

**Older Adults and Oral Health:
Inspiring Community-Based Partnerships for Healthy Mouths
May 15, 2013
3:00 pm ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question-and-answer session. At that time to ask your questions, please press star then 1 on your phone.

Today's conference call is being recorded. If you have any objections, you may disconnect your line at this time. I would now like to turn the call over to your host, Ms. Danielle Nelson. Ma'am, you may begin.

Danielle Nelson: Hello and welcome. Thank you for joining us for today's Webinar. I quickly want to share with you some housekeeping announcements to ensure our event goes smoothly.

If you have not already done so, please use the link included in your e-mail confirmation to get onto the WebEx system. In order to follow the slides, you will need to be on WebEx.

Your questions can also be entered through the chat function on WebEx so if you are not logged-on yet, please go to www.webex.com, W-E-B-E-X. Click on attend the meeting at the top of the page and then you will enter our meeting number which is 667862269.

The event password is 1234. If you have any problems with the WebEx system, please call WebEx technical support which is 866-569-3239 and lastly we just want to let you know if you'd like to ask questions you can do so throughout the Webinar.

There are two ways. Because you are in listen-only mode at this time, you can enter your questions through the chat function in WebEx. You can enter your questions and we will sort through them and get them as best we can following the final presentation.

In addition, after our panel wraps up, we will offer you a chance to ask your questions through the audio line. When that time comes, our operator (Laurie) will give you the instructions of how to queue-up and ask your questions.

If there are questions we cannot get to in the course of this Webinar, we invite you to e-mail them to me at Danielle.nelson@aoa.hhs.gov. This e-mail address and all the other resources are included in the PowerPoint slides that are the basis of this Webinar.

The Webinar will be posted at the AOA Webpage as well as HRSA's oral health Webpage by next week. At that I'd like to turn things over and get us started. I'd like to pass things over to Dr. Matoff-Stepp who is the Director of the Office of Women's Health at the Health Resources and Services Administration. Thank you.

Sabrina Matoff-Stepp: Well, good afternoon everyone. Thank you so much Danielle and this is Sabrina Matoff-Stepp. I'm really pleased to be cohosting this Webinar this afternoon. Again the title of our Webinar as you know is Older Adults and

Oral Health: Inspiring Community-Based Partnerships for Healthy Mouths
and as you can see this is quite a collaboration across HHS.

You see all our logos at the top. Again our goal today is to describe the oral health status of older adults in the U.S., provide useful resources and highlight two innovative community approaches to improving oral health access for older adults.

We have a great lineup of speakers this afternoon. I just wanted to give you a little background again you may be asking so why, why did we come together? Why this particular topic? Some really good questions and again HHS has an oral health initiative that we started in 2010.

This is across federal initiatives of the HHS coordinating committee on women's health, the Administration for Community Living, the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the Office on Women's health in the Department of Health and Human Services.

And we are right now very concerned and putting as a very high priority the issue of oral health access for older adults but also for all U.S. citizens. This is a really important topic. Again when we look at some Medicare beneficiary data, I think this really paints the picture.

Many of you may know this but just a few quick facts. Medicare does not provide coverage for routine dental care. A lot of beneficiaries that have dental coverage have to access this through private plans or through Medicaid and that scope often varies.

One in four Medicare beneficiaries have no natural teeth. This condition can also lead to other health issues including nutritional deficiencies. Almost half of all Medicaid beneficiaries report no dentist visit in the past year and 22% report they have not seen a dental provider in the last five years and then finally Medicare beneficiaries who have used any dental service in the Year 2008 spent more than \$600 out of pocket for dental care and these facts all come from a Kaiser commission on key facts that was posted in June of 2012.

So really, really important topic and one that we're very concerned about. We want to work with all of you to find solutions and best practices so at this time I'm very pleased to quickly introduce and we'll get right into the presentations our list of very wonderful speakers this afternoon.

First up we have RADM William Bailey. He is the U.S. Public Health Service Chief Dental Officer and Acting Director at Division of Oral Health National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention.

Next we'll hear from Captain Angel Rodriquez-Espada. He's the Chief Dental Officer here in the Bureau of Primary Health Care at the Health Resources and Services Administration.

Next we'll hear from Laura Lawrence. She's the Director of the Office of Nutrition and Health Promotion Programs Administration on Aging in the Administration for Community Living. Next we'll hear from Dr. Omar Ghoneim. He's the Corporate Dental Director for Harbor Health Services, Inc.

Next we'll hear from a group of presenters, Donna Bileto. She's Community Service Specialist at Northwestern Illinois Area Agency on Aging; Betty Hillier, she's the Assistant Administrator for the Presence St. Anne Center;

(Cate Osterholtz), Assistance Administrator, Presence Core Marie Center; and Becky Cook Kendall, Executive Director at Rockford Health Council.

So I invite you to take the next hour and a half, learn, listen, collaborate with us all, ask good questions and I'm really pleased to have everyone onboard this afternoon for this very important topic so with that I will turn it over to our first speaker, RADM William Bailey. Thank you.

William Bailey: Thank you and it's a real pleasure to be here not only because of this important topic but also because this is being done in such a collaborative manner and I'd like to give my thanks to Danielle Nelson from the Administration on Aging, (Marian Mehegan) and Mary Worstell from Office of Women's Health and (Renée Joskow) from HRSA who did so much work planning and coordinating this Webinar.

We all know that oral health is vital to overall health and well-being and that's true for people of all ages and we know that good health is achievable if you have the necessary components such as access to needed preventive and clinical services, good self-care and adequate health literacy to be able to understand healthcare information and make appropriate healthcare decisions about how and when and where to get care, how to fill-out forms, how to navigate the healthcare system and so forth.

But we know that many older adults are not getting the care they need and if care is not received, then untreated oral diseases will not resolve on their own and they can greatly affect quality of life.

In fact in advanced stages tooth decay reaches the nerve of the tooth or the pulp and eventually can destroy the entire crown of the tooth leaving only root

fragments that can ulcerate and abscess and can be there for months or even years in older adults.

And we know that periodontitis can destroy the supporting tissues around the tooth and also result in swelling, bleeding and pain and can also cause receding gums that put root surfaces at risk for decay.

National data for older adults indicates that disparities exist with regard to unmet dental treatment needs, oral health status, quality of life issues and these disparities exist whether they're self-reported or found clinically.

We know that tooth decay and periodontal disease share common risk factors with other chronic diseases including poverty, poor diet and tobacco use and that general health can affect oral health and oral health can affect general health.

And factors of aging associated with aging can increase the risk for tooth decay. For example chronic conditions and medications taken to treat those conditions increase the likelihood of dry mouth. Many of the commonly-used drugs such as anti-depressants, anti-psychotics, beta blockers, antihistamines lead to dry mouth and that reduces the saliva.

Without saliva you don't have the lubricating of the mouth and gums which prevents/reduces bacterial growth and you also don't have the necessary minerals such as calcium, phosphate and fluoride needed to remineralize the surface of the tooth when decay is beginning.

And so we also see this huge disparity with regard to the oral health residents of long-term care facilities and homebound people in comparison with their non-institutionalized counterparts.

In the years ahead, we have heard and we know we're facing a tsunami of dental needs for older adults and this is due to several factors. The biggest factor is that the population is aging so rapidly. We've all heard that 10,000 people a day are turning 65 in the United States and a recent AARP survey found that 4 of 10 were where they wanted to be from a financial standpoint so we have many people that are aging, many that don't have the financial resources they wanted.

And also so many people are keeping teeth longer which is a good thing but at the same time all those teeth that are kept are at risk for dental decay and they have to receive - people have to receive - treatment in order to keep that decay at bay.

We tend to think of prevention for children and adults or children and adolescents but don't think of it for adults especially older adults but studies have found that fluorides whether they're self-applied as in toothpaste or professionally applied or through community water supplies reduce tooth decay by about 25%.

And so we should think about prevention activities as well as treatment for older adults. We continue to see the barriers to achieving good oral health.

We know that older adults have more difficulty in assessing effective interventions to prevent and control diseases than younger adults and one of those barriers is lack of insurance. We heard that Medicare doesn't cover the majority of dental procedures and that states have limited coverage through Medicaid.

And because of this older adults are paying an increasing portion of their dental expenditures out of pocket as they age. National data indicate that the percentage of dental expenditures that the private insurance pays decreases with age so for persons aged 55 to 64, private dental insurance covers about 50% of their dental costs.

For persons aged 75 and older, only about 14% of costs are covered by private insurance and so we see that changing and we know that it's harder and harder for some older adults to come up with the resources they need.

So some choose to forego treatment or choose lower-cost treatment options such as tooth extraction rather than a root canal and a crown and we also know that as older adults age, they may develop difficulties brushing their teeth and seeking care due to decreased mobility or lack of transportation.

And so we also see that low utilization of dental care may be attributable to a lack of perceived need and this goes back to health literacy because older adults with similar clinical dental needs seem to report less perceived need for dental care.

And so I would recommend that everyone on this call take a course in health literacy because we can all do our part to make people more aware of oral diseases.

So with regard to quality of life, pain from untreated oral diseases can restrict normal activities of daily life and disturb sleep and we also know that poor oral health can limit food choices.

And so studies show that having significant tooth loss can result in people eating less healthy foods, those foods that are higher in carotenes, Vitamin C

and fiber for example and switching them out for foods that are softer and rich in saturated fats and cholesterol.

And so interestingly people who have significant tooth loss may either limit their intake of food or choose other types of food so tooth loss has been associated with both weight loss and obesity.

We also know that extensive and complete tooth loss may restrict social contact, inhibit intimacy and that tooth loss can affect speech which in turn limits social interaction and detracts from physical appearance and lowers self-esteem.

So if we can look at the next slide, we'll start looking at some self-reported health status. This shows time from last dental visit and you can see that the blue bars show less than - that is less than - one year as reported by those groups but if you look at the yellow bar, that's more than five years since the last dental visit.

And we know also that self-reported data isn't always the same as what we see from claims reports. Claims reports show that really only about 40% - just over 40% - of all persons in the U.S. have at least one dental visit for any reason per year.

If we look at self-reported oral health status by gender, we see that there's not a whole lot of different between males and females - next slide - but if we look at the self-reported oral health status by race/ethnicity, we see large disparities in people.

In fact for white non-Hispanics we see 65% report excellent or very good or good health whereas for Hispanics over 65% report only fair or poor health. Next slide, and the most striking disparity comes with poverty level.

You can see that people that are less than - there's a three-fold difference - in those reporting excellent or very good health between those who are below 100% of the federal poverty level and those who are above 200% of the federal poverty level.

Next slide, we see that same disparity by educational level and we know that educational level and poverty level are tied in some ways so that's not surprising.

Now this starts getting into not what's self-reported but what's actually observed clinically on a nationally representative study, the (Inhane) study and so this is broken down in various ways, various groupings and you can see that there is significant disparities when it comes to untreated decay especially by poverty level.

And again that gets back to being able to access care, afford care and make good decisions based on the amount that you can afford. Now prevalence of root carries or root decay doesn't include untreated decay.

This is the decay that's on the root surfaces and again we see pretty profound disparities broken down in similar fashion. Next. Now this is kind of interesting. This is average number of teeth and it's for only people who have teeth left and you can see that there's not as great of disparity.

There are disparities but it's not as great a disparity but if we can see the next slide, you'll see that when it comes to total tooth loss where people have

absolutely no teeth left, there's a huge amount of disparity and it's the greatest again is with poverty level but there's disparities in a number of ways with that.

If you look at total tooth loss and average number of teeth, you can see that it increases with age. In fact people who are 75 years and older are three times more likely to have lost all their teeth than people aged 50 to 64 years and have four fewer teeth on average.

And this shows it broken down same type of statistics with tooth loss and total tooth loss and number of teeth by the various groupings and the dentate means with teeth and edentate means without.

So we see lots and lots of issues and problems and so what do we need to do? At least some of our priorities should be to have better data. We need better data to quantify treatment needs and characterize the impact on quality of life and to plan programs.

We know that for nursing homes, long-term care facilities, some data is collected but for example there's no data collected on whether a resident has chewing problems, pain or discomfort or poor-fitting dentures.

We also know that the ASTDD the Association of State and Territorial Dental Directors has a basic screening survey that can serve as a simple screening tool to look at treatment needs.

One goal might be for long-term care facilities to provide adequate daily oral hygiene care at a minimum and to provide some access to regular preventive dental care and then also if we could work towards having access to

restorative services either on-site or away as appropriate and increasing that safety net has to be part of what we do.

Integration of oral health into medical care needs to be true for not only this group but for everywhere because poor oral health can significantly diminish overall quality of life and affect other diseases.

And at the same time primary care providers need to understand the common oral conditions, the risk factors, healthy behaviors and understand the medical, functional, emotional and social consequences of poor oral health. Improved health literacy is important and it's something that we all have to take under our wing and try to promote as health literacy includes everyone.

It isn't just patients and then enhanced communication and coordination is essential and that's what we try to do with the oral health coordinating committee at HHS is to look for those commonalities, look for those ways that we can coordinate and reach collective impact to advance the health of the nation so with that I'd like to turn it over to Angel Rodriguez-Espada.

Angel Rodriguez-Espada: Thank you Admiral Bailey and good afternoon. My name is Angel Rodriguez and it is a pleasure for me to spend some time this afternoon sharing with you some information about the Bureau of Primary Health Care and in the Health Resources and Services Administration and the health center program.

The mission of the Bureau of Primary Health Care is to improve the health of the nation's underserved communities and vulnerable populations by ensuring access to comprehensive culturally-competent quality primary healthcare services.

We provide care for the community people, for migrant farm workers, public housing, and also for the homeless. The health center program has a history that spans more than 45 years with an impressive track record of consistently providing comprehensive high-quality cost-effective primary care.

Health centers provide services on a sliding fee scale which allows patients to pay rates adjusted based on their income as it relates to the federal poverty level. Patients below the 200% federal poverty level usually get discounts depending on the center they access care from.

Currently there are more than 1100 health centers operating more than 8500 health service delivery sites and in 2011 the health center program provided care for more than 20 million patients.

Data collected through the Uniform Data System or UDS during the Calendar Year 2011 shows that health centers across the country provided comprehensive healthcare to more than 20 million patients through 80 million visits. Ninety-three percent of those patients were below the 200% federal poverty level and 60% of them represented racial and ethnic minorities.

Our workforce is now 138,000 strong with close to 10,000 physicians and almost 7000 mid-level practitioners. As you can see as far as revenue, most of the revenue for the health centers comes from Medicaid which accounts for 38% of the revenue.

With respect to oral health, in 2011 the health center program provided care to 4 million patients through 10 million dental visits. That is 200,000 more patients and 800,000 more dental visits than in 2010.

There was also a 9% increase in our dental workforce and now we count on 3095 dentists, 1285 dental hygienists and close to 6,000 dental assistants. Data from the 2012 for Year 2012 is being received and is now being reviewed and should be available later in the year.

The health centers provide care to patients of all ages but as far as patients 65 and older, between 2007 and 2011 the health center program saw an increase of 24% in the number of patients 65 and older that were served and in 2011 they served close to 1.4 million patients ages 65 and older.

We can appreciate the strength and coverage of the health center safety net across the U.S. and its territories with almost 1,200 HRSA grantees and over 8500 sites. In this map the red circles represent the health centers or grantees and the green dots represent service size.

As you can see, there is a lot more green than red because the ratio between service sites and health centers is approximately 7.5 to 1. There are health centers that only have one site but there are centers that have, 20, 30 delivery sites and that's how we have so many health service delivery sites.

And this is a representation of our health centers that have on-site dental services. According to the 2011 UDS data, 856 out of 1,128 health centers or grantees reporting provided on-site dental services. If you do the math, that accounts for 76% of all HRSA grantees or health centers providing on-site dental services.

From 2008 to 2011, the health center network saw a 13.1 increase in the number of sites. This has had a local impact in our communities with over 25,000 new jobs and an 18.4 percent increase in patient base and we expect

these numbers to increase even higher to go even higher with the data that we are currently analyzing from 2012.

The health center program enjoys a good reputation with the population it serves as reflected in this data from the 2009 patient survey which showed that over 80% of the patients reported that quality of services received was either excellent or very good.

Eighty percent of them were very likely to refer friends, patients or relatives and 75% reported that the main reason for getting access to healthcare at the health center was because it was convenient, affordable and because of the quality of care they were receiving. The main focus of the Bureau of Primary Health Care is to provide primary healthcare to the populations we serve and through the health centers.

And we accomplish this by providing public health leadership and supporting HRSA grantees to improve their performance through outreach and providing quality care, measuring health outcomes and elimination of disparities all the while containing the costs and maintaining financial viability which is one of the requirements of oral health centers and HRSA grantees.

All grantees must comply with 19 program requirements that cover the main areas of need, services, management and finance and governance.

And this depicts our quality strategy. In order to provide quality healthcare, we need to have four basic elements. We need to provide access. We must provide comprehensive services and we need integrated services and integrated health systems.

The health center program continues to develop the infrastructure and workforce to provide access to comprehensive health services and BPHC provides the policy to shape the healthcare delivery.

We also provide funding and technical assistance and we develop indicators and measures and collect and analyze data. We have learned we cannot do this by ourselves and we must engage partners in collaboration efforts.

One important quality improvement activity that the Bureau has engaged in the last couple of year is the patient center health home initiative and participation in this initiative helps health centers to improve the quality of care and health outcomes of communities, increases access and provides healthcare in a cost-effective manner.

And the Bureau usually covers all the fees that involve getting recognition with a patient center medical health home initiative. The Bureau also supports and participates in various HRSA-wide and HHS-wide initiatives including the National Oral Health Initiative and more recently the Behavioral Health Initiative.

In summary the Bureau of Primary Health Care is committed to (grow then) and strengthening the safety net of primary healthcare for underserved communities and vulnerable populations through the health center program and throughout all life cycles and I thank you for your time and I now am pleased to introduce our next speaker, Laura Lawrence.

Laura Lawrence. Thank you, Dr. Rodriguez-Espada. I'm very pleased to be here today and I'm so glad that you're all with us as we call attention to this oral health tsunami. As Mother Teresa said, "I alone cannot change the world but I can cast a stone

across the waters to create many ripples”. So let’s continue casting some stones.

About a year ago the Department of Health and Human Services formed the Administration for Community Living or ACL as you see here. It’s comprised of the Administration on Aging and the Administration on Intellectual and Developmental Disabilities.

The functions of HHS’ Office on Disability are also now part of ACL. I work in the AOA part of ACL and a critical part of our mission is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that enables older people to maintain their dignity and independence in their homes and community of their choice.

Obtaining quality affordable oral healthcare fits right into that mission. So we’ve said it already and I’m going to say it again and you see it here, oral health is essential to health.

We just heard from Dr. Rodriguez-Espada about community health centers.

They play a key role in improving access to oral healthcare. Because community health centers are positioned to serve patient populations that are likely to be experiencing unmet needs for oral health services, they’re a cornerstone of the national strategy to address this tsunami.

So you can improve the quality of life of older adults by connecting them to these safety net clinics to receive affordable care for their dental needs. You can also refer older adults to their local aging services.

Most area agencies on aging - those are part of the aging services network I'll talk about in a little bit - provide transportation services which means if mom needs help getting to her dental appointment, you or she can contact the local area agency on aging and ask about available transportation. Health centers are key, the Aging Services Network is key so now let's take a quick look at where they're located and how to locate the services nearest you.

So you'll probably recognize this is the same map you saw oh, I don't know, 10 slides ago from Dr. Rodriguez-Espada and it shows the 8500 community health center service delivery sites. There's a lot of them and the link right there at the top on that previous page is where you can find this map.

HRSA also has another cool tool and you can go to the URL that's listed right here and you can locate community health centers nearest you but this time not on a map but in the tools page. You can search online or through a widget or mobile form so visit that link and you can find out more about these tools.

Now let's turn to the Aging Services Network. Aging and disability resource centers or ADRCs - that's our lingo - are part of the Aging Services Network. They're local resources where people of all ages and income levels can get information on community services and a wealth of other information including where to get oral healthcare in their communities.

As you can see from this graphic - look at that red oval - ADRCs are person-centered. They focus on the person and what that individual wants and needs, what services are available, how to access those services, how to pay for the services and how to improve the quality of those services in the ADRCs themselves by getting feedback from those individuals.

Thirty-one states and territories have achieved statewide coverage with their ADRCs so now let's take a look at a map that shows by state the spread of the ADRCs. As you can see, there's over 500 ADRCs which currently cover about 75% of the U.S. population and this is growing.

Another good tool is the elder care locator. You've heard me talk about the Aging Services Network, the area agencies on aging, the ADRCs, so how can you find information and locations for the Aging Services Network places?

I'd like to introduce you to the Aging Services Network through the elder care locator you can see here. It's a public service of AOA and there's a toll-free number and there's also a Website.

The Aging Services Network is comprised of 56 state units on aging, 629 area agencies on aging, the 500 ADRCs I just talked about, 11,000 senior centers and thousands of volunteers and providers so through this telephone number or on the Website, you can find locations nearest you.

Services provided to older adults include caregiver respite, in-home services, information on health insurance, elder abuse prevention, Alzheimer's disease support, food and nutrition assistance which we heard of course is vital to oral health, home repair modification assistance, legal assistance, chronic disease self-management education and where to find affordable quality oral healthcare.

Here's a little bit more information on the elder care locator phone number component. You can see the hours there and very importantly information specialists are bilingual and also use a language line so not only English but many other languages so language should not be a barrier in someone accessing this service.

The elder care locator also is available on the Website as you can see www.eldercare.gov. You can search for locations and information in several different ways, by location, by topic, and you can even do an online chat. I always find that to be very helpful because you can ask real-time questions and someone can help you and there's other links and publications.

We also have some of the new media tools. There are widgets, you can access the elder care locator on your smartphone, Facebook and Twitter.

Next slide, so this is reality. We live and work in a world where expectations are high but the time to produce results is not.

Okay, so maybe we can quibble about the 74 years shown on this slide. I certainly hope I have more years than that but clearly we don't have forever to deal with this silent epidemic of poor oral health so to set the stage for our next speakers from community-based oral health programs serving older adults, here's a quote from Henry Ford.

He said, "Coming together is a beginning. Keeping together is progress. Working together is success" and we need success. To increase access to oral healthcare for older adults, we must work together so no matter what area, network, profession you come from, become an oral health champion and let's get that success.

Find out what resources exist in your area and make connections to improve the oral health of older adults in your community. Thank you very much. Here's my contact information. Now let's hear from an oral health champion in Boston. Dr. Ghoneim, I'm turning it over to you. Thank you.

Omar Ghoneim: Thank you everybody. I'd like to welcome and thank everyone again for participating and attending this Webinar and also for giving me the opportunity to share our experience with Harbor Health Services.

As the previous presenter references, my name is Omar Ghoneim. I'm the Dental Director with Harbor Health Services. We are a community health agency based in Boston. We are comprised of four federally-qualified community health centers. We're a private non-profit agency.

In addition to having, four federally-qualified community health centers, we also have an Elder Services Plan (ESP) program and which is why I'm here today. We also have a elder services plan program which is a mental healthcare program and a PACE program, PACE standing for Program of All-Inclusive Care for the Elderly.

We do include and offer dental services at all the sites and I'm here to speak specifically about our ESP program. Next slide, please, so as I referenced before, ESP is a PACE program. It's designed specifically to, you know, give health services and support to elders in the community and keep them out of nursing homes.

Our specific ES program with Harbor Health Services is responsible for providing all healthcare including dental services as well as, you know, other support for over 400 elders. Right now we have 410 for elders for our program here in Mattapan in Massachusetts.

I thought I'd give a little bit of a background regarding PACE programs, again programs for all-inclusive care for the elderly. The origins date back to 1978 in the Chinatown area in San Francisco and with the intent being to address the needs for providing healthcare for elder patients.

Right now there's about 30,000 programs in the United States. Our specific program here at Harbor Health originated in 1996 when it was, you know, recognized that the care and services we were providing for our elderly patients was just simply inadequate.

And I came onboard in terms of providing dental services for elder services client program in July of 2010. Initially we were here day a week and right now we're a day and a half a week on-site and we're going to be actually ramping that up to two days a week.

In terms of the ESP program, in terms of structure, it is a provider-based capitated program that combines Medicaid and Medicare which is unusual in that sense. One way to look at it is really ESP because they're responsible financially for all the health services for all participants whether it's medical, dental, podiatry, optometry, physical therapy, what have you.

They are in essence really the provider and the insurer and they basically are responsible for all the financial burden that comes with it. It's comprised of a strong interdisciplinary team of clinicians, nutritionists, dietitian, you know, a case manager, physicians, nurse practitioners, dentists, you know, ranging the entire spectrum and that's really at its core the strength of the ESP program.

And the other integral part of an ESP program is the emphasis on care coordination and care planning with all the healthcare providers. ESP programs do contact specialty services when they are unable to provide that on-site.

You know, specifically for dental we do refer out when either I'm not on-site or when we need, you know, the services of an oral surgeon or an endodontist.

As referenced earlier, ESP assumes all the clinical oversight and management as well as the financial burden that comes with it.

In terms of eligibility for participants, you know, patients need to be 55 or older, needing nursing home level of care. They need to live in a designated service area similar to federally-qualified community health center and the participant needs to be deemed able to live safely in the community.

And age range of our 410 participants ranges from age 55 to 105 and most participants remain in the program for the rest of their lives unless even for those that are living at home, have support or moving to other long-term care facilities and that's the case with a lot of our participants where their living arrangements vary but they get a range of services, you know, that they need as part of being enrolled with our elder services plan program.

In terms of sort of the framework and structure of dental services at ESP, we use portable dental equipment in our (mementarium) so we have an intelligent one in the exam rooms so our ESP facility has 10 exam rooms and we have one room that's pretty much designated for use and houses all the portable equipment.

However I can tell you we've used this very same equipment to do outreach events off-site but it's comprised of a portable laboratory or delivery unit that has suction, high-speed handpiece lines and then there's a patient dental chair as well as a provider's chair and assistant's stool and those three are all portable and can be disassembled and can be, you know, transported to and from as needed and (oversights) duffel bags.

But for our particular purposes, we have because we have a regular set schedule, we're here a day and a half a week as I referenced before. We also

use in terms of additional equipment that we have, we use a statem in terms of autoclaving, sterilizing all our instruments, ultra, you know, sonic unit and we do use though we'll be phasing to digital X-rays we do use a fixer and developer, one of the smaller units.

In terms of scheduling, you know, right now we do also have the ability to use another room when we need to. I'll go over the mix of services offered momentarily but right now we're here a day and a half a week and because we have the ability to use another exam room, we often times will see emergencies as well as patients that aren't scheduled.

That being said and I referenced this earlier that we're on-site a day and a half a week and we're going to be ramping-up to two days a week, there are instances when I'm not here and, you know, patients are referred out to contracted dentists in the community specialists when, you know, they simply cannot wait.

One of the main strengths of the ESP program is the support. You know, I regularly have dialogue with the case managers for the patients as well as the patient's physician or nurse practitioner as well as sometimes the home aide and the clinical director.

We also have support in terms of transporting the patients. All the patients here at ESP are transported via third-party transportation if they don't come with a family member or designated healthcare proxy that accompanies them to the visits.

In terms of scope of services that are offered, you know, we offer diagnostic preventive services, endodontic procedures, a lot of restorative. We do a

limited amount of periodontics, a reasonable amount of oral surgery as well as removable and fixed prosth.

Services are reimbursed by the ESP program at the extent it's reimbursed by Medicaid. Anything that is from a non-covered services I've defined in Massachusetts under Medicaid we basically get a preapproval with a clinical director in terms of trying to make sure it's a practical treatment option for the patient and often see also drug-linked causes.

As referenced earlier, I mean, ESP is responsible for all the care, managing it as well as the financial part of it and certainly there a lot of issues that come into play in terms of coming up with treatment plans that are practical and in the best interest for the patient.

In terms of emergencies and patient demand, we do try to because of the limited amount of time that we're here, we'll see new patients sort of dependent on when we complete treatment plans for patients or for patients in pain.

In terms of referrals to dental, you know, if a patient does not have a dentist or, you know, has had an emergency or acute episode that has an oral origin to it, that patient will be seen right away and that's definitely a, you know, main driver for patients being seen and having dental services.

In terms of a breakdown by category, since July 2010 to the end of March of this year, we've treated 161 patients. I alluded to a little bit the breakdown of services we provide.

You can see that the lion's share is diagnostic and preventative as well as restorative, endodontic and periodontic less so. Same thing with fixed

prosthetics basically being single unit crowns, large number of removable prosthetics and also oral surgery a small percentage.

We are lucky because we do contract to an oral surgeon when I'm either not here or where it's deemed, you know, best in terms of managing the patient to do so. One of the benefits here is we're able to get a INR for patients, you know, basically on the same day which is, you know, ideal.

In terms of practice management metrics and this was referenced a little bit, you know, in community health centers there are and even dentistry as a whole and coming from a private practice background, you know, some of the treatment or the practice management metrics that one would typically look at in terms of assessing and evaluating a, you know, a practice in, you know, private setting just simply doesn't apply in community health centers.

And there are a couple of metrics and the main one is really treatment plan completion and we're at 43% and I think some of these are actually underreported. I did not adjust or account for, you know, participants that have either unfortunately passed away or ended-up moving over the course of the, you know, the three years we've been here.

So these are a little bit low but per the (dentaquest) foundation based here in Massachusetts, the treatment plan completion ideal percentage is, you know, really being over 40% and ideal being 50 to 60% and I'd guess we're probably a little bit, you know, maybe 5, not quite 10 percentage points probably higher than the 43% referenced here.

And the same thing similarly with percentage of patients in recall and this is customized, you know, ESP has again based on need and demand and

realizing that, you know, the recall regiment of seeing patients and trying to prevent acute emergencies and episodes.

And certainly given, you know, large or majority of patients that I treat at our facility have some degree of dementia or Alzheimer's where, you know, some more regular follow-up is ideal because of concerns about communication being able to really follow-up ideally with patients.

In our ESP program again because they have that flexibility but also needing to be cognizant of costs, it allowed us to see patients every three months. We offer fluoride treatment to all of our patients.

In terms of overall outcomes, you know, or dental at ESP we have not actually come up with any so what I've shared here is really the outcomes that ESP looks at and which most PACE programs reference.

In terms of hostile readmission rate, we're lower than the national average. Our particular facility has the same thing with avoidable hospitalizations I referenced earlier that, you know, our facility if a patient has any type of dental pain or has had an acute episode, they're immediately referred to me for evaluation.

And certainly they look at patients being at risk for falls and our facility has, you know, been, you know, exceeded the standards in that regard.

Keys to success for this program, you know, I referenced it earlier is really the continuous dialogue and rapport with the other care coordinators, the physicians, the dietitian, physical therapist, the case manager as well as the, you know, either the family member or healthcare proxy, I'd say probably

70% of the time I end-up speaking with family members or healthcare proxies that, you know, do not or are unable to accompany the patient.

And that does require quite a bit of follow-up and time to do that but I think that's also a good reflection of some of the great outcomes and experiences patients have had. The care coordinating team meets daily and then the care team planners as well as the participant and any family members meet on a weekly basis.

And that's really been the strength of the program, the follow-up, just constant dialogue and communication between providers has really minimized some of the issues and problems that you run into when you don't have open regular dialogue with providers to ensure that, you know, treatment is well-coordinated and that there's no gaps in terms of communication or any redundancy or whatnot.

In terms of challenges, I'd say the main challenge, you know, for an ESP program because of the Medicaid and Medicare reimbursement is any changes to reimbursement. You know, that can have a pretty profound impact because, you know, the ESP program is solely responsible for providing all the care, coordinating it as well as all the financial costs that come with it.

Even, you know, at our particular facility the panel size in terms of providers and patient is about 150 to 1 and obviously, you know, our program here has, you know, over the last several years has been around 400 but certainly if we had a large influx of new patients, you know, concern would be how that could compromise or impact the coordinating and delivery of treatment.

You know, with that I'd like to once again thank everyone for giving me the opportunity to share our particular experience and we'll turn it over to my colleagues in the State of Illinois.

Donna Bileto: All right, well welcome everyone. I want to thank the Administration on Aging and you for allowing our coalition to share our dental program with you but before we engage you in this process of how we were able to successfully implement the program, we believe it's important that you understand the purpose of the Area Agency on Aging so

As you may know, there are over 600 Area Agencies on Aging in the United States and 13 of those are in Illinois. We all have the same goal and administer programs under the Older Americans Act.

In addition, it is our responsibility to assess and address unmet needs in our individual communities. I'd like to bring your attention to the slide which indicates NIAAA is a non-profit serving older adults and caregivers in Northwestern Illinois.

Our mission is to enable persons to live with dignity and independence and in order to do that, NIAAA must collaborate with other organizations.

So while the Area Agency on Aging was in the process of developing a three-year area plan in 2011, the Department on Aging required us to include a local initiative to the plan.

Fortunately we had links to funded agencies serving older adults and were able to find an established group of individuals who are already discussing senior dental access in the community.

We attended a few meetings and it became apparent that the Area Agency on Aging needed to focus on senior dental care access and it made perfect sense and met our goals and mission under the Older Americans Act.

But then we thought well what could we bring to the table? We saw that the group was already moving and shaking with plans to coordinate servicing agencies but there was one missing piece and that was funding so that's what we could bring to the table.

We were able to allocate a portion of our Title III-B Older Americans Act gap funding to help pay for services received at partnering agencies and finally the group became Winnebago County Senior Oral Health Coalition so with that, I'm going to turn it over to Becky Cook Kendall who will discuss the foundation for developing the Oral Health Coalition.

Becky Cook Kendall: Welcome, everyone and thank you for allowing us to be a part of this.

Before I get started on this webinar, I would like to introduce Rockford Health Council.

Rockford Health Council is a community forum and collaborative for addressing health issues. We have over the last 10 or 12 years coordinated a Healthy Community Study, at least three or four of those studies, one being a minority health survey.

We have found this an invaluable opportunity to connect with community stakeholders and discover those unmet needs. It's a clearing for a foundation of shared responsibility and a commitment to create change and address the needs together.

So therefore what I'd just like to re-emphasize to those of you who already are informed and bring forward to those of you who are not familiar with the Health Community Study, what it is, what are the benefits and challenges and then I turn it over to (Cate) to talk about how we collaborated together to address this need.

What is it? It is integral to responding to the needs. Administering this community study is a process of gathering and analyzing data and developing a plan to meet those essential needs and convening partners.

The benefits and challenges are on the next two slides but I want to talk just a moment about the benefits. The implementation of this partnership approach is effective because it represents different community interests, sectors and experts who are related with these various needs.

It brings together different resources to support the process and it also is really an opportunity to breakdown silos.

Challenges. The ability for the community to respond and act on an issue is very important. I talked about bringing people to the table. I talked about experts. I talked about those familiar with the issue and I guess the right people who are at the table while at the same time breaking down the silos.

As you well know, one person can sometimes wreck the whole process but that's okay. You bring them into the fold which requires a lot of patients and commitment. Sustaining the commitment is very, very, very important.

We're at the intervention. This slide is very important. We pulled together a team of 20 people, representatives from the community. We focused through a

prioritization process that included brainstorming, understanding why the issue is important.

Why is it a priority? Who is able to commit to the effort? What are the consequences of not addressing this issue and how and what is already going on in the community? With that, we established two criteria.

One being lack of sufficient oral health services for the elderly. We already had in the background a senior oral health coalition that was beginning to meet and so it was the key decision of that workgroup that we convene together so that they could be included in the work that was already going on in the community.

Another intervention that we have talked about that has not gained a lot of momentum on as of yet is convene a group of health professionals and general health practitioners to look at coordination of services and oral health literacy that will help us to integrate oral health into the wider healthcare system.

So I'm going to turn it over to (Cate) and let her talk about how we brought the organizations to the table and what's happening today.

(Cate Osterholtz): So our goal at Presence Core Marie Center and Presence St. Anne Center was to become involved in addressing a community need. After reviewing the data in the Healthy Communities Study collected by the Rockford Health Council, we decided that we wanted to help address an unmet need of our community by addressing senior oral health.

So in the beginning the coalition was created by establishing partners with community organizations who all have one common goal of either advocating for seniors or providing access and resources around oral health and as Becky

mentioned, the important component was bringing the right people to the table.

The Winnebago Senior Oral Health Coalition was started by our organization's Presence Core Marie Center and Presence St. Anne Center which are two not-for-profit nursing and rehabilitation centers in Rockford and included other key community stakeholders such as Rockford Health Council, NIAAA, Crusader Community Health, Rock Valley College, Lifescape and the Winnebago County Health Department.

When working on community needs like senior oral health, it is important to evaluate your community resources and build partnerships. By building partnerships you can better utilize resources.

For example we were looking for ways to access dental care within our community. Rock Valley Community College School of Dental Hygiene was needing more patients for the students to work with.

Our partnership built a relationship to refer more patients to the school while achieving our goal of helping seniors obtain low-cost dental services. It was a win-win situation.

Next our coalition decided it was important for us to assist in educating our seniors in our communities. In doing so, we discovered that our community needed an educational resource focused on senior oral health so we developed the Healthy Mouth, Healthy You educational booklet.

Within the booklet we talk about things like how to care for my teeth, warning signs, signs of oral cancer, dry mouth, maintaining oral health and the link between the healthy mouth and the healthy body.

Sorry about that. We so in developing the Healthy Mouth, Healthy You education booklet, we also were able to - we had to - find the donations and we decided that we wanted to distribute that free of cost to our community and to other organizations.

We also organize educational presentations at low-income senior housing properties about how to achieve optimal oral health, what resources are available for low cost and what financial assistance is available for preventative and restorative dental treatment.

Next in order to meet our mission of improving dental care access, we found that the best way to approach this goal in our community who has limited financial resources was again to first focus on what community resources are already developed and build a link between community organizations.

Crusader Community Health is a federal qualified health center in our community. By working with Crusader Community Health, we were able to increase the availability of dentists and access to seniors.

Our coalition built that collaboration and starting in 2012 was able to advocate 10 additional appointments per month for seniors. In addition, coalition members from Lifescape community services coordinate referrals and implement a systematic link to improving dental care access.

Seniors age 60 and older are referred to Rock Valley College with preventative oral health needs and as I mentioned earlier, while acute and urgent needs are referred to Crusader Community Health.

Through NIAAA and Title III-B Older Americans grant, we were now able to assist in providing those seniors referred within our program financial assistance and Betty will now discuss what accomplishments we have.

Betty Hillier: Thank you (Cate). To begin our prior history of senior oral health coalition accomplishments, we began as a team with Presence St. Anne Center and Presence Core Marie Center in partnering with Rockford Health Systems to participate in developing questions of our community for the completion of the Healthy Community Needs assessment.

Our participation helped us develop questions relating to oral healthcare and how care is provided within our community. We continue to stay actively involved upon completion of the assessment as data collection was totaled and evaluated.

The outcome of this assessment showed a definite area within our community showing a lack of providers and funds needed to give appropriate both emergency and preventative oral healthcare to seniors. In 2011 the coalition developed an opportunity to crossover to offer dental care services.

NIAAA began to explore opportunities to obtain grant funding. Lifescape and members of the coalition came together to develop and assessment process for screening applicants for emergency restorative care and financial criteria. Although the community outreach effort may seem small, we were able to provide nine senior citizens access to dental care and provide \$428.

In 2012 the coalition began to build upon its efforts and once again with NIAAA obtaining grant funds and Lifescape providing the assessment program, clients were referred to the Rock Valley College dental program and Crusader Clinic for emergency and restorative care. To date they were able to

reach out to 13 senior citizens and provide over \$3300 in preventative and restorative dental care.

This past year the coalition came together with Rock Valley Community College and the Winnebago County Health Department to offer community education. The coalition determined early on the importance of not only providing care and services but educating our population to the importance of oral healthcare.

As (Cate) has shared previously, the coalition developed a learning tool, Healthy Mouth, Healthy You and began our community education through the outreach program and we were able to educate 75 seniors within our low-income housing senior facilities.

Annually our community holds a community-wide event titled Senior Expo. Our coalition members made up of Winnebago County Health Department and Rock Valley College dental hygiene program and other coalition members conducted 70 oral cancer screenings. During this event, eight clients manifested suspicious lesions with two requiring urgent care.

We recognize the importance of community education and the need for dental supplies for our seniors. Members of the coalition worked with local vendors and dentists to compile dental supplies, the brushes, floss and toothpaste to be given free to participants of our educational events.

We are currently in the process of reviewing our charter which has been the contributing factor in the development of our 2013 strategic plan. The coalition is continuing its efforts to build upon a larger grant opportunity and develop a process for measuring effectiveness of the program.

As Laura has mentioned, we too want to continue to reinforce our linkage to the community in preventative and restorative oral healthcare. As our story is being shared with the community, we seek more members to join our coalition efforts.

We recognize the importance of utilizing volunteer dentists for coalition support and guidance and we continue to adopt strategic action steps to develop and implement community education and utilize volunteer dentists to assist in our program. Donna, would you like to share our integral steps in making a community impact?

Donna Bileto: Yes, absolutely. As Becky, (Cate) and Betty pointed out already, in order to respond to community needs, integral steps to make an impact are Number 1, having data to support the actions; Number 2, convene critical partners who can develop a plan for implementation; and Number 3, implement the plan so that concludes our presentation and we welcome your questions and we'll be on the line. Thank you.

Sabrina Matoff-Stepp: Great, well this is Sabrina Matoff-Stepp again and a big thanks to all of our presenters. It was just an amazing amount of information that we heard this afternoon and I know there's been a number of questions that have come in. We have a little time left now to take some of those questions and I know one of the questions that's been asked a couple of times is when can we get the slides?

So the slides will be available on the archived presentation in the next week or so so check the Administration on Aging or the HRSA oral health pages and the slides will be available and perhaps we can also send out a note to everyone who has signed-in to this Webinar to let you know when those slides are available.

So let's get right to some of the questions. I'm going to take a question or two on the chat and then ask our operator too if there are some people who want to ask an audio question, we can do that as well.

So let's start with one of the first questions. I'm going to sort of go in order of who has come in originally so there's a question about sending adults to community health centers for dental care.

Most state Medicaid dental programs cover little more than emergency care for adults so expecting community health centers to care for these adults will result in decreasing their revenue base. I would assume this comment is for Dr. Rodriguez-Espada so I'll start with you and if others want to add, we'll go from there.

Angel Rodriguez-Espada: Certainly, thank you for this very important question and as I mentioned during my presentation, the Bureau of Primary Health Care supports these health centers and their service sites through grants.

So we know that there are limitations with what Medicaid covers and Medicare covers but seniors are always welcome to community health centers because they pay based on their income and the family's size.

So they usually qualify for a sliding-fee scale and that is a considerable amount of money that they can save because whatever is not covered by the out of pocket comes from the grant that HRSA provides through the Bureau of Primary Health Care so community centers continue to grow.

As I mentioned before we expect to have way over 1200 reporting this year and every year there are grants for new access points. Just this year we

announced that there's going to be 19 new access points. That means that these opportunities for 19 new grantees with God knows how many service sites they will add.

So there is always this support from the grant and the seniors are always welcome to go to the community health center. Based on the numbers I provided, about 7% of the patients we serve in the community health centers are 65 and older. We'd like to see that number increase.

Omar Ghoneim: Yes, I was just going to add too, this is Omar speaking, you know, speaking from our perspective we have four community health centers, three which have dental services and we actually we also applied for a couple of access points that are being opened up.

You know, Dr. Rodriguez mentioned, you know, do you have the sliding-fee scale which is beneficial, you know, for any patient that comes in and a lot of patients let's face it are just not well aware and educated as to the options that they have.

So we have enrollment specialists that sort of help guide them and walk them through what they're eligible for and if that's an issue, there's a sliding-fee scale as well and that also can impact too the services that you provide as well.

And obviously some community health centers will dictate either based on their providers and their scope of care what treatment that they'll be able to provide so there is some flexibility in that sense as well.

Sabrina Matoff-Stepp: Thanks for those comments. This is I think a follow-up question that is related to a community health center so I'll pose this again probably to our

same panelists. Our community health centers in our area only serve individuals with no health insurance including Medicaid and Medicare. What do you recommend for these individuals?

Angel Rodriguez-Espada: Well, according to statute, community health centers have to accept everybody who comes through the door. We accept people who have the highest-paying health insurance and we have the people who are medical indigent and cannot even afford to pay a nominal fee.

By accepting the federal grant monies, the board of directors which governs these community health centers agrees that all patients - everybody who comes through that door - will receive services regardless of their ability to pay.

So that includes Medicare and Medicaid, whatever insurance they may have or no insurance whatsoever. We know that the main purpose of the health center program is to provide access to care to the uninsured and the underinsured but we take everybody and nobody can be turned away.

Sabrina Matoff-Stepp: So maybe that particular inquirer if you would like to follow-up separately with Dr. Rodriguez-Espada separately to maybe follow-up, that might be a good follow-up.

Angel Rodriguez-Espada: Yes, my contact information is on the slides so feel free to contact me.

Sabrina Matoff-Stepp: Great, okay. Next question here, back in the '90s the Administration on Aging gave out dental grants for community planning and training, sometimes for interdisciplinary teams. California has one of these grants used to train

nurses to do oral health assessments of elders. Are there any plans to do similar types of grants again so for perhaps for one of our AOA speakers.

Laura Lawrence: Okay, this is Laura Lawrence. Yes, back in the '90s we had funding to do that and at this time we do not have funding that we're able to use for such a project right now but we continue of course with each year going over our priorities and what is needed in the states and the communities and we make decisions based on the needs and the funding that we're given to be able to send out as grants.

And so I don't want to close the door on anything but I know of no current plans that we have this fiscal year or next to have the same type of grants that we were very fortunate to have been able to offer back in the '90s and yes, rats.

Sabrina Matoff-Stepp: Good, good comment there. One other question on the chat that I see now and then perhaps we'll see if there's any audio questions, no, I see another coming in but anyways this next question that came in, thank you for waiting patiently on this question, a really good question.

Are there oral health programs thinking specifically about meeting the needs of people with cognitive impairment, dementia, including training for dental staff, adapting rooms, etcetera, so really good question. Any of our speakers want to try for that one?

Omar Ghoneim: Well, I mean, I can speak to our program and to be quite candid, we're a little bit spoiled, I mean, certainly in Boston, you know, there's three, you know, fine dental schools and they are great sources of continuing education and definitely focused on the needs of our elderly geriatric patient population in terms of management and treatment planning and rendering treatment.

But specific to other ESP program, I'll be, you know, honest with you. We have staff that are trained to transport and assist in moving the patient and we have obviously caregivers and I should say care providers and staff that are trained specifically with, you know, being able to manage these type of issues and needs.

And like I say, I think, you know, here in Boston we're a little bit spoiled because we have three schools that, you know, have a lot of continuing education and it's definitely gotten better in terms of continuing education for dentists, assistants and hygienists to address some of the needs and challenges that come with, you know, treating this particular patient demographic.

Laura Lawrence: Yes, and this is Laura. Let me just add a little bit. The Administration on Aging, you know, Administration for Community Living does have grant programs specific to Alzheimer's disease and other dementia and we have programs for helping states look at their options counseling process, their ADRCs, how best to help people who, you know, present themselves needing help, many of whom of course do have cognitive impairments.

And so whether a particular state with one of our grants is using any of that money related to cognitive impairment and oral health, I unfortunately don't know that specific question but I can certainly find out but we do indeed have money that goes toward making things easier for those who have cognitive impairments and their caregivers.

Angel Rodriguez-Espada: This is Angel Rodriguez. Many health centers now are linking with some residency training programs and we know that we have over 80 residents nationwide through the Lutheran Medical Center program in New York and they are stationed - they are usually stationed - three to six months

at community health centers and one of the requirements of the residency program is that they learn how to manage the geriatric population.

I also want to add to this that we have a small number of dentists who have gone through geriatric fellowship training specifically to oral health and some of our community center dentists also have gone to mini-residencies in geriatric dentistry and those of course are the dentists who are closer to dental schools and so we're trying to make an effort in getting ready for that wide tsunami.

Omar Ghoneim: Dr. Rodriguez, oh, go ahead.

(Renée Joskow): Sorry, no, I just wanted to add this is Dr. (Renée Joskow), Senior Dental Advisor for HRSA. I wanted to also add to what Dr. Rodriguez just said which is that HRSA actually funds specific programs in geriatrics and allied health and they're funded by the Bureau of Health Professions.

So there's a number of funding mechanisms specifically geared towards, for example, geriatric education programs or academic career awards but also specifically- geriatric training for physicians, dentists, behavioral and mental health providers.

So not only is there training and funding available from HRSA specifically for those issues that might be related to individuals or populations as they age but there's also an interdisciplinary effort and funding that HRSA's providing currently into those areas.

Sabrina Matoff-Stepp: Great. I think we're almost at the end of our allotted time. I want to be respectful of people's time. There is one more question I see on the chat and

that was what is a III-B grant? That must have been on someone's slide and I think that's probably a quick question someone could answer.

Laura Lawrence: Yes, this is Laura. That Title III-B, that's referring to a section of the Older Americans Act where the Administration on Aging receives money to send out in grants to state units on aging for various programs for adults, mainly adults over age 60 who are in a vulnerable population and need assistance and so that is referring to a particular type of service under our statutory authority. Specifically, Title IIIB is the section in the law that covers Supportive Services. We did use some jargon and thanks for pointing that out to us.

Sabrina Matoff-Stepp: Yes, so at this time I'll turn it back to Danielle and I know there might have been some additional questions that have come in. We are capturing and archiving this and if there are additional questions that we were not able to answer, we'll be able to farm those out to our speakers after the Webinar and we'll be following-up with you so a big thanks to our speakers again for a wonderful presentation and I will turn this back to Danielle for a few final comments.

Danielle Nelson: Yes, the Webinar will be archived on the Administration on Aging and HRSA oral health Webpages that you see here on the slide. They will be posted next week by the 22nd.

Also if you have follow-up questions that you were not able to get answered today, we invite you to send them to me at danielle.nelson@aoa.hhs.gov. Thank you for your time and have a wonderful rest of your day. Bye bye.

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