No data for Hawaii and Maine)
Percent With a Dental Visit by Income  2010

- **CHILDMREN**:
  - <100% FPL: 36%
  - 101-200% FPL: 42%
  - 201-400% FPL: 46%
  - 401%+ FPL: 58%

- **ADULTS**:
  - <100% FPL: 13%
  - 101-200% FPL: 23%
  - 201-400% FPL: 34%
  - 401%+ FPL: 51%

Reference: [www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0213_2.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0213_2.pdf)
HPSA: Dental
Family Health Center of Marshfield, Inc.’s Dental Journey

• First services (March 1974)
• Added dental with contract providers (January 1975)
• Dental contract providers begin to refuse Medicaid and begin to drop their contracts with us for the uninsured (1991-2002)
• September 2001 Board prioritizes direct delivery of dental services
• We start offering dental services in temporary quarters in Ladysmith (November 2002)
Engagement requires a vision and a road map

“If you don’t know where you are going, any road will take you there.”

Lewis Carrol

Alice in Wonderland
Major Components of the Plan

• Rapidly expand dental capacity and don’t leave anyone behind (developmentally disabled, geriatric, pediatric, children with special health care needs)
• Develop integrated oral/medical electronic health record with decision support
• Foster collaboration across medicine, public health, and dentistry addressing oral/systemic interactions, health literacy issues and prevention
• Develop a dental school designed to produce dentists for the safety net prepared to work collaboratively with medicine and public health
Key Strategic Plan Elements

• Regionalize care

• Integrated EHR

• Train Workforce

• Leave No One Behind
Ladysmith, November 1, 2002
Temporary Quarters in Mt. Senario College Building
Following a Labor Day tornado that destroyed our planned (to acquire) dental facility
OUR FIRST REGIONAL DENTAL FACILITY
THE LADYSMITH DENTAL CENTER ✶ OPENED JULY 2003

8,840 square feet
17 operatories
5 dentists/5 hygienists
Building funded with State Rural Health Dental Clinic funds and FHC reserves

OUR SECOND REGIONAL DENTAL FACILITY
THE CHIPPEWA FALLS DENTAL CENTER ✶ OPENED JUNE 18, 2007

17,700 square feet
29 operatories
7 dentists/8 hygienists
2 oral surgeons
Special space and equipment to serve the developmentally disabled
Building leased from Chippewa County Dental Foundation
OUR THIRD REGIONAL DENTAL FACILITY
THE PARK FALLS DENTAL CENTER  OPENED MARCH 3, 2008
9,700 square feet
15 operatories
4 dentists/5 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by USDA Rural Development

OUR FOURTH REGIONAL DENTAL FACILITY
THE NEILLSVILLE DENTAL CENTER  OPENED AUGUST 10, 2009
10,900 square feet
19 operatories (includes 4 training operatories)
5 dentists/3 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by USDA Rural Development
OUR FIFTH REGIONAL DENTAL FACILITY
THE MEDFORD DENTAL CENTER ❖ OPENED DECEMBER 1, 2009

10,990 square feet
19 operatories
   (includes 4 training operatories)
5 dentists
4 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by USDA Rural Development loan (American Recovery and Reinvestment Act)

OUR SIXTH REGIONAL DENTAL FACILITY
THE RICE LAKE DENTAL CENTER ❖ OPENED JUNE 22, 2010

12,500 square feet
20 operatories (includes 4 training operatories)
5 dentists
4 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by USDA Rural Development (American Recovery and Reinvestment Act)
OUR SEVENTH REGIONAL DENTAL FACILITY
THE MARSHFIELD DENTAL CENTER ☰ OPENED AUGUST 16, 2010

13,000 square feet
19 operatories (includes 4 training operatories)
5 dentists/4 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by USDA Rural Development (American Recovery and Reinvestment Act)

OUR EIGHTH REGIONAL DENTAL FACILITY
THE RHINELANDER DENTAL CENTER ☰ OPENED JANUARY 9, 2012

18,050 square feet
26 operatories (includes 4 training operatories)
5 dentists/5 hygienists
2 oral surgeons (TBH)
Special space and equipment to serve the Developmentally disabled
Building funded by USDA Rural Development
OUR NINTH REGIONAL DENTAL FACILITY
THE BLACK RIVER FALLS DENTAL CENTER  ❖  OPENED OCTOBER 1, 2013

12,600 square feet
20 operatories (includes 4 training operatories)
5 dentists/4 hygienists
Special space and equipment to serve the developmentally disabled
Building funded by Health Resources and Services Administration, Capital Development Building Capacity grant
### 2014 Current Oral Health Infrastructure

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Centers</td>
<td>9</td>
</tr>
<tr>
<td>Square Feet</td>
<td>114,600</td>
</tr>
<tr>
<td>Total Operatories</td>
<td>184</td>
</tr>
<tr>
<td>Training Operatories</td>
<td>24</td>
</tr>
<tr>
<td>Dental Students</td>
<td>0</td>
</tr>
<tr>
<td>Dental Residents</td>
<td>2</td>
</tr>
<tr>
<td>Dentists (includes general dentists, oral surgeons and a pediatric dentist)</td>
<td>50</td>
</tr>
<tr>
<td>Hygienists</td>
<td>42</td>
</tr>
<tr>
<td>Total FTEs</td>
<td>327.7</td>
</tr>
</tbody>
</table>
Zip codes with 10 or more patients treated at FQHC Dental Sites by Year

Dental Activity by Calendar Year

<table>
<thead>
<tr>
<th>Categories</th>
<th>2003</th>
<th>2007</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>29,970</td>
<td>48,664</td>
<td>144,910</td>
</tr>
<tr>
<td>Encounters</td>
<td>70,888</td>
<td>119,443</td>
<td>365,912</td>
</tr>
<tr>
<td>Average Enc/pt</td>
<td>2.37</td>
<td>2.45</td>
<td>2.53</td>
</tr>
<tr>
<td>On-site dental centers</td>
<td>11</td>
<td>14</td>
<td>32</td>
</tr>
</tbody>
</table>

Legend
Patient Volume
- 0 - 9
- 10 - 35
- 36 - 100
- 101 - 300
- 301 - 800
- 801 - 4202

On-site dental centers
The Importance of Ground Breakings, Ribbon Cuttings, and Big Check Ceremonies

Chippewa Falls Dental Center
Groundbreaking – May 2006

Ladysmith Dental Center
Ribbon Cutting – August 2003

Senator Decker laying the cornerstone at the Ladysmith Dental Center

Park Falls Dental Center
Check Presentation – August 2007
Capital Partners

• USDA Rural Development Program (bricks and mortar)
• Chippewa County Dental Foundation (bricks and mortar)
• HRSA capital grant program (bricks, mortar and equipment)
• Congressman Dave Obey (equipment)
• State grants (equipment)
HIT/Research/Education Partners

- Delta Dental of Wisconsin
- DentaQuest
- Marshfield Clinic Research Foundation
- Marshfield Clinic Division of Education
The Need to Integrate Medicine and Dentistry

• “key recommendations in the IOM report including calls for more links between dentistry and medicine have gone unheeded.”

• “the demographic data are quite clear, future dentists will be asked to care for greater numbers of ambulatory elderly patients who have significant medical concerns.

Ref: Baum BJ. Inadequate training in the biological sciences and medicine for dental students, JADA, Vol 138, January 2007, 16-25
“The future belongs to people who see the possibilities before they become obvious.”

William Osler, MD
Teaching Oral Health in U.S. Medical Schools: Results of a National Survey

<table>
<thead>
<tr>
<th>Hours of Oral Health Curriculum</th>
<th>Percentage of U.S. Medical Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10.2%</td>
</tr>
<tr>
<td>0 – 2</td>
<td>38.6%</td>
</tr>
<tr>
<td>0 – 4</td>
<td>69.3%</td>
</tr>
<tr>
<td>0 – 6</td>
<td>80.7%</td>
</tr>
</tbody>
</table>

Why? Growing Evidence for the Need to Integrate

**THIRD PARTIES DRIVING IT**

- 2009 U of MI study included **21,000 BCBS members** and found that with regular periodontal care, it was observed:
  - **10% reduction in diabetes related medical costs.**
  - **20% reduction in cost** related to the treatment of cardiovascular disease in patients with heart disease and diabetes;
  - **30% reduction in cost** related to treatment of kidney disease for patients with diabetes and kidney disease;
  - **40% reduction in costs** related to treating congestive heart failure for patients with diabetes.

According to research cited by **CIGNA**, expecting mothers with chronic periodontal disease during the second trimester are 7 times more likely to deliver preterm (before 37th week).
Why is this important?

- Estimated # of diabetic adults who didn’t get a dental visit = 43.2% or 8,035,200  
  [Journal of Public Health Dentistry, 2009]

- Estimated additional cost of diabetic care per diabetic adults who don’t get dental care = $1728  
  [BCBS of MA Estimated $144 PM/PM]

- Estimated high end avg. national annual cost for comprehensive dental care to an adult underserved population is approximately $1200*

- Estimated national shared annual savings if adult diabetics were provided coverage for oral health care = $4.2 Billion

*Based on sampling of “worse case” patients
Our Pets’ Veterinarian Gets it!

Source: Virbac Animal Health
Ending the Silence
Supporting Solutions

New Dental School Sought

“Mindful of the severe shortage of dentists in large swaths of rural Wisconsin, the Marshfield Clinic and the State’s largest community health center have begun putting together the pieces to start a second dental school in Wisconsin....”

(Reference: Front page, Milwaukee Journal Sentinel  April 5, 2009)
Ending the Silence
Supporting Solutions

Closing the gap

A new effort in northwestern Wisconsin aims to close the gap in access to dental care between the poor and everyone else. It deserves support.

“....State and federal authorities, along with corporations and foundations, should support the Marshfield effort and close the wide gap in access to dental care that now exists between the poor and everyone else.”

(Reference: Editorial, Milwaukee Journal Sentinel, April 8, 2009)
Our First Investor

The Governor signs bill into law allocating $10,000,000 in State bonding authority under a dollar for dollar matching requirement.
The importance of dual accountabilities to those in need we seek to serve and to those who pay (HRSA, Medicaid) as well as those who ultimately foot the bill (taxpayer).

• Competing interests vie for limited oral health investments
• Organized dentistry “just pay us fairly and we will solve the problem”
• Free clinics, hospital sponsored Medicaid-only clinics, mobile dental safety net clinics all overwhelmed with patients and in need of funds
• Community Health Centers offer a comprehensive solution under a new model – group practice integrated with medicine and the promise of leaving no one behind
"Picket Fence Strategy"
Percent of patients in each zip code under 200% of poverty who were seen at Ladysmith Dental Center.
Penetration into twice poverty population by FHC Dental System in Calendar Year 2012.
Number of additional residents needed to reach 100% of all low income persons with a dental service.

Number of additional residents needed to reach 70% of all low income persons with a dental service.
# Targeted Initiative: Eliminate Access Disparity for Disabled Residents on Medicaid

Eligible Medicaid Populations with Billed Oral Health Service
State Fiscal Year 2010 and 2013

<table>
<thead>
<tr>
<th>Medicaid Population</th>
<th>Year</th>
<th>County Group</th>
<th>Total Members</th>
<th>Total Members Served</th>
<th>% with Services</th>
<th>% with FHC Service</th>
<th>Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicaid</td>
<td>2010</td>
<td>FHC Counties (5)</td>
<td>35,939</td>
<td>14,275</td>
<td>39.7%</td>
<td>26.5%</td>
<td>66.6%</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>FHC Counties (8)</td>
<td>74,463</td>
<td>31,134</td>
<td>41.8%</td>
<td>24.3%</td>
<td>58.1%</td>
</tr>
<tr>
<td>Percent Change</td>
<td></td>
<td></td>
<td>107.2%</td>
<td>118.1%</td>
<td>90.4%</td>
<td>5.3%</td>
<td>-8.3%</td>
</tr>
<tr>
<td>Medicaid Disabled</td>
<td>2010</td>
<td>FHC Counties (5)</td>
<td>1,542</td>
<td>760</td>
<td>49.3%</td>
<td>29.2%</td>
<td>59.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FHC Counties (8)</td>
<td>3,165</td>
<td>1,693</td>
<td>53.5%</td>
<td>29.7%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Percent Change</td>
<td></td>
<td></td>
<td>105.3%</td>
<td>122.8%</td>
<td>108.7%</td>
<td>8.5%</td>
<td>-6.3%</td>
</tr>
</tbody>
</table>
Targeted Initiative: Eliminate Access Disparity for Disabled Residents on Medicaid

<table>
<thead>
<tr>
<th>County Type</th>
<th>Number of Counties</th>
<th>Number Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>8</td>
<td>523</td>
</tr>
<tr>
<td>Adjacent</td>
<td>16</td>
<td>1,289</td>
</tr>
<tr>
<td>Non-Adjacent</td>
<td>14</td>
<td>1,146</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>2,958</strong></td>
</tr>
</tbody>
</table>

Number of Additional Medicaid Disabled Individuals with Services Needed to Achieve 70% Access for Oral Health Services
State Fiscal Year 2013
you guys gave me the best Christmas present

NO PAIN!!

Merry X-Mas

[Signature]
## Multiple Dimensions of Key Strategic Decisions: Regionalized Care

<table>
<thead>
<tr>
<th>Decision</th>
<th>Service</th>
<th>Education</th>
<th>Political</th>
<th>Research</th>
</tr>
</thead>
</table>
| Build new facilities to house 5 or more dentists in communities people living in rural routes relate to | • Regionalizing care  
  • Recruitment  
  • Retention  
  • Flexibility  
  • Continuity | • Critical mass  
  • Dedicated infrastructure  
  • Recruitment  
  • Retention | • Over tipping  
  • Betting on the community  
  • Economic development  
  • Here to stay | • Critical mass  
  • Learning laboratories  
  • Recruitment  
  • Retention  
  • Problem solving  
  • Future refinements |
## Multiple Dimensions of Key Strategic Decisions: Integrated EHR

<table>
<thead>
<tr>
<th>Decision</th>
<th>Service</th>
<th>Education</th>
<th>Political</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the integration of medicine and dentistry through integrated EHR and data warehouse technology</td>
<td>• Address health literacy Support: • Dental diagnosis • Quality improvement • Patient safety • Patient centeredness • Effective care • Efficient care • Timely service provision</td>
<td>• Train next generation of dentists in a future oriented integrated team based health care home setting • Ability to track and monitor student clinical work</td>
<td>• Decision support generated medical care cost offsets • Prevention • Early Intervention • Taxpayer Savings</td>
<td>• Key data repository infrastructure • Test bed for decision support tools • Outcome based research • Comparative effectiveness research • Supporting practice based research networks</td>
</tr>
</tbody>
</table>
### Multiple Dimensions of Key Strategic Decisions: Train Workforce

<table>
<thead>
<tr>
<th>Decision</th>
<th>Service</th>
<th>Education</th>
<th>Political</th>
<th>Research</th>
</tr>
</thead>
</table>
| Develop new dental school/residency programs/research internships | • Expanded capacity to see patients in our system  
• Contribute to HRSA workforce needs by supplying dentists trained for careers in (not rotations through) the safety net | • Put the school where the need is  
• Foster integration with medicine  
• Train for careers in safety net | • Net savings to taxpayers  
• Increased rural student recruitment  
• Economic development “up north” | • Student workforce  
• Enhanced educational experience |
Multiple Dimensions of Key Strategic Decisions: Leave No One Behind

<table>
<thead>
<tr>
<th>Decision</th>
<th>Service</th>
<th>Education</th>
<th>Political</th>
<th>Research</th>
</tr>
</thead>
</table>
| Leave no one behind | • Large treatment rooms  
• Wheelchair lifts  
• Inpatient practice  
• Outreach  
• Tele-dentistry  
• Referral collaborations | Well rounded experience with diverse population | • Expanded voice  
• Political reality  
• Tipping point  
• Improved job opportunities for treated patients | All groups represented in data set |
| • Disabled  
• HIV/AIDS  
• Nursing home  
• Vets  
• Jobless  
• Publically insured  
• Poor/near poor uninsured  
• Children  
• Pregnant women |