
April 7, 2003
Maine’s Oral Health Crisis:
Developing an Action Agenda for 2003-2004

A State Oral Health Summit Meeting
April 7, 2003

Acknowledgements

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and presenting this meeting are gratefully acknowledged:

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Maine Dental Association
Maine Dental Hygienists’ Association
The Maine Health Access Foundation
Maine Primary Care Association
New Hampshire Endowment for Health
Northeast Delta Dental

We thank all of these organizations for sharing our objectives
to elevate the understanding of oral health as a primary health issue,
to improve access to oral health care in Maine, and to enhance the quality of life
for all Maine people through improved oral health.
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Purpose, Planning and Overview

Maine’s Oral Health Summit, titled “Maine’s Oral Health Crisis: Developing an Action Agenda for 2003-2004,” was held on April 7, 2003. Its purpose of the summit was to bring together current and new stakeholders to share our objectives to elevate the understanding of oral health as a primary health issue, to strengthen and broaden the engagement of stakeholders and policy makers, to create a momentum to sustain and further the current focus on access to oral health, and ultimately, to enhance the quality of life for all Maine people through improved oral health.

The impetus for the meeting was twofold (see also Background section): to carry out a central action step formulated by Maine’s participation in the National Governors’ Association (NGA) Center for Best Practices Policy Academy on Improving Oral Health Care for Children in October of 2001, and the interest of a group of private foundations interested in supporting efforts to improve access to oral health services and improve oral health in Maine. In addition, an objective for the meeting sponsors was that in the follow-up phase, the summit process would facilitate the development of a state oral health improvement plan.

As the planning developed, the Maine Department of Human Services (now the Department of Health & Human Services, through the Oral Health Program, took the role of lead sponsor. The group of foundations were involved in the planning and made a commitment to support certain follow-up activities. The summit was conceptualized to serve as a working meeting where participants would work to further articulate objectives and action steps in identified priority areas. There was little need perceived to identify problems – they were and are well known – beyond presenting core information to provide a common base from which to work on that day. The summit was intended to serve as a jumping off point and not as an end in itself.

Partners/sponsors included the State Oral Health Program, MaineCare (Maine’s Medicaid Program), the state dental and dental hygiene associations, safety net providers through the Maine Primary Care Association, the various other parties involved through our participation in the NGA Policy Academy, and a number of private funders, along with the broad-based Maine Dental Access Coalition (see Background section). It was anticipated that some partners would become more involved in the follow-up stage, along with the funders group, which made a commitment to support it.

Desired attendance was no less than 60 participants to somewhat over 100. Invitees included known stakeholder groups, legislators, advocates, the business community, health center and rural health association Board members and health center administrators, Head Start directors and Health Coordinators, and public and private health program administrators. Key legislators received follow-up invitations to encourage their attendance but very few were able to attend because of concurrent legislative activity. The Associate Director of the Governor’s Office on Health Policy was specifically invited, as was the Health Policy Specialist in the Senate Majority Leader’s Office.

Over 100 individuals registered and approximately 95 people attended the summit. Their participation was active and enthusiastic. They represented dental and other health professionals, community organizations, state agencies and the state legislature, community and rural health centers, and the sponsors. They included members of the statewide Maine Dental Access Coalition and representatives of professional associations, health community coalitions, funders, insurers, educational institutions, and interested individuals, and they came from all over the state. Those who pre-registered up until about 10 days before the meeting received a mailing that included several background papers and Maine dental workforce data. Packets provided at the meeting included a variety of additional information, both for participant
use during the day and for reference afterward. This ranged from Maine specific oral health data to national review articles.

Participants were asked to develop a series of action steps that could be reasonably expected to improve the oral health of Maine citizens over the short, medium and long term; these steps were to build on research and planning as well as on recent developments that have already been accomplished in Maine and elsewhere in the country. Participants were asked to join one of four workgroups – workforce development, increasing access, enhancing MaineCare (Maine Medicaid) participation, and data and surveillance. Prevention and education were explicitly stated “sub-themes”. Each group was asked to formulate specific steps designed to achieve progress in their issue area, with the assistance of skilled facilitators, a recorder, and a resource/content expert.

The plan was that at the end of the day the facilitators would also assist in developing a single comprehensive action plan, and the groups would work together to make specific plans to address and implement short-term action steps in the months after the meeting. Given recent legislative history, and ongoing fiscal constraints, the planners felt it was likely the summit action plan would have more of a policy and administrative focus rather than one centered on program expansions requiring new fiscal commitments.

The day began with a plenary session, including remarks from Maine’s Acting Commissioner of Human Services; a national perspective presented by a national speaker; and an overview of progress in Maine to date, continuing challenges, and the perspective of the co-sponsors in supporting the meeting and follow-up activities. Participants then met in workgroups where they were to develop objectives and action steps for four priority areas: Workforce Development, Expanding Access, MaineCare Participation, and Data and Surveillance. They were given several priority issues to work from; these were not presented as being exclusive of other concerns, but rather for consideration as “drivers” for oral health improvement in Maine. The workgroups were then to identify and if possible prioritize several short-term and longer-term objectives, action steps and activities that would help carry these objectives forward.

Following lunch the workgroups reconvened and reported on their discussions, noting (if identified) short, medium and long-term objectives, and describing the associated action steps or activities that should be undertaken to move those objectives forward. Following the individual workgroups’ reports, a facilitator presented a synthesis of their work, summarizing each group’s top priorities and weaving those priorities together, and, if appropriate, will speak to how the synthesis supports a state oral health improvement plan.

The workgroups were encouraged to meet after the summit; the private funder partners committed to provide resources for the groups to meet two to three more times develop more specific objectives and identify activities from their summit recommendations. These funders supported this component of the summit’s work with facilitators and provision of meeting space. The funders group left open the consideration of a follow-up meeting in a year or two.

Follow up activities were conceived to start as workgroup meetings that were convened by facilitators to take the objectives articulated at the summit further into action steps. The partnering private funders supported this component of the summit. Most workgroups met twice during the summer of 2003 and their facilitators provided summaries to the funders group. Several workgroup recommendations were completed and others remain works in progress. Follow-up activities are discussed in another section of this report.
Funding for the summit was provided by the Maine Oral Health Program, through a systems development grant from the Health Services & Resources Administration, Maternal & Child Health Bureau (H47MC00013), and support from the Association of State & Territorial Dental Directors. The National Governors’ Association sponsored the national speaker. The Maine Health Access Foundation, the Bingham Program, the Betterment Fund, Northeast Delta Dental and Anthem Blue Cross & Blue Shield of Maine participated in the planning of the meeting and provided direct support for follow-up activities. The Maine Health Access Foundation and The Bingham Program commissioned the writing of the background papers.

Background

1. Policy Academy on Improving Oral Health Care for Children
The National Governors’ Association (NGA) Center for Best Practices convened a series of Policy Academies on Improving Oral Health Care for Children throughout 2000 and 2001, to help a select number of states bolster their ability to serve the oral health needs of low-income children. Twenty-one states participated. Participant states were selected through a competitive process based on their demonstrated need for and potential to benefit from the project, including their long-term commitment to implementing the ideas generated from the Academies. Maine participated in the third Academy at the end of October 2001 in Jackson, Mississippi.

The Academy’s objectives seemed timely and appropriate in terms of activities ongoing in Maine at the time the opportunity was presented. The impetus to apply was generally the recognition of an unprecedented level of interest and activity around oral health issues in Maine, and the sense that participation in the Policy Academy, with the structure and resources that it could offer, would assist us in coordinating and focusing all the various efforts that were then underway. We saw the Policy Academy experience as one that would offer an opportunity to assess, synthesize and prioritize objectives and initiatives, to help coordinate efforts and as a process that could contribute to the creation of a state oral health plan. The Policy Academy could be both a tool and a catalyst.

The first step in the Academy process was the designation of a team. Team members were chosen based primarily on the guidance provided by the NGA. Another initial step was the development of a preliminary vision statement. The team developed the following:

“We envision a Maine where every resident has the opportunity to achieve optimal oral health as part of total health and well-being; and where

- Prevention and education are priorities;
- Treatment is available, accessible, affordable, timely and culturally appropriate;
- Responsibility is shared among families and providers, insurers and government; and
- Collaboration among government, higher education, and the private sector ensures human and financial resources, quality and patient protection.”

Before attending the Academy, the team also spent time in the identification of priority areas with the understanding that these priorities could be used to frame and develop an action plan. Four priorities were identified: surveillance, workforce concerns, prevention, and funding. The group returned with the vision statement unchanged, and with a draft action plan built around those priorities. The plan was presented to the Department of Human Services (now the Department of Health & Human Services).

A cornerstone of that plan was to convene a state oral health summit, the goal of which was seen as twofold: to elevate the understanding of oral health as a primary health issue; and to
strengthen and broaden the engagement of stakeholders and policy-makers and create a momentum to sustain and further the current focus on access to oral health care. In addition, the team felt that a meeting of this nature – a "state summit" – could strengthen the understanding of and commitment, or buy-in, to identified priority areas as focal points in moving toward solutions.

Following the Policy Academy, there was a hiatus resulting from working within State government to assure support from DHS as well as the Governor’s Office. This moved the projected date for the meeting from June to at least November of 2002. Early in the summer of 2002, however, a group of private foundations and others that fund health services and development programs in Maine began meeting specifically about how they best might support efforts to improve access to oral health services and ultimately to improve oral health status in Maine. With their interest and involvement, the idea of a “Stakeholders’ Meeting” was put forward. The content was very similar to the plan for a summit, and a decision was made to work further on a common agenda and defer the planned meeting until the spring of 2003.

Desired outcomes of the NGA Team’s Action Plan were used in guiding the workgroups and the post-summit process. These include but are not limited to the following:

a. An institutionalized capacity for monitoring and surveillance of oral health status of Maine people, particularly children, through data collection, analysis and dissemination.

b. Expanded access to oral health services, both preventive and restorative, related to increased numbers of dental professionals and expanded/enhanced partnerships with other non-dental health providers in prevention and early intervention activities.

c. Integration of oral health promotion and oral disease prevention activities within other health promotion initiatives at state and local levels.

d. Sufficient and secure funding, from public and private sources, dedicated to oral health promotion/disease prevention efforts, including capacity building and the development of an integrated system of care to enhance service delivery.

e. Policy changes that facilitate systems changes and enhancements that will result in improved oral health care for children, their families, and all residents of Maine.

2. Maine Dental Access Coalition

Maine has had an active and effective ad hoc, grassroots coalition, the Maine Dental Access Coalition (MDAC), working to advocate for oral health issues for over six years. A catalyst in recent years, the MDAC was co-convened in June 1997 by the Oral Health Program and the non-profit Maine Children’s Alliance, the state children’s advocacy organization. From an initial mailing list of 30-35 names, the Coalition now maintains a membership of over 125 individuals, representing a variety of dental and health professional organizations, state and private agencies, legislators, advocates, and interested individuals. The Coalition has been involved in the various activities listed below, and has come to be recognized as both a forum for productive discussion, a functioning network for participating organizations, and a strong voice for advocacy around issues related to oral health in Maine. In planning the summit, the activities and accomplishments of the MDAC were carefully considered, so that the meeting and its outcomes would supplement and not supplant the Coalition’s work. In addition, the planners of the meeting wanted to facilitate integration of summit outcomes with the current objectives of the Coalition.

3. Legislation and policy

Legislative and policy activity has been a constant for the past 5 years or so, resulting in:

• funding with tobacco settlement dollars for a state-defined dental education loan and repayment program;
funding (through the state Oral Health Program) using tobacco dollars for a two-pronged capacity building program (includes a subsidy for community-based agencies providing clinical services and a competitive grants program for agencies building capacity);

• a feasibility study in 1999 for a general practice dental residency program in Maine, a state without a dental school;

• clarification and expansion by the state Board of Dental Examiners of the definition of “Public Health Supervision” for dental hygienists, which allows hygienists to provide preventive services in public health and certain other settings without a dentist being present and paved the way for Title 19 reimbursement of these services; and


In addition, there were several Medicaid dental policy and rate changes, although a major proposal to significantly raise dental rates finally died in June 2002 after two years of discussion. Also, after funding allocated in 2001 for an implementation plan for the dental residency was rescinded by the former Governor as a budget-saving measure, an ad hoc consortium of interested parties too on the development of a plan with funding for this stage from private foundations.

Presentations

Peter Walsh, Acting Commissioner, Maine Department of Human Services

Mr. Walsh welcomed participants on behalf of Governor Baldacci and acknowledged the work of many of the participants: “The results of your work are evidenced in the changes we can see in our oral health delivery system, in approaches to providing needed dental care, in MaineCare policies and procedures, and in an increased awareness among policy-makers, legislators, health professionals, and others of the role that oral health plays in total health. I know that many of you have been involved in this work for a very long time, and the rate of those changes seems too slow. But change is often incremental, and it is cumulative. So please, be encouraged by your successes.”

He noted that one of the day’s objectives was to set in motion some actions that would help elevate the general understanding of oral health as a primary health issue, and hoped that this meeting would provide new and added energy to help sustain the efforts already underway and the progress made in Maine to improve oral health. He then spoke about objectives and accomplishments from the Department’s point of view, and his hope that the work of the summit, in developing an action agenda for the next two years or so, “will help move all of us along toward our shared goals.”

Mr. Walsh noted specific accomplishments and successful strategies. With funding from the Fund for a Healthy Maine (Maine’s tobacco settlement fund) and administered by the Bureau of Health, along with support from private and other public sources, several new community-based dental programs started up during the past two or three years. The increase represents a 25 percent increase in the number of community-based dental centers in Maine. All of these centers are now providing needed dental services to Maine citizens because public health advocates, community agencies and activists, and dental and other health professionals worked together to establish these new facilities. He acknowledged community-based initiatives, such as community water fluoridation and school-based oral health programs providing sealants and other preventive services, as critical strategies in improving oral health.
MaineCare, Maine's Medicaid program, has worked to maximize the impact of available funds to increase reimbursement rates. But rates still lag behind market rates and may not meet the costs of providing care. In the absence of significant resources to direct to a rate increase, Maine has looked at policy changes and other procedural approaches to make MaineCare as "user-friendly" as possible, for both dental providers and MaineCare members. Mr. Walsh noted that many of those present had worked collaboratively with DHS to explore those issues and to shape those policies. In the past few years, there have seen some increases in the number of individuals receiving services, but there is still much work to be done.

James J. Crall, DDS, ScD, Director, Nation Oral Health Policy Center
“Improving Oral Health in Maine: Issues and Choices”
Dr. Crall, who had prepared one of the background papers for summit participants (a non-published conference draft focusing on Medicaid reimbursement and the dental workforce in Maine), presented a broad overview tying together a national perspective and Maine data. He noted significant contributing background and environmental factors, offered statistics on childhood tooth decay and health insurance, and described trends in the financing of dental care. He made the point that programs that don’t start with adequate funding cannot succeed in meeting program requirements or the needs of children, and discussed reimbursement considerations for “engaging marketplace providers.” He also described Medicaid program payment innovations in several other states, as well as other elements of demonstration projects intended to enhance access to care. Data specific to Maine included dentist participation in Medicaid as well as numbers relevant to workforce concerns. (PowerPoint presentation available.)

Lisa Miller, MPH, Senior Program Office, The Bingham Program
“The Maine View: Progress, Accomplishments, and Continuing Challenges”
Ms. Miller’s presentation provided an overview of accomplishments in Maine over the past several years, acknowledging the work of all the involved parties. A well-known and long-time public health practitioner and advocate, Ms. Miller served as the spokesperson for the group of private funders involved in the planning of the summit and coordination of follow-up meetings for the workgroups.

She noted areas where progress has been made as well as continuing challenges. She mentioned new sources of funding for health issues in Maine, such as tobacco settlement money, the Maine Health Access Foundation (a "conversion" foundation created as a result of the sale of Maine Blue Cross Blue Shield to Anthem), and several targeted federal grants. Advocacy for oral health has been fruitful, resulting in funding for a Maine dental loan education and repayment program, and for capacity building and support of community-based oral health programs, using tobacco settlement monies, and retention of those funds for oral health programs through difficult financial times. There have been changes in Maine’s Dental Practice Act that enhance access to dental services, with changes that improve reciprocity for dentists and, through a rule change, facilitate the expansion of settings where dental hygienists may practice. Prevention programs include school-based and school-linked oral health education programs with fluoride mouthrinse and dental sealant components; Head Start and WIC programs incorporate oral health education and prevention strategies for children and parents. An Early Childhood Caries Prevention and Intervention Program, with a training curriculum geared for non-dental health providers, is under development by the state Oral Health Program and the Maine Dental Access Coalition.
Ms. Miller also noted the continuing challenges for Maine. The public’s understanding and perception of the importance of oral health is still less than optimum for change. MaineCare reimbursement rates are low. Dental care is not included in many employment benefit packages, and is being dropped as smaller employers look to contain their health care costs. Retaining the Fund for a Healthy Maine (tobacco settlement dollars) for health services will be a continuing challenge as Maine continues to project budget deficits into the next biennium. Sustaining the recently expanded public health infrastructure for oral health will be a challenge as well, and fostering new innovations will need to be weighed against supporting existing programs. These challenges underlie the interest of the group of private funders. Aware of the urgency of the needs around oral health, and faced with an increasing number of requests for grants and financial assistance, this group is interested in enhancing collaboration and coordination of efforts, both among themselves and between and among the agencies and organizations seeking their help. Participation in the state summit and activities following is a way to better understand the oral health landscape and to determine future roles.

**Workgroups**
Each of the four workgroups met, working with a facilitator and recorder. Following a outline, each was directed to identify and if possible, prioritize, several short-term and longer-term objectives. They were also asked to identify primary action steps needed to carry these objectives forward. The groups were give a series of questions to consider in their discussions, and also asked to seek commitments from members to participate in the post-summit workgroups.

Following are brief summaries of the objectives noted in the Workgroup reports.

**Workforce Development**
- Expanding the functions and roles of providers
- Enhancing health/dental career awareness
- Better marketing of Maine – lifestyle, etc.
- Expand articulation opportunities
- False dichotomy of oral health vs. health – need to explain and resolve
- Dentists, hygienists and assistants need to work together
- Development of the dental residency program as a tool

**Expanding Access**
- Expanded roles – Hygienists and assistants
- Look at a “mid-level” type practitioner (international model)
- Define and protect the Public Health Supervision role
- Visibility and urgency of oral health relative to the public, providers, policy makers
- Case management in oral health, e.g., related to linkages between preventive and restorative services; increasingly related to language and cultural issues
- Link oral health and medical health appointments – co-location of services
- Parental involvement in School Oral Health Program
- Reimbursement issues
- Develop/host a joint conference for medical and dental providers (this is a two-way street)
- Assure oral health questions on general health screenings
MaineCare Participation
- Reimbursement – later
- Educate all new policy-makers about the importance of oral health
- Consistency in administrative procedures between MaineCare and private insurances
- Talk to each dentist in person to explain recent changes in MaineCare – encourage “another try” – a “detailing” approach
- Concept of medical and dental home as one, together
- Expand coverage of periodontal services to pregnant women
- Role of Head Start in case management

Data and Surveillance
- Use CDC definition of public health surveillance and use data to inform the work
- Develop a surveillance system for Oral Health – BOH will take the lead – base on national oral health indicators, plus a few additional
- Will meet again and pull in some additional stakeholders

Following the workgroup presentations, a facilitator presented a summary to begin to synthesize the four groups’ work and offered the following as overarching themes:
- What can we identify, decide or develop here today that is any different from what we’ve been talking about and working on for the past two to five years
- We need to identify the immediate next steps and
- Protect the progress (on all fronts) that has been made
- Consider the image of turning a “Rubik’s Cube” over and over to change perspective, and things will click into place
- Dovetail with the work and energy of the Dental Access Coalition over the past 5 years

Evaluation
Just over half the participants completed evaluation forms. Highlights of that evaluation are provided here.

1. How useful was today’s meeting for you? Very useful: 37 Useful: 17
2. How effective was the day in meeting its objectives? Very: 31 Somewhat: 17
3. Keynote Speaker (J. Crall) Excellent: 45 Good: 9 Fair: 1
4. Maine View (L. Miller) Excellent: 25 Good: 27 Fair: 2
5. After participating today, do you plan to remain or become involved in further work of the workgroup you attended? Yes: 41 No: 2 Not sure: 11
6. Would you like to attend another state oral health summit meeting? Yes: 47 No: 0 Not sure: 8
   When should such a meeting take place? In one year: 35 In two years: 8

Thoughtful comments were provided about ways the meeting could have been improved and for follow-up meetings and topics to include in another statewide meeting. Overall, the meeting was well received. One participant suggested better time management (the morning ran very late) but added “best organized meeting I’ve ever been to!” Participants were positive about the main speakers and about the materials provided to them in their packets.
Follow-up Activities

The four workgroups met during the summer of 2003. Following are summaries of their plans for follow-up activities.

I. Oral Health Data and Surveillance: The workgroup met to react to draft materials developed by epidemiologists from the Bureau of Health and Oral Health Program staff.

- Working documents were presented – these are “templates” for oral health surveillance and analysis plans along with an annotated list of data sources.
- The goals of the overall plan are: to monitor (1) the burden of oral disease, (2) the use of the oral health care delivery system, and (3) the status of community water fluoridation.
- At this point, the plans cover oral health status, but other variables, such as those related to workforce and infrastructure or system capacity, are yet to be added.
- Certain gaps in immediately available and reliable data were identified: for example, there is minimal statewide data on adolescents, adults (other than BRFSS), the elderly and the institutionalized population. How indicators might be further prioritized could be discussed further, as well as how to assess such factors as nutrition and preventive behaviors.
- The group’s initial recommendations were:
  1. Short-term, complete a surveillance plan. This would include identifying all variables of interest to stakeholders along with appropriate sources of data for those variables.
  2. Medium: the surveillance plan should be initiated and a first document produced. This document could be the plan itself, a product of the plan, selected variables, etc.
  3. Long-term: the plan should be evaluated and refined, as is the nature of an ongoing surveillance system. Variables may be added, data sources may be added, and the level of analysis may be changed.

Topics addressed at a later meeting included addressing gaps and specifying other variables, resources that are available as well as those that are needed, who else could be involved, and dissemination of information and products.

II. Expanding Access: The workgroup chose initial priorities from a longer list; these center around expanding settings for oral health services, promoting a case management approach to delivery of services, and improving linkages between oral health and medical health. Developing activities – action steps – around these would bring in several other of the priorities developed at the summit (and identified by the MDAC), such as expanding settings for preventive care and hygienist services; advocacy and education, related both to policy-makers and the public; and systems issues, such as broken appointments and consumer/customer service. However, it was pointed out, a focus on the linking of oral health and medical health along with an emphasis on advocacy and education would garner more public attention, which for other health issues has been effective in gaining support and funding.

Discussion focused on the ideas of expansion and new services, and/or better use of existing resources. Three “domains” were identified: schools, clinical dental and medical settings, and settings or programs where very young children and/or their caregivers are present, such as WIC and Head Start centers, home visitation programs, and pre-natal health providers. Education of health services providers and of children, parents, and/or caregivers, fluoride use, oral screenings, dental sealants and cleanings are services that can all be maximized in these various settings. Mechanisms for referral and case management would need to be identified and supported.
III. Workforce Development: Three major areas of discussion were:
1. how to improve the promotion and utilization of dental education loan and repayment programs (with special attention to dental hygienists)
2. where to start on expanding functions for dental hygienists and assistants
3. what can be done to develop and increase dental health careers awareness in Maine’s school-age population (middle school and high school students)

Activities/actions to be pursued include:
- outreach to education-related groups and foundations interested in funding education, to enhance a broader understanding of oral health and access as their issue as well
  - this would support further activities around increasing dental health careers awareness and pursuing strategies identified to promote dental professional career choices
  - more marketing of loan and particularly loan repayment programs, especially to dental hygiene students, not only in Maine but throughout New England
- analyze appropriate data to determine which expanded or new functions are needed and how these can best be provided, such as through changes in scope of practice
  - utilize information that can be provided by/facilitated by Data Workgroup
  - survey professional groups and community programs/assess the current workforce
  - review experiences/models in other states

IV. MaineCare Participation: After reviewing the priorities and issues raised at the summit, the workgroup generally agreed that MaineCare has, or is in the process of, addressing many if not all of these through policy changes and other program changes and enhancements. Discussion then focused on the proposed Dirigo Health Plan and how dental coverage can be linked to the plan through a “wrap around” package:

- The ultimate goal of the MaineCare Work Group is to have dental services be a covered Dirigo product. Because oral health is not yet included in Dirigo, the Work Group’s interim goal is to have dental services be part of a “wrap around” package, which covers things that are not covered by Dirigo. In order to enhance participation in MaineCare, all wrap around services, including dental, should be handled with ease for both providers and consumers. The more people who leave MaineCare and join Dirigo, the higher the rates providers will be paid for dental services.

Recommended action steps include developing strategies to:
- continually remind the Legislature that adequate MaineCare reimbursement for dental services is a priority;
- continually advocate for the inclusion of oral health care as part of the Dirigo plan;
- assure that dental services are an integral part of a wrap-around package, that oral health is included in the hospital planning process required under Dirigo and that a comprehensive oral health plan is included in the State Health Plan.

In addition, the workgroup would recommend:
- tracking dental needs of patients in hospital emergency rooms by looking at certain ICD-9 codes and gathering other pertinent information; identifying lessons learned from managed dental care programs in other states.
- exploring how to match dental clinic funding with federal Medicaid dollars, keeping in mind the model of the community mental health centers.
• making sure every dentist in Maine has information about the improvements in MaineCare’s provider application process and billing process.
• supporting and supplementing efforts by MaineCare, its Dental Advisory Group, the Maine Dental Association, and the Maine Dental Access Coalition to promote participation by dentists in MaineCare.
• Providing dentists with a list of transportation providers so they can let patients know
• Seeking funding to demonstrate the impact of strategies for the education and outreach of dentists

Outcomes

Many of the activities described above remain in progress and represent issues to be addressed, although progress continues to be made in many areas. Selected examples include:

1. Data and Surveillance: The Surveillance Plan has been developed and is a working guide for oral health data collection, coordinated by Oral Health Program staff with assistance from the Epidemiology Program within the Bureau of Health. Products of the plan should begin to be available late in 2004.
2. Expanding Access: one notable outcome of this group’s work was a project with Maine’s Department of Education, to integrate oral health “key concepts” to the health education standards and performance indicators outlined in Maine’s Learning Results, an assessment tool used Maine. Key concepts are included in the Comprehensive Health Education Program. The target audience is the school health education curricula committee. Key concepts should not be considered a curriculum, and should be used as a guide when developing or revising curriculum.
3. Workforce Development: Several working groups have proceeded with efforts to increase dental health careers awareness among middle and high school students. A dental careers component will be added to the health science careers cluster at one of Maine’s technical high schools within the next year as a demonstration program.
4. MaineCare Participation: MaineCare staff proceeded with efforts to communicate changes in the program to Maine dentists, working collaboratively with the Maine Dental Association and others, in efforts to promote participation in MaineCare. A letter was sent to the Governor’s Office on Health Policy and Finance supporting the inclusion of dental benefits in the Dirigo Health Plan, or at the least, inclusion of dental benefits in any wrap-around package.

Many of the objectives and activities articulated at the summit continue to be the focus of the Maine Dental Access Coalition and small working groups. The Oral Health Program plans to convene a statewide oral health meeting in May of 2005, where attention will be given to following up on the April 2003 summit.