Our children are our future. They will inherit the earth and care for us as we grow old. If we do not invest in their health and well being, what kind of future are we creating for ourselves?
Managed Care Organization (MCO) – An MCO is a new kind of health care organization designed to provide services to Medicaid recipients in Maryland. MCOs can be licensed HMOs or new non-HMO organizations meeting the definition of MCO developed by the Maryland Insurance Administration and the Maryland Department of Health and Mental Hygiene.

Maryland Medical Assistance Program (MMAP) – Maryland’s Medicaid program.

Maryland Medical Assistance Program Fee-for-Service System (known as Fee-for-Service) – Providers are reimbursed directly by the State of Maryland on a fee-for-service basis. A dentist must sign up with the State to see patients under the Fee-for-Service system. While the majority of MMAP recipients are enrolled in HealthChoice, the MMAP Fee-for-Service program continues to provide dental coverage for the following recipients up to age 21 who are not covered under HealthChoice:

- Individuals who are dually eligible for Medicare and Medicaid;
- Individuals who are institutionalized in nursing homes, Chronic Hospitals, Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
- Individuals who are eligible for the Maryland Medical Assistance Program for a short period of time;
- Individuals those recipients in the Model Waiver program for children who are medically fragile; and
- Individuals receiving family planning services through the Family Planning Waiver.

Maryland Medical Assistance Program Managed Care System (known as HealthChoice) – Providers are reimbursed by the Managed Care Organization’s Dental Benefit Vendor on a fee-for-service basis. A dentist must sign up with a Managed Care Organization to see patients in the HealthChoice system. The majority of Maryland Medical Assistance Program Recipients are in the HealthChoice Program.

Medicaid – A program jointly funded by the states and the federal government, that provides medical aid for people who are unable to finance their own medical expenses.

* There is no program in Maryland that reimburses dentists through a capitated payment.
The **Oral Health Care for Maryland Kids Summit** was held in Baltimore on September 22, 2000. The Summit began with presentations by Dr. Burton Edelstein, Children’s Dental Health Project, and James J. Crall, DDS, ScD, Director, Oral Health Disparities and Policy Center, Columbia University School of Dental and Oral Surgery. Maryland resident and advocate Ms. Cleader Warren also provided a short talk on “the patient perspective.” These presentations emphasized the importance of oral health and access to oral health services for children.

### Issues Identified

Summit participants identified the following major areas for strategy development, in order to continue the momentum around oral health efforts in Maryland:

- **Financing** required for the provision of dental services.
- **Partnerships** that sustain the momentum required to improve access to oral health services at the local, state and national level.
- **Replication of best practices already in place in Maryland**, including the identification of common elements in these best practices around administration, case management, monitoring and financing.

### Strategies

Dr. Warren Brill, Chair, Oral Health Advisory Committee, summarized the following strategies identified for implementation as a result of discussion at the **Oral Health Care for Maryland Kids Summit**:

- Efforts to increase Maryland Medical Assistance Program (MMAP) Managed Care System (heretofore known as HealthChoice) and MMAP Fee-for-Service System (heretofore known as Fee-for-Service) payments for dental services, so they are realistic, and cover the cost of services.
- Strategies to attract and retain dentists to the HealthChoice program other than financing, such as streamlining paperwork and procedures.
- Effective case management strategies to help get patients to the dentist, and follow up on the care provided.
- Communities must be involved in the process. Partnerships to broaden ownership for the issue must continue, and include dentists, patients, legislators, educators and parents – and work at the community level.
- The “outcome must match the expectation” around the number of low income Fee-for-Service and HealthChoice insured children seen by dentists.
- Dental care for low income Fee-for-Service and HealthChoice insured children is two fold: 1) taking care of the acute pathology and disease treatment and 2) dental disease prevention and oral health promotion efforts.
- Local strategies must be developed throughout Maryland. Modification of ideas at the local level is the key to their success.
- Patients, parents and others can participate in educating the legislature and the public about the importance of oral health and the seriousness of the problem.

### Summit Follow Up

The Oral Health Care for Maryland Kids Summit Planning Committee will continue to meet and plan follow-up activities. The Office of Oral Health at the Maryland Department of Health and Mental Hygiene will continue to post information and progress towards improved oral health and access to dental services, including new strategy developments. Continue to check www.mdpublichealth.org/oralhealth for updates and information on how to get involved in the strategies proposed at the Summit.

For additional information, contact the Office of Oral Health, Maryland Department of Health and Mental Hygiene, 410-767-6742 or oralhealth@dhmh.state.md.us
Oral Health Care for Maryland Kids Summit
September 22, 2000
Baltimore, Maryland
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I. Purpose Statement: Oral Health Care for Maryland Kids Summit

The **Oral Health Care for Maryland Kids Summit** was held in Baltimore, Maryland on September 22, 2000.

The purpose of the **Oral Health Care for Maryland Kids Summit** was to enhance awareness regarding oral health and the related access issues facing Maryland’s most vulnerable population. The summit sought to provide a forum for Maryland’s health officers, legislators, health policy makers, practicing dentists, State dental organizations, advocates and consumers of oral health to develop strategies and offer solutions to address the oral health issues affecting Maryland residents.

The **Oral Health Care for Maryland Kids Summit** was held because:

- Dental caries (tooth decay) is the most common chronic disease of childhood.
  - Maryland children have nearly 3 times the U.S. average in untreated dental cavities (MD - 55%; US-21%)
  - Twenty percent (20%) of children have 80% of the dental cavities

- Only 19% of children age 3 and above enrolled in the Maryland Medical Assistance Program Managed Care System (heretofore known as HealthChoice) actually receive dental services.

- Dental caries is an infectious disease that can be transmitted from parent/care giver to child along with other known etiologies.

- Periodontal disease appears to affect systemic health (e.g., cardiovascular disease, low birth weight) and may exacerbate nutrition problems.

- Pain due to dental caries diminishes school/work productivity.
  - Sixty percent (60%) of school children in Maryland have at least one untreated dental cavity.

- Poor oral health leads to diminished self-esteem from an unattractive smile.

- Maryland children eligible for HealthChoice, the Maryland Medical Assistance Fee-for-Service System (heretofore known as Fee-for-Service) or reduced school lunch have a 30% higher tooth decay rate than other children.
Ms. Cleader Warren
“Children mean something to me in my community.”
“The data I want to see are how we are killing gum disease and cavities in our children.”

Ms. Warren began by thanking those in the State working for improved access to oral health services for children – she is “glad that somebody took the time to say it is needed.” The University of Maryland Dental School has provided wonderful care for her children. Ms. Warren encouraged efforts to involve local communities and community members, and use of local advocates, in promoting the importance of oral health. For example, Ms. Warren has incorporated messages about the importance of oral health into her home based program that teaches reading to parents and children.

Burton L. Edelstein, DDS, MPH
Director, Children’s Dental Health Project

The five questions:
What? Access to dental services for kids.
Where? Everywhere in Maryland.
When? Now.
Why? Because it really does matter.”

Dr. Edelstein described children’s oral health as a “sentinel marker for the new morbidity among children” and that “positive health behaviors – like those that WIC and Head Start and Title V programs throughout Maryland – work toward, that can be incorporated in child care programs, that can be encouraged at every opportunity with every parent can, should, and must include specific reference to oral health.” Additionally, Dr. Edelstein stated that, “We have the stark juxtaposition of the best and the worst – the dental haves and the dental have nots, the children and adults who enjoy the best oral health of probably any nation in the world and the subset of children and adults who suffer – yes suffer – from unmet dental need.

The comments from Dr. Edelstein’s presentation can be found in the Summit Materials section of the proceedings.

James J. Crall, DDS, ScD
Director, Oral Health Disparities and Policy Center
Columbia University School of Dental and Oral Surgery

“Dental care expenditures account for over 20% of all pediatric health care expenditures and approximately 30% of all health care expenditures for children ages 6 to 18. In contrast, the Medicaid program spends 2.3% of its total budget on dental care for children.” Dr. Crall presented key issues for the nation and Maryland around the financing and utilization of oral health services for children. The key issues and recommendations from Dr. Crall’s presentation include:

- “Mainstream” program operations
• Adequate funding
• Market-oriented reimbursement tied to fee percentiles, not %’s of “UCR”
• Prevention AND (not instead of) Treatment
• Integration, not fragmentation

The overheads prepared by Dr. Crall for his presentation at the Oral Health Care for Maryland Kids Summit can be found in the Summit Materials section of the proceedings.
III. Facilitated Discussion: Maryland’s Oral Health Issues

Current issues and challenges around oral and dental health in the State of Maryland identified by Summit participants included the following:

Funding

- Reimbursement rates from the HealthChoice Managed Care Organizations (heretofore known as MCOs) for dental services beg a critical question – what is the fair rate? Dentists need fair pay to get involved. It is important to recognize that this reimbursement is not only the cost of delivering care but also assists in covering the ability of dentists and other professionals to provide services to completely uninsured people.
- Maryland’s dental school cannot take advantage of federal money for dental residency training because of the unique way Maryland manages federal Medicare funds and hospital rate structures, whereas dental schools in other states can.
- Funding is not in place to support the needed or expected “outreach” efforts of MCOs to connect enrolled individuals with services. These organizations have the primary responsibility for outreach, and their efforts are not as visible in this area.
- Partnerships between MCOs, health departments and dentists can be used to effectively get people into the system.
- MCOs need to be held accountable for what they have been given the resources to do: provide reasonable reimbursement, case management, and documentation of services provided.

HealthChoice enrolled children

- Only 19% of HealthChoice enrolled children age 3-20 had at least one dental visit in the last year.
- It is important to follow up and learn more about the 19% -- do they have other services that help to keep them healthy such as immunizations, or other well child care? Or are they largely children who were seen because of a crisis situation or referral? The outcomes from the services delivered to that 19% also need to be looked at to evaluate how we are spending our resources.

Systems for Care

- There is very little community involvement, or community representation in any part of the “system.”
- The MCOs administrative “process” must be made easier for dentists (i.e., contracts, eligibility verification, claims processing).
- The State’s true capacity to handle the current volume of need is unknown. A good survey or data study about the State’s real capacity is needed.
- There is both a public as well as a private system for oral health services for poor and uninsured persons in the State: the public system includes the University of Maryland Dental School, local health departments, federally qualified health centers and other public agencies. The private system includes those private practices that have agreed to accept Medicaid and CHIP payment for services in the HealthChoice system.
• The entire foundation of the HealthChoice and Fee-for-Service programs need to be looked at, especially around the delivery of oral health services.
• Oral health services are largely delivered through private practices and dentists around the State – these practices must be more involved in the development of solutions.
• There is low participation in the HealthChoice Program by dentists, particularly on the Eastern Shore, despite an increase in the reimbursement for services.
• There is the need for specialists to treat children in the HealthChoice and Fee-for-Service programs; periodontists and oral surgeons are needed to address the needs of the currently untreated population. Along with active recruitment efforts, the reimbursement necessary to attract these providers to the system must cover the cost of care.
• Dental hygienists can be used creatively to address the screening and dental hygiene needs of more children.
• School based dental screening and services for children should be promoted: Baltimore City, as well as other counties have models for school-based services that could work. Dentists might also be willing to be engaged in school-based services if they will relieve the burden of the uninsured from their private practice. Other school health professionals, such as nurses, can help to enhance the screening and educational opportunities available.

Education and Health Promotion
• Education of the public around the need for oral health services and the importance of oral health would greatly help health department and other program’s efforts to outreach to individuals and families for services and to advance health promotion efforts.
• Healthy children are not visualized as a unit, rather, by the health issues they have: bad teeth, poor reading skills, behavioral issues. Funding needs to follow a vision of healthy children as a complete unit, and fund accordingly.
• It would be important to come up with the picture of a healthy child and then describe what services are needed at what point in a child’s life to achieve this picture.
• It is important to remember that we are dealing with dental disease in many children, and that for the 20% or 25% of children who have 80% of the tooth decay, we may need to concentrate funding strategies to fight disease, as we would with any other pathology.
• WIC, Head Start, Early Head Start all have mandatory preventive services they must provide. Legislative support for these programs to continue, especially to meet or expand oral health education and screening requirements, would be an important benefit to low-income children. These programs are also the best way to reach children as early as possible to detect dental decay and disease.
• We need to think along a continuum of providing services that begins with an emphasis on early identification, management of high risk cases identified, early stage treatment with case management, coupled with health promotion and prevention for the broad population.
• Women are enrolled in HealthChoice when they are pregnant – education about the importance of oral health through MCOs should begin then.
• Parents need information on oral health services: how to access care and what exactly is available to them and their children. Parents should be a specific target group for any informational or education campaign messages.
Local Efforts and Models

- A challenge for local people trying to make changes is finding strategies to get on the radar screens of local officials and State officials, compared to other issues in the State.
- Garrett County is beginning to put a pilot project in place – outreach support from neighboring states and communities needs to be investigated for communities and counties along the borders of Maryland. In Garrett County, approximately 2000 children are enrolled in MCHIP, and about 60% of those do not have oral health care. There are 8 dentists for 30,000 people; these dentists are not participants in the HealthChoice or Fee-for-Service programs. Transportation has been identified as the biggest barrier to receiving services for these families.
- St. Mary’s county has an excellent model that may be replicated, where the health department is providing the intake and eligibility service, outreach, nurses do case histories and scheduling of patients and match patients with a dentists office. The health department also has an in-house line for oral health information. Pediatricians and OB/GYNs who tend to participate in the HealthChoice and Fee-for-Service programs are also used as avenues to educate parents about the importance of oral health.
- Many smaller counties need to determine how we get programs to “piggy back” – for example in Washington County, there are many single mothers with children who need dental care, but they have no transportation. In Washington County, HealthChoice will pay for transportation for a medical visit, but not a dental visit; therefore we are looking for ways to overlap these services. One size does not fit all when applying the existing models in the State to other areas.
- Allegany County was successful in implementing fluoridation at the local level through successful partnerships with the State and the local community.

Other Policy Issues

- The uninsured are not being addressed at all in the State.
- The number of undocumented children is increasing in the State, however, many dentists and other professionals do not know how to treat these groups. We may need to use incentives to recruit providers to use more culturally competent strategies, such as offering continuing education credits or enhanced reimbursement.
- The Oral Health Advisory Committee in the Department of Health and Mental Hygiene should funnel ideas from the Summit, to the Secretary and on to the Governor.
IV. Priority Issues Defined

Priority issues identified as a result of the presentations and facilitated discussion included the following:

- **Financing** required for the provision of oral health services.
- **Partnerships** that sustain the momentum required to improve access to oral health services at the local, state and national level.
- **Replication and dissemination of the best oral health practices already in place in Maryland**, including the identification of common elements in these best practices around administration, case management, monitoring and financing.

These issue areas were the topics for the afternoon small group discussions around strategy development.
V. Small Group Reports: Strategic Direction Around Financing, Partnerships and Replication of Best Practices

Summit participants were divided into three small groups for facilitated discussion at the Summit: Groups A, B and C. A representative from Felix, Burdine and Associates facilitated each small group. Small group discussion participants were asked to answer the following questions for each priority area:

- What issues and challenges did we hear during the morning and lunch sessions on this issue?
- What ideas or strategies address the issues and challenges we heard?
- What needs to be done next?

These questions helped shape the small group facilitated discussions. This section of the proceedings includes a summary of the discussion from each small group, as recorded during the discussion on flip charts. The facilitator of each group presented a summary of these small group discussions during the closing session of the Summit. Each small group focused on one of the three strategy areas, and commented on other issues if time was available.

Group A: Financing

Issues and Challenges
- The HealthChoice and Fee-for-Service Programs are under-funded.
- The rate setting process must be revisited.
- The payment provided by the Fee-for-Service and HealthChoice Programs to dentists for services relates directly to the ability to recruit dentists to participate in the program.
- There are major issues around access to oral health services that have to do with financing and the ability of individuals, health plans and others to pay for services.
- The value of oral health services and overall oral health may not be fully appreciated, which relates to the imperative for funding.
- Outreach and case management are necessary, and they cost money.
- Resources for other strategies to recruit and retain dentists, such as loan assistance repayment, are needed.

Strategies to Address Issues
- Identify strategies to work with MCOs, especially in a public/private partnership.
  - $16 million increase in HealthChoice program dental funding should go to increasing reimbursement rates. The State should measure the increases in funding and corresponding utilization of services.
  - Develop a rate setting process that accurately and realistically reflects the cost of providing dental care.
  - Utilize multi-year contracts for HealthChoice services.
  - Collect and make public baseline information and progress towards utilization objectives, as well as the outcomes of care provided to HealthChoice enrollees.
  - MCOs should serve as an administrative services organization, and manage costs, utilization and facilitate access to services.
  - MCOs have experience in trying to connect people to services; their consultation and experience should be cataloged and shared with all providers of services to the HealthChoice enrolled population.
- There needs to be a forum or regular process that can improve the interaction between dentists and the MCOs.
- Coordinate the outreach services provided by all MCOs for dental, with the efforts of agencies and organizations at the local level.
- Demonstrate outcomes: the State must hold MCOs to the utilization targets set by Senate Bill 590 that was passed in the 1998 Maryland General Assembly.

**Increase reimbursement in the Fee-for-Service Program.**
- Increase in dental reimbursement for most dental procedures by 30% should be an important step to achieving rates that meet dentists’ cost of providing care.

**Advise the Secretary that more resources are needed, particularly for a public affairs strategy.**
- Create a group that can disseminate the proceedings of the Summit.
- Email newsletter and website can be used to disseminate information about oral health and access to dental care.
- Declare “Children’s Oral Health Year” in Maryland.

**Implement partnerships and community/consumer involvement as the methods to improve and increase support for funding of oral health services and oral health strategies.**
- Utilize consumers to create a “public outcry.”
- Create a direct partnership between patients and legislators.
- Consumers need to be recruited to participate in legislative lobbying efforts. One approach would be to hold discussion groups with consumers across the State and invite legislators. Ask consumers to identify barriers and get commitments to participate in policy change process.
- Increase the number of legislators who are willing to advocate for oral health resources in the session. There has been a transition and there are new leaders in the legislature; these individuals have to be approached and provided with information. Help these legislators to advocate for the funds needed to fulfill their legal obligations under Medicaid.
- Secure a position for a consumer on the Oral Health Advisory Board.
- Enhance communication between the Oral Health Advisory and Medicaid Advisory Committees.
- Develop partnerships at the local level between dentists, health departments, schools, community groups, providers of preventive and supportive services to children and parents. Provide support to these local partnerships and help them develop their own local approach, using elements of what is working in other parts of the State. Give these partnerships examples of action they can take at the local level, especially with their legislators.
- Partnerships at the local and state level should emphasize the coordination of services to more efficiently bring services to consumers. Also promote the use of non-dental professionals in the screening process and in the process of connecting people with services.
- Provide support to local leaders – county commissioners, city council, health department officers, dentists and others – who are working to improve oral health and get this issue on the community “radar screen.”
- Develop an email newsletter that can be a means to deliver the message about oral health and resources needed to multiple audiences across the State.
• Redesign the reimbursement system for dental services.
  o Remove dental services from the Medicaid waiver provision by HCFA as a ‘carved-out service’.
  o Remove the HealthChoice Program and enroll all Medicaid eligible patients in the Fee-for-Service program.
  o Increase reimbursement for pediatric dentistry and specialty services needed by children.
  o Survey providers and utilize Maryland Dental Society and Maryland State Dental Association experience to determine what fees would be required to secure their participation in the program.

**Group B: Partnerships**

**Issues and Challenges**

• Partnerships are sometimes difficult to implement, but are necessary to make gains in oral health and access to oral health services.
• Every community and every partnership is different.
• There are some strategies based on partnerships that are working at the local level to improve access.
• Partnerships with dentists in private practice are important to really address the root causes of the problems.
• Partnerships at the state level are good and can continue to be strengthened.

**Strategies to Address Issues**

• Formalize a partnership between HealthChoice and Fee-for-Service beneficiaries and the Oral Health Advisory Committee.
  o Increase leverage with legislators if consumers and beneficiaries are represented.
  o Work together to provide testimony in the legislature to support budget and other requests.

• The Oral Health Advisory Committee could formalize a partnership with the Maryland Rate Setting Commission to address the impact of Medicare reimbursement and cost regulation on the ability to provide and maintain dental residency programs through Maryland schools and hospitals.

• Create partnerships to address a specific facet of the access issue:
  o Transportation
  o Lack of understanding about the benefits covered under HealthChoice/ CHIP
  o No shows
  o Low reimbursement rates
  o Enrollment process/paperwork issues for providers and enrollees

• The case management function at the community level for connecting people to oral health services needs to be handled as a partnership between local health departments, case management staff from MCOs and other programs that have this function, or staff who perform this function for clients.
Partnerships between Providers of Services

- Utilize the Head Start Local Advisory Committee model to develop local advisory boards for oral health and advocacy for oral health services. Also, make personal contact with the Chair of each local Head Start Board to ask that oral health services be part of their advocacy efforts with local legislators.
- A partnership with WIC at the state and local level could advance awareness of the importance of oral health; this topic will be stressed at the annual WIC meeting this year.
- Partner with Head Start, Early Head Start, home school programs, school nurses, and MCOs to develop and provide a basic educational program for parents on nutrition, snacking and the importance of oral health and hygiene.
- Develop a partnership between the Maryland Academy of Pediatric Dentistry (MAPD) and managed care organizations to help increase the number of pediatric dentists who participate in the HealthChoice Program.
- Partner to implement additional sealant application projects and fluoride rinse programs in the schools. School nurses, parents, Head Start, social workers and principals need to be involved.

Partnerships based on Models

- Model programs in the State located on the Eastern Shore, St. Mary’s County and other counties need to catalog the partnerships they had to put in place to get their program off the ground. For example, St. Mary’s County created a partnership between the local health department, the managed care organizations, the local dental society and an advocacy group.
- The ABCD program in Washington State is a good program to model.

Partnerships between providers of care

- There are differences in local health departments staffing and ability to support a dental program – 10 out of 24 counties have some kind of dental program, but not all see HealthChoice enrollees. There are grants through the Office of Oral Health to provide funds to establish programs, but partnerships are needed to implement programs once the funding is received. The Office of Oral Health can provide assistance and guidance on what partnerships are needed to make programs successful.
- Community health centers (CHC) and local health departments can and should partner in communities where both services exist. LHDs may have expertise and support that can be offered around case management, education, promotion, outreach and community involvement that can work with CHC dental health programs.
- Primary care providers for children can provide basic oral health promotion messages during well child visits. A Pediatric Oral Health Work Group or Partnership could be established that incorporates health departments, WIC, Early/Head Start, schools, managed care organizations, health educators and providers of health services to children – including family practice physicians and pediatricians -- to stress the importance of oral health. A formal partnership at the state level with the Maryland Chapter of the Academy of Pediatrics and Family Practice physicians could also be formed.

Group C: Replication and Dissemination of Best Oral Health Practices
Issues and Challenges

- There are not many “best oral health” practice models to draw from in the State.
- Many “best practices” have yet to overcome the challenges associated with eligibility and enrollment.
- The value that people place on oral health directly determines how involved they will be in programs; the patient perspective is currently lacking.
- Dentists are not adequately trained, or there are not enough dental specialists, to work with children in the State.
- Recognize that the profit motive is fundamental to the current dental system’s survival, which is largely based in private practice. Solutions must also be built around the private practice model, not a public model.
- We may not understand the current system well enough to even determine what a best practice is!

Strategies to Address Issues

- The Maryland Dent-Care Loan Assistance Repayment Program is a best practice.
- Expand pediatric dental specialty training, which requires funding.
- Integrate oral health services into existing health programs, such as at community health centers and local health departments. Community health centers are now required to have a dental “plan” in applications for expansion grants.
- Recognize that we are trying to serve an underserved population; therefore, the function of case management or having an ombudsman is a critical feature of any program that we would call a best practice. Decrease the work involved for families who need to negotiate the system.
- Data on oral health status, extent of disease, numbers and locations of providers, and access indicators are necessary to measure the effect of all “best practices.” Use geographic mapping to look at the distribution and number of dental providers across the State. Then we can focus our efforts on those areas that need dental providers. Develop a statement about or a “standard of access” that every community needs to provide, but better information on the local system would be needed to measure if the standard is being met.
- Look at the traditional practice model and rethink the role of dental hygienists in prevention.
- Catalog all the steps and changes required to implement the model in St. Mary’s County so that others can determine what might work best in their community or how it could look in other counties.
- We already have best practices for advocacy in the legislature for financing, given the huge gains seen in recent years. Political will needs to continue to be built at the community level. A stronger coalition with an identified message, audience and partners (parents, consumers, pediatricians, MCOs, private practitioners/dentists, community health centers, public health, school nurses, and consumers) is needed to promote existing models and the resources needed to continue to maintain their efforts.
- Medical case managers in the local health departments and in the MCOs could be used to provide a session or information on what works from their perspective, possibly as part of a continuing education session. Case managers responsible for connecting individuals and families to oral health care could then borrow the pieces or practices that work for this issue. Case managers for the HealthChoice enrolled population that work in community health centers could be the source of this educational information.
• Build on a renaissance of public health dentistry in the State.
• Implement things differently in rural and urban areas.
**VI. Summary and Follow Up Activities**

Dr. Warren Brill, Chair of the Oral Health Advisory Committee, summarized the following as key areas for strategy development in follow-up to the **Oral Health Care for Maryland Kids Summit**:

- Efforts to increase HealthChoice and Fee-for-Service payments for dental services, so they are realistic, and cover the cost of services.
- Strategies to attract and retain dentists to the HealthChoice and Fee-for-Service program other than financing, such as streamlining paperwork and procedures.
- Effective case management strategies to help get patients to the dentist, and follow up on the care provided.
- Communities must be involved in the process. Partnerships to broaden ownership for the issue must continue, and include dentists, patients, legislators, educators and parents – and work at the community level.
- The “outcome must match the expectation” around the number of low income and Fee-for-Service and HealthChoice insured children seen by dentists.
- Oral health care for low income and Fee-for-Service and HealthChoice eligible children is two fold: 1) taking care of the acute pathology and disease treatment and 2) oral disease prevention and oral health promotion efforts.
- Local strategies must be developed throughout Maryland. Modification of ideas at the local level is the key to their success.
- Patients, parents and others can participate in educating the legislature and the public about the importance of oral health and the seriousness of the problem.

The Planning Committee developed, organized and helped to facilitate the **Oral Health Care for Kids Summit** with support from the Abell Foundation, University of Maryland at Baltimore Dental School, the Health Resources and Services Administration, and the Maryland Department of Health and Mental Hygiene. Members of the Planning Committee -- composed of representatives from the Maryland Department of Health and Mental Hygiene, Office of Oral Health, the Baltimore City Health Department, University of Maryland, and Maryland Dental Association -- will continue to meet to plan and organize Summit outcome activities. The Planning Committee has already met several times in follow up to the Summit. Other follow-up activities include:

- Media attention around the State has contributed to an awareness of the importance of children’s oral health in Maryland. Op Ed pieces as well as segments on television and radio news shows have continued since the Summit. The University of Maryland included the outcome of the Summit on its homepage for several days following the event.
- Interest from State senators and legislators continues, with many making calls to the Office of Oral Health to request follow up information.
- The development of a webpage on the Office of Oral Health website to post information from the Summit and all follow-up activities.

The Office of Oral Health, Maryland Department of Health and Mental Hygiene, will continue to post information and progress towards improved oral health and access to oral health services, including links to partner agencies and organizations, news and follow up strategy developments. Continue to check www.mdpublichealth.org/oralhealth for updates and information on how to get involved in the strategies proposed at the Summit.
For additional information, please contact the Office of Oral Health, Maryland
Department of Health and Mental Hygiene, 410-767-6742 or
oralhealth@dhmh.state.md.us