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Report on the June 23, 2008

Medicaid Provider Symposium

Chicago, Illinois

Council on Access, Prevention, and Interprofessional Relations
American Dental Association

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Executive Summary

The 2007 American Dental Association (ADA) House of Delegates authorized a Medicaid Provider Symposium for 2008 by adopting Resolution 44H (*Trans.*2007:421). The resolution called for a one-day symposium to be held at the ADA Headquarters in Chicago to provide background information to attendees of the anticipated Access to Dental Care Summit scheduled for March 2009. Invited participants would include one dental representative from each trustee district, who had at least 1,000 Medicaid or State Children's Health Insurance Program (SCHIP) patient visits in the last calendar year. These participants were to be ADA members in good standing and in private practice (i.e., not practicing in a free clinic, community health center, a county or state public health unit, nor practicing in a dental school setting).

The primary goal of the Symposium was to gain an understanding of the challenges to providing care to Medicaid recipients and discuss successful strategies to integrate Medicaid patients into private practice settings. Numerous challenges to serving a large number of Medicaid patients within a private dental practice were described. Many went beyond the confines of individual practices to include systematic concerns, such as a lack of awareness of the oral health needs of this population and the educational preparedness of dental providers to meet those demands. The primary challenges participants identified included:

- Legislators are not fully aware of the growing oral health needs of the Medicaid population, which requires greater advocacy efforts and collaboration with stakeholders to increase awareness.
- A basic understanding and appreciation of oral health as an integral part of overall health often appears lacking within this target population.
- The current dental school curriculum inadequately prepares dental providers to address the oral health needs of this population, especially young children.
- The administration of state Medicaid dental programs is often inefficient.
- The lack of coordination of the dental home with the medical home perpetuates a lack of emphasis on preventive care among Medicaid-eligible children.

In response to these challenges, participants developed strategies to increase access to dental care for Medicaid patients. Most of the group's recommendations for action were directed to systemic concerns, rather than changes that could be implemented immediately within an individual practice. Addressing these larger concerns may significantly decrease barriers to care for this population. These recommendations included:

- Establish a strong working relationship among the state dental association, the state Medicaid dental program, and the state oral health program. Augment that relationship with strong collaborative advocacy efforts on the part of interested stakeholders.
- Urge state Medicaid dental personnel and state dental association representatives to develop viable business models for private practices looking to provide more dental care for Medicaid patients. Educate legislators as to the cost savings and benefits associated with running an efficient state dental Medicaid program.
- Develop consistent oral health promotion messages for multiple audiences, including patients, parents, oral health professionals, medical professionals, service organizations and advocacy groups.
- By the first year of life, every Medicaid-eligible child should be assigned a medical and dental home. Coordinate the integration of oral health into all aspects of a patient's overall health. For example, include oral health education in all perinatal classes. Request that the American Academy of Pediatrics implement their caries risk assessment policies directing medical

professionals to evaluate children beginning at six months of age and refer appropriately to dental providers any child exhibiting less than optimal oral health. Train physicians to place greater emphasis on the importance of a dental home and provide basic oral health anticipatory guidance as a routine part of all well-baby visits. Encourage the use of fluoride varnish in medical practices, especially those serving this target population.

- Change the current dental curriculum to include more general exposure to pediatrics. Provide dental students with practical public health experience in multiple locations to increase their familiarity with underserved populations.
- Provide continuing dental education stressing the importance of a dental visit by one year of age and to enable dentists to be more comfortable treating young children.
- Encourage state Medicaid dental programs to hire a director who has practical dental experience and is part of organized dentistry. Simplify provider enrollment procedures by shifting the administrative burden from the dentist to the Medicaid system.

The Medicaid Provider Symposium provided insights into the challenges faced by dentists who successfully provide care to Medicaid patients within their private practice settings. This was a unique group, unlike any convened on this issue previously. This group represented the types of dentists who are needed to serve the Medicaid population if problems associated with providing access to care for underserved populations are truly to be solved. They represent efforts to place Medicaid patients into the mainstream of oral health care, rather than to maintain their separate status. Monitoring the success of this group, and identifying others like them, may be a very useful gauge of the viability of the Medicaid dental program.

Background:

Improving access to dental care for Medicaid recipients continues to be challenging for patients, the dental profession, state Medicaid programs, and the federal government. In 1998, the U.S. Health Care Financing Administration (later to become the Centers for Medicare and Medicaid Services), the Health Resources and Services Administration, and the National Center for Education in Maternal and Child Health sponsored a national conference entitled “Building Partnerships to Improve Children’s Access to Medicaid Oral Health Services,” which raised the visibility of the extremely low utilization of dental services by children enrolled in state Medicaid programs, despite the appearance of well-funded and structured programs.

In 1999, the American Dental Association (ADA) sponsored a conference entitled “AIM for Change” (Achieving Improvements in Medicaid) inviting state legislators and Medicaid officials, federal program administrators, Medicaid patients, state dental associations, and private dental practitioners to continue the discussion. Both of these conferences highlighted access to care setbacks experienced by Medicaid enrolled patients, even though states were enjoying a period of economic growth and budget surpluses. It was becoming apparent that there was a lack of political will at the state level to improve the oral health of Medicaid enrolled children and adults.

In 2003, the ADA sponsored a Medicaid Symposium that brought together representatives from state Medicaid agencies, dental specialty and allied organizations, health policy researchers, state legislators, federal officials, third-party payers and state dental associations. It is interesting to note that dentists providing care to Medicaid patients and the patients themselves were missing from the participant list. This diverse group met in light of reform proposals emanating from the White House as well as threats to Medicaid spending from state legislatures and governors seeking relief from staggering budget deficits. This Symposium confirmed that Medicaid program administrators were frustrated, dental providers were wary and Medicaid patients continued to suffer. Recommendations from this Symposium were overarching and broad-based, such as “educate society at large on the need for appropriate dental care” and “provide stability and flexibility in the Medicaid program based on a federal-state partnership.”

The 2007 ADA House of Delegates authorized a Medicaid Provider Symposium for 2008 by adopting Resolution 44H (*Trans.*2007:421). The resolution called for a one-day symposium to be held at the ADA Headquarters in Chicago to provide background information to attendees of the anticipated Access to Dental Care Summit scheduled for March 2009. Invited participants would include one dental representative from each trustee district, who had at least 1,000 Medicaid or State Children’s Health Insurance Program (SCHIP) patient visits in the last calendar year. These participants were to be ADA members in good standing and in private practice (i.e., not practicing in a free clinic, community health center, a county or state public health unit, nor practicing in a dental school setting). The ADA Council on Access, Prevention and Interprofessional Relations (CAPIR) was charged with coordinating the planning and implementation of this event.

The Symposium’s purpose was to identify barriers to care for Medicaid patients other than reimbursement levels. After identifying these challenges, the participants were to share successful strategies for enhancing access to dental care for Medicaid patients. The intent was to discover what strategies are used by private practice dentists who successfully integrate Medicaid patients into their practices. What unique characteristics distinguish these practices and make them successful? How do they operate efficiently and maintain viability? These strategies could then be communicated to other dentists to better assist them in providing care to Medicaid recipients.

In October 2007, Dr. Mark Feldman, president, ADA, issued a call for nominees to the Board of Trustees. Potential participants were identified by the Board and submitted to CAPIR. An electronic survey was distributed to the participants before the Symposium to determine some characteristics of these 17 dentists

providing care to Medicaid patients and their private practices. Participants were asked to name the greatest challenge in providing care to Medicaid patients in their private practices and whether their state Medicaid program had implemented any changes over the past five years to make it easier to serve these patients. The dentists were asked what, if any, specific changes had been made within their practices to streamline patient flow and administrative functions associated with serving this population. In addition, participants were asked what they would say to a young dental student who was considering practice options after graduation about providing oral health services to Medicaid clients.

CAPIR formulated two major goals for the Symposium. The primary goal was to gain an understanding of the challenges to providing care to Medicaid recipients and discuss successful strategies to integrate Medicaid patients into private practice settings. A secondary goal was to generate a report to inform both members-at-large and participants in the 2009 Access to Dental Care Summit about challenges and successful strategies for integrating Medicaid patients into private practice settings and develop a mechanism to determine the benefit of these recommendations.

2008 Medicaid Provider Symposium:

On June 23, 2008, 17 private practice member dentists, one from each trustee district, gathered at the ADA's Chicago Headquarters Building to provide a personal perspective on delivering dental care to Medicaid patients. There were 11 general practice dentists and six pediatric dentists. Nine practitioners work in urban practices, seven in rural practices and one has a suburban practice. Thirteen provide care at one site, while four provide care at multiple sites. Medicaid and SCHIP patients constitute 52% of the practice patients on average, ranging from 10% to 100% (see Attachment A).

After a welcome on behalf of the ADA Board of Trustees by Dr. O. Andy Elliott, second vice president, ADA, Dr. Samuel Low, member, CAPIR, set the stage by providing an overview of the process to be used during the Symposium and stating the desired outcomes. The participants were divided into three facilitated breakout groups with the six pediatric dentists evenly distributed among the groups. Each group addressed the focus question: "From your perspective, what are the major challenges, other than financial, in serving a large number of Medicaid patients?" The breakout groups reported back to the larger group about common themes and the nature of the barriers identified. These common challenges were later prioritized by the participants as to which would have the greatest impact if addressed.

Utilizing the results generated from the morning session, afternoon breakout groups addressed the focus question: "From your perspective, what are successful strategies to overcome the non-financial barriers and enhance access for patients enrolled in Medicaid?" The groups used the prioritized common barriers as starting points for offering successful strategies and recommendations for improving access to oral health services for Medicaid recipients. The following provides a summary of the small and large group discussions about challenges and solutions experienced by participants in their care of Medicaid patients.

Focus Question 1: From your perspective, what are the major challenges, other than financial, in serving a large number of Medicaid patients?

During the morning discussion, numerous challenges to serving a large number of Medicaid patients within a private practice were described. Many went beyond the confines of individual dental practices to include systematic concerns, such as a lack of awareness of the oral health needs of this population and the educational preparedness of dental providers to meet those demands. The challenges included:

- Legislators are not fully aware of the growing oral health needs of the Medicaid population, which requires greater advocacy efforts and collaboration with stakeholders to increase awareness.

There are inconsistent messages about the importance of good oral health to legislators, thus oral health is not well integrated into local, state and federal health assistance programs. Advocacy for improvement to state Medicaid dental programs may be impeded by a less than favorable relationship between state dental associations and state Medicaid directors.

- A basic understanding and appreciation of oral health as an integral part of overall health are often lacking within this target population.

Medicaid patients and/or caregivers of Medicaid-enrolled children often exhibit little understanding of the dental disease process and how caries is transmitted. Limited oral health literacy within this target population, though not unique to this patient population, contributes to miscommunication and a lack of understanding. Treatment plans are often complex due to the high disease burden and patients frequently are challenged to understand them. This can be discouraging for patients and may jeopardize follow-up and completion of the needed treatment. This may be manifested by numerous last minute cancellations and missed appointments. Some mothers do not believe “baby teeth” are important to retain. A limited knowledge of oral health among caregivers, especially among grandparents who are the primary guardians for grandchildren, can inhibit effective information sharing about prevention.

There is a gap between patient and provider expectations. The importance of punctuality and follow through by patients and providers may not be a shared value. Adherence to appointments is further complicated by overwhelming transportation barriers experienced by many Medicaid patients, especially those living in rural areas where there is no public transportation.

Often, beneficiaries appear not well-educated about provider expectations of their cooperative participation in their care, as well as their rights and responsibilities as patients. Some Medicaid patients seem to perceive that they are viewed as “second class” citizens by dentists, while others may give an impression of a growing sense of entitlement to dental care. Some Medicaid recipients seem to regard the dental services they receive as substandard. With little or no financial responsibility for their care, patients may tend to not fully value the dental care provided.

Providers and dental staff members have high expectations of Medicaid patients that are often not met. Often dentists cannot reach their patients as phones are often disconnected or out of service. Bringing extended family members along tends to congest the waiting area. Children sometimes appear for dental treatment without parent or guardian. Some non-Medicaid patients have objected to Medicaid patients being in the same waiting room.

- The current dental school curriculum inadequately prepares dental providers to address the oral health needs of this population, especially young children.

The participants felt that dental students and many current practitioners have not been adequately exposed to underserved populations during their training. Many are misinformed about the unique characteristics of some segments of the Medicaid population, thus leading to dentists unknowingly being culturally insensitive. Their training does not fully prepare students to assess and address their community’s oral health needs. General practitioners are insufficiently prepared to treat young children exhibiting severe caries, thus many dentists are apprehensive about providing care for these patients. Some dentists are uncomfortable seeing any child before age four or five, regardless of the nature of the oral disease present. These dentists may be willing to provide anticipatory guidance and screening for children six months of age or older, but prefer to refer to a pediatric dentist those children less than four years of age who require definitive treatment.

Dental students are not exposed to successful business models utilized by general dentists who actively treat Medicaid patients and retain viable practices. Dental school is expensive, and the resulting debt is staggering, which can be a hindrance in financing a new dental practice. Loan repayment and/or debt forgiveness options are not adequate incentives to treat Medicaid patients, who displace regular fee-for-service clients. Dental school admission requirements do not adequately screen for individuals who might be more willing to treat underserved populations based upon their previous volunteer experience. Dental students are more often taught treatment modalities, rather than equity issues. There is increasing emphasis placed upon esthetic concerns within the dental curriculum and not enough attention is paid to exposing the students to dental public health principles.

There is a definite fear among some dentists that their private practice will be overrun by Medicaid patients. There is a belief that seeing Medicaid patients requires additional staffing. Some older dentists believe they saw “their share of Medicaid patients” early on in their practice, and it is someone else’s turn to shoulder the burden now. This is ironic as experienced practitioners are the ones most likely to have the financial stability and clinical expertise to meet the demands of this target population most efficiently and effectively.

- The administration of state Medicaid dental programs is often inefficient.

Dentists view state Medicaid dental programs as disorganized, inefficient, and “severely broken,” especially in those states without dentists as program administrators. Dentists complain about their staff’s inability to efficiently submit reimbursement claims due to cumbersome forms and processes. Excessive legal and regulatory rules discourage provider participation. The program does not adequately address the high dental disease burden seen in this target population. There appears to be little evidence of ongoing evaluation of the efficacy of state Medicaid dental programs. Medicaid practice audits investigating fraud or abuse are often conducted by non-dental administrative staff.

- The integration of dental and medical homes is not well coordinated.

There is more demand for oral health services than can be met with the prevailing dental delivery system, especially among the Medicaid population; therefore, physicians do not seem to be playing as important a role as they could in preventing dental disease. The lack of coordination of the dental home with the medical home perpetuates a lack of emphasis on preventive care among Medicaid-eligible children.

Focus Question 2: From your perspective, what are successful strategies to overcome the non-financial barriers and enhance access for patients enrolled in Medicaid?

During the afternoon session, participants reacted to the challenges noted previously and identified strategies to increase access to dental care for Medicaid patients. Most of the group’s recommendations for action were directed to systemic concerns, rather than changes that could be implemented immediately within an individual practice. Addressing these larger concerns may significantly decrease barriers to care for this population.

- Challenge: Legislators are not fully aware of the growing oral health needs of the Medicaid population, which requires greater advocacy efforts and collaboration with stakeholders to increase awareness.

Recommendations for Action:

Build consensus for advocacy. Establish a strong working relationship among the state dental association, the state Medicaid dental program, and the state oral health program, where the latter is traditionally assigned the oral health prevention and often the leadership role in state government. Augment that relationship with strong collaborative advocacy efforts on the part of interested stakeholders. Plan unified action aimed at improving access to care for Medicaid recipients within a state-wide oral health coalition or access advocacy group. Utilize lobbyists and special interest groups, such as those representing senior citizens and children with special needs, to coordinate and gain additional legislative support for increasing Medicaid access. Advocate for the incorporation of oral health into state health plans to provide greater visibility and sustainability. Seek legislative regulations that support greater dental team efficiency through more effective use of expanded function dental assistants (EFDAs).

Establish personal contacts with state legislators well before their vote is needed. Share oral health information routinely with key legislative staffers. Ask for regular legislative updates from these staffers. Invite legislators to participate or send representatives to grass roots oral health coalition events. Urge state Medicaid dental personnel and state dental association representatives to develop viable business models for private practices looking to provide more dental care for Medicaid patients. Educate legislators as to the cost savings and benefits associated with running an efficient state dental Medicaid program.

- Challenge: A basic understanding and appreciation of oral health as an integral part of overall health are often lacking within this target population.
- Challenge: The integration of dental and medical homes is not well coordinated.

Recommendations for Action:

Increase the oral health literacy of Medicaid patients and/or their parents. Develop consistent oral health promotion messages for multiple audiences, including patients, parents, oral health professionals, medical professionals, service organizations and advocacy groups. Solicit support from the ADA to increase awareness of the importance of oral health in this target population through a national campaign.

By the first year of life, every Medicaid-eligible child should be assigned a medical and dental home. Coordinate the integration of oral health into all aspects of a patient's overall health. For example, include oral health education in all perinatal classes. Request that the American Academy of Pediatrics implement their caries risk assessment policies directing medical professionals to evaluate children beginning at six months of age and refer appropriately to dental providers any child exhibiting less than optimal oral health. Train physicians to place greater emphasis on the importance of a dental home and provide basic oral health anticipatory guidance as a routine part of all well-baby visits. Encourage the use of fluoride varnish in medical practices, especially those serving this target population. Recommend that state Medicaid programs require a caries risk assessment and anticipatory guidance as a pediatric medical standard of care and a referral to a dentist when appropriate. Consider mandating an oral health evaluation before admission into daycare, preschool and/or kindergarten.

- Challenge: The current dental school curriculum inadequately prepares dental providers to address the oral health needs of this population, especially young children.

Recommendations for Action:

Change the current dental curriculum to include more general exposure to pediatrics. Educate dental students in the use of expanded function dental assistants to increase practice productivity and efficiency. Encourage all dental school clinics and specialties to accept Medicaid patients. Dental students should treat more Medicaid patients as part of their training. Invite students to practice in free clinics or Mission of Mercy projects as extracurricular opportunities. Advocate for an increase in Title VII funding to support greater numbers of general practice and pediatric residencies. Encourage the ADA's Commission on Dental Accreditation (CODA) to develop and/or enforce curriculum standards to provide graduating dentists with the knowledge, skills, and abilities to address the needs of this population.

Provide dental students with practical public health experience in multiple locations to increase their familiarity with underserved populations. Teach students the ability to assess oral health factors at the community level, contemplate solutions and evaluate the impact of implementing programs to address those issues. Continue the community-based education efforts started by the Robert Wood Johnson Foundation's *Pipeline, Profession & Practice: Community-Based Dental Education (Dental Pipeline)* program and the Arizona School of Dentistry and Oral Health at A.T. Still University (Mesa, AZ) as models for admissions and community-based training.

Education of the current dental workforce is essential to increase access to care for Medicaid patients. Provide continuing dental education (CDE) stressing the importance of a dental visit by one year of age and to enable dentists to be more comfortable treating young children. Provide CDE to allow dentists to better navigate state Medicaid dental programs. Consider CDE about providing care to the underserved as part of the ethics requirement for licensure. Consider active participation as a Medicaid provider as a criterion for dental licensure. Consider allowing dentists to treat Medicaid children in exchange for CDE credit.

Investigate incentives to increase provider participation to provide oral health access for Medicaid patients and other underserved populations. Examples of possible incentives include community-sponsored grants to supplement housing and dental facilities for the provider, student loan repayment programs, financial support for practice building and tax deductions.

- Challenge: The administration of state dental Medicaid programs is often inefficient.

Recommendations for Action:

Encourage state Medicaid dental programs to hire a director who has practical dental experience and is part of organized dentistry. Establish strong collaboration among the state Medicaid dental director, the state dental director and local social services directors. Fill positions on the state Medicaid dental advisory board with state dental association representatives and oral health coalition stakeholders to demonstrate adequate and equitable provider representation.

Simplify provider enrollment procedures by shifting the administrative burden from the dentist to the Medicaid system. Consider outsourcing the Medicaid administrative claims function to qualified third-party administrators or overhaul the claims administration and program integrity components. Inform dentists promptly of patient contact informational changes to ensure continuity of care. Encourage dialogue among health maintenance organizations, participating dentists, state and local dental societies and the state Medicaid dental officials on how to best administer the program. Develop a Medicaid credit card or some form of program identification that is indistinguishable from a dental insurance card. Establish one dental benefit manager within a state or elect a dental carve out.

When eligibility is determined, a state Medicaid dental liaison should instruct program recipients on provider expectations, as well as patient rights and responsibilities. At the same time, Medicaid clients should be clearly informed as to why they should seek out a dentist for oral health evaluation and treatment. Utilize the current science of pediatric cariology within state dental Medicaid programs (caries transmissibility from mother to baby) to enable pregnant women and mothers to readily secure Medicaid dental benefits as well as their child. Coordinate transportation for Medicaid patients for better access to medical and dental care delivery systems.

Conclusions:

The Medicaid Provider Symposium provided insights into the challenges faced by dentists who successfully provide care to Medicaid patients within their private practice settings. At the same time, these dentists represent a diverse group of ADA members who have structured their practices to serve some of our nation's most vulnerable citizens. The Symposium participants expressed a sincere appreciation that the ADA had recognized them for their efforts. They were thankful for the invitation to come to Chicago to share their thoughts on what could be done to improve the oral health of a segment of the population that they have chosen to integrate into their practices. They also expressed a desire to continue to participate in the ADA's efforts to develop policies focused on improving the systems of care that currently exist to provide care to the Medicaid population.

This was a unique group, unlike any convened on this issue previously. This group represented the types of dentists needed to serve the Medicaid population if problems associated with providing access to care for underserved populations are truly to be solved. They represent efforts to place Medicaid patients into the mainstream of oral health care, rather than to maintain their separate status. Monitoring the success of this group, and identifying others like them, may be a very useful gauge of the viability of the Medicaid dental program. It should be stated that the discussion focused primarily on providing access to care for Medicaid children. The comments of the participants did not fully address the strident oral health needs of particularly vulnerable adults.

It would be useful for the ADA to investigate just how these dentists are able to "afford" to treat Medicaid patients. Identifying and sharing their economic and practice management techniques could help other dentists to more readily incorporate Medicaid patients into their practices.

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