Maternal and Child Health Oral Health Institute: Atlanta

Atlanta, Georgia
May 15-16, 2006

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Table of Contents

Executive Summary ................................................................. 1
Introduction ................................................................................. 5
Day 1, May 15, 2006................................................................. 7
Welcome, Introductions, and Overview of Institute ...................... 7
Luncheon Plenary Session.......................................................... 9
Afternoon Plenary Sessions ...................................................... 12
Day 2, May 16, 2006.................................................................. 18
Morning Plenary Sessions ......................................................... 18
Luncheon Plenary Sessions ......................................................... 26
Breakout Sessions ..................................................................... 31
Wrap-up and Conclusion ......................................................... 35

Appendix A: Participant List
Appendix B: Agenda
Appendix C: Peer Group Assignments
Appendix D: State Action Planning Grids
Executive Summary

The Maternal and Child Health Bureau (MCHB), through its “Building Maternal and Child Oral Health Knowledge and Enhancing Expertise in States and Communities” contract with Health Systems Research, Inc. (HSR), is investing resources in the development and execution of tailored oral health learning opportunities called Oral Health Institutes (OHIs). These OHIs have a special focus on developing and sustaining partnerships that improve oral health outcomes for the MCHB target populations: mothers, pregnant women, children, and children with special health care needs (CSHCN). As defined by the MCHB leadership, the intents of the OHIs are to:

- Create or reinforce partnerships between State maternal and child health (MCH) programs and State dental programs
- Involve CSHCN Directors in State-level oral health planning opportunities
- Elevate the visibility of oral health needs with MCH stakeholders and the general public
- Create learning components that are driven by the needs identified in advance by participants.

The MCHB identified the following key stakeholders as the OHI participants most able to implement changes at the State level:

- MCHB Directors and key staff members
- State Dental Directors
- CSHCN Directors and key staff members
- Medicaid, State Children’s Health Insurance Program (SCHIP), and/or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Directors
- Head Start (HS) Collaborative and/or Regional Offices.

On May 15–16, 2006, the fourth OHI convened since late 2005, was held in Atlanta, Georgia. The nine States in attendance included Alabama, Florida, Indiana, Kentucky, Maryland, Mississippi, Missouri, New Jersey, and Oklahoma. Each State team included
the State Dental Director and representatives from the key stakeholder groups. In addition, an expert faculty was available throughout the OHI to answer questions and provide guidance during the planning process.

The format of the Atlanta Oral Health Institute included a combination of educational plenary sessions and State partner and peer-to-peer breakout sessions. The breakout sessions were used to identify collaborative activities that participants could undertake to improve the oral health of MCH populations. The OHI was designed to meet the needs of all participating States regardless of where they were on the planning continuum. The content of the plenary presentations were identified by a planning committee and included the following topics:

- Establishing the dental home and facilitating its inclusion in the medical model
- Using Medicaid/SCHIP/EPSDT resources to fund oral health services
- Defining the dental workforce challenge and opportunities to utilize non-dental medical providers to expand access to care
- Providing an overview of oral health issues facing CSHCN
- Building public awareness on oral health through social marketing and policy development
- Optimizing oral health services in rural areas.

In addition to the interactive plenary sessions, States were given the opportunity to learn from their counterparts in other states during two peer-to-peer breakout sessions. These sessions encouraged attendees to share successful strategies and promising practices for enhancing the oral health of MCH populations. Attendees were asked to focus on identifying collaborative strategies, both large and small, for enhancing oral health that could be replicated in different States. The evaluation information gathered from participants at the conclusion of the meeting indicated that participants found the peer-to-peer sessions especially informative. For many of the peer groups, this was a unique opportunity to convene specifically to discuss the oral health needs facing their respective States.
The Institute also included two State Partner sessions where key stakeholders from the same State were asked to identify three oral health priorities and corresponding activities among MCH, CSHCN, Medicaid/SCHIP, and State dental program representatives and brainstorm how partners could work together to improve oral health outcomes for MCH populations. These activities were to augment any oral health planning efforts currently underway in their States and were considered the priority outcome of the OHI. The activities identified by the State Partners in Atlanta were included in an action planning grid that States were asked to revise and submit in the weeks following the OHI.

A number of States mentioned collaboration in the activities identified during the State Partners sessions. Several planned to collaborate with the HS Program through Statewide forums or summits. Some States also mentioned collaborating with HS at the community level by promoting oral health through community HS health teams. One State would like to integrate oral health activities into its State Maternal and Child Health Early Childhood Comprehensive Systems Grant. Three States discussed improving collaboration between medical and dental providers, such as by training nurses to conduct oral health screenings. Three States will place greater priority on the continuation of planning activities, either by developing a State Oral Health Plan or by working with a Statewide Oral Health Coalition to promote oral health activities.

Five States mentioned the population of CSHCN as an area of priority. A few States planned to provide training and education to dentists to increase the number of dentists willing to treat these children. Other States will expand their emphasis on the oral health needs of CSHCN within existing programs, such as an early childhood caries (ECC) program.

Almost all States included a policy-related strategy. Five States specifically mentioned their interest in reviewing Medicaid and EPSDT guidelines and policies. Three States recognized the limitation of their current dental practice acts and planned to review the appropriate legislation. One State mentioned expanding the responsibilities of public health hygienists.
During the closing plenary session, each State was asked to present a brief summary of their priorities, corresponding activities, and partners. They were also asked to identify any specific technical assistance need, if possible. Considering the brief amount of time available for planning in Atlanta, the States are to be commended for making bold progress in identifying strategies with the potential to significantly impact oral health outcomes.

Introduction

The Maternal and Child Health Bureau (MCHB), through its “Building Maternal and Child Oral Health Knowledge and Enhancing Expertise in States and Communities” contract with Health Systems Research, Inc. (HSR), is investing resources in the development and execution of tailored oral health learning opportunities called Oral Health Institutes (OHIs). These OHIs have a special focus on developing and sustaining partnerships that improve oral health outcomes for the MCHB target populations: mothers, pregnant women, children, and children with special health care needs (CSHCN). As defined by the MCHB leadership, the intents of the OHIs are to:

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- Head Start (HS) Collaborative and/or Regional Offices.
In addition to receive travel support for their respective representatives to participate in the OHI, each State was eligible for follow-up onsite training and technical assistance (TA) resources to support implementation of identified priority strategies.

The format of the OHIs included a combination of educational plenary sessions and State partner and peer-to-peer breakout sessions. The breakout sessions were used to identify collaborative activities that participants could undertake to improve the oral health of MCH populations. The OHIs were designed to meet the needs of all States regardless of where they were on the planning continuum. In addition, an expert faculty was available throughout the OHI to answer questions and provide guidance during the planning process.

This MCH OHI, the fourth in a series held around the State between late 2005 and mid 2006, was held on May 15–16, 2006 in Atlanta. The nine States in attendance included Alabama, Florida, Indiana, Kentucky, Maryland, Mississippi, Missouri, New Jersey, and Oklahoma. Each State team included the State Dental Director and representatives from the key stakeholder groups. For a full participant list, see Appendix A. The following report details the presentations, discussions, and outcomes from this OHI.
Day 1, May 15, 2006

Welcome, Introductions, and Overview of Institute

Anne Hopewell, M.S.W., Senior Associate, HSR

Ms. Hopewell welcomed participants to the meeting and pointed out that the meeting agenda included a number of opportunities for discussion and presentations by well-known experts in oral health. She encouraged participants to provide feedback and comments throughout the meeting. Next, Ms. Hopewell introduced the first speakers of the day: John Rossetti, an oral health consultant for the MCHB, and Galo Torres, the Health Resources and Services Administration (HRSA) Region IV HS Migrant Dental Consultant. As the former Dental Director at the MCHB, Dr. Rossetti was representing MCHB and was also instrumental in the planning of the OHI.


Dr. Rossetti welcomed participants to the 4th OHI on behalf of MCHB and Mark Nehring, the Dental Director at the MCHB. He provided a historical perspective of the Title V program and described the impact of some programmatic changes.

The Title V program was created by the Social Security Act of 1935, which also created the Medicaid program. Since its inception in 1935, the Title V program has undergone several programmatic changes. When first passed, the Title V language specified that each State would have a dentist, physician, social worker, and nutritionist to address the comprehensive health needs of children. Over time, these areas operated as increasingly separate programs, which compromised the comprehensive approach of the Title V program. Legislative changes in the early 1980s changed the structure of the grant and consolidated the categorical funding streams into a single block grant (BG) while reducing the total budget by 15 percent. Some programs, including oral health, became less important within the State programs.
In 1989, the Federal Government issued BG guidance, which stipulated that States conduct a comprehensive needs assessment every 5 years as part of the BG application process. Once States began conducting these needs assessments, oral health emerged as a major need in many communities. Oral health has become a larger issue as research has shown that oral health contributes to overall health, can exacerbate chronic health conditions, and can impact children’s ability to learn and succeed in school. Because of this, the MCHB has placed greater emphasis on oral health and encouraged States to leverage partnerships to improve the oral health of children and CSHCN. Dr. Rossetti expressed his hope that States use this meeting to achieve this result and develop the partnerships necessary to address the oral health needs of their MCH populations.

**Galo Torres, Region IV HS Migrant Dental Consultant**

Dr. Torres expressed his pleasure to be greeting such a select group of participants. He extended greetings from Dr. Gonzalez, who is a supporter of oral health. Dr. Torres explained that he promotes the importance of oral health in his work with the Bureau of Primary Health Care. He commended the MCHB on its efforts to improve oral health and was eager to review the action plans that resulted from the meeting.

**Anne Hopewell, M.S.W., Senior Associate, HSR**

Ms. Hopewell reiterated that the MCHB funded these Institutes with the intent that the meeting be crafted to address the needs of participating States and include the attendance of key stakeholders from each State (e.g., MCH, HS, Dental Directors, and Medicaid). She noted that this OHI attempted to include States that have not had the opportunity to participate in other planning meetings, such as the Robert Wood Johnson Purchasing Institute. Ms. Hopewell described the format of the meeting, which included plenary sessions and State partner and peer-to-peer breakout sessions, giving participants an opportunity to learn from one another. Ms. Hopewell noted that the intent of the Institute is to augment the current oral health planning activities in each State.
Ms. Hopewell then briefly reviewed the recent oral health accomplishments and challenges submitted by each State team. Some of the accomplishments shared by States included the implementation of fluoridation and sealant programs and improvements in serving rural communities. Other accomplishments included successful collaboration with dental schools and implementation of social marketing activities. Some of the main challenges identified by States were related to workforce shortages, the lack of Medicaid providers, and the long distances that families must travel to be seen by a provider. Lastly, Ms. Hopewell noted that States were most interested in hearing about promising practices and successful strategies that other States have used to address some of these challenges.

**Luncheon Plenary Session**

**The Realities of Establishing a Dental/Medical Home**

- Olson Huff, M.D., Fellow, North Carolina Child Advocacy Institute

Dr. Huff opened his presentation by highlighting the following points:

- The dental home is a solution to a problem.
- The dental home and medical home will not co-exist without collaboration.

He began by sharing his experience in 1994 when he started a new program designed to meet the medical needs of children in 21 counties in western North Carolina. When he traveled to meet with the practitioners serving in these areas, he consistently heard that oral health services were needed and that the youngest children, ages 0–2 years, were suffering the most. Significant access barriers were identified including lack of insurance and the inability to pay which can result in health consequences such as nutritional deficits and speech abnormalities. Dr. Huff also noted that placing less emphasis on prevention and delaying treatment also has economic consequences, as illustrated by analysis of North Carolina Medicaid spending showing that 40 percent of Medicaid funds spent on oral health care went to paying for hospital care. After incorporating all of this information, he and his colleagues were determined to find solutions.
The communities responded in a number of ways, opening community dental clinics and conducting oral health screenings on children during health fairs. They created incentives for dentists to practice in this region of North Carolina by addressing the dental practice laws and licensing procedures and advocating for an increase in Medicaid reimbursement rates.

Dr. Huff felt that from a medical viewpoint, there were four components to health care:

1. Treat existing illness or disease
2. Prevent illness and disease whenever possible
3. Advocate for the changes that will improve the ability to provide and deliver health care services
4. Build capacity to strengthen the whole system of care.

He described the existing oral health care system as a disorganization of care resulting in multiple providers, lack of continuity, poorly defined expectations, limited preventive measures, and marginal health. For this reason, he emphasized the importance of establishing a dental home. He defined a dental home as a place where a child or family receives consistent, continuous, affordable, and high-quality oral health care.

Dr. Huff identified a number of ways that a provider benefits from serving as a dental home. There are financial opportunities for serving as the dental home, as well as the personal reward of contributing to the community and improving the level of health care. He explained that a dental home also provides opportunities to collaborate with other medical professionals, work with schools of dentistry and medicine, and expand the role of the “dental home” in the future provision of medical and dental care.

Next, Dr. Huff discussed the barriers in establishing dental homes and grouped them into the following categories:

- Systemic
- Political
- Economic
- Fear
- Lack of vision
- Status quo.

He described systemic barriers as those that are built into the existing institutions and systems of care. He shared an example of a political barrier that he encountered in North Carolina when he discovered a law that permitted only teaching hospitals to employ dentists. He enlisted the aid of a local Representative and met with the legislative body and with the legal representation of the State Dental Society to change this law. There was some political resistance to amending the law, but he was able to demonstrate how this law negatively impacted children’s access to dental care. As a result of the law change, there are now five dentists employed in non-teaching hospital facilities. Dr. Huff suggested that advocates must be aware of the political landscape. He pointed out that often the dental community is fearful of supporting changes that could impact their members negatively, but Dr. Huff explained that this fear is misplaced, as his efforts have focused on patients who are not being seen by the dental community.

In 1995, a dental taskforce was convened with the goal of enhancing Medicaid reimbursements. Although he reported that they did not achieve glorious results, they were successful in changing 20 dental codes and brought additional dentists into the Medicaid program. This progress served as a catalyst for other events, including the opening of mobile dental units to treat Medicaid/SCHIP-eligible children living in rural areas. Within a few years, they began implementation of a Smart Smiles Project and were able to secure Medicaid reimbursement for pediatricians to apply fluoride varnish.

Dr. Huff was proud to report that these efforts have resulted in expanded access to oral health services in primary care settings. Primary care providers have applied fluoride varnish in 70,000 encounters with children aged 0–2 years, exceeding the amount applied by dentists. This preventive effort has resulted in lower caries rates throughout the State. Dr. Huff ended the presentation with recommendations for the future:
1. Dentists and physicians should be located in cooperative practices.

2. Increase the use of mid-level providers for preventive oral health care and better utilize dental hygienists.

3. Increase “crossover” training in medical and dental schools.

4. Advocate for improved and consistent reimbursement rates for all dental providers.

5. Improve training for dentists to enable them to manage small children during the provision of dental care.

**Afternoon Plenary Sessions**

**Medicaid/SCHIP/EPSDT and Oral Health**

- Jim Crall, D.D.S., M.P.H., Director, National Oral Health Policy Center

Dr. Crall reinforced Dr. Olson’s remarks that access to oral health services has been a chronic problem and that funding for these services has been a significant issue. He noted that although dental disease is highly preventable, it is not necessarily easily preventable due to a number of factors that impact dental disease, such as lifestyle choices and workforce issues.

He illustrated the real economic challenge for families in poverty. Although Medicaid covers almost half of dental care for poor children, close to 40 percent of families must pay out of pocket for these services. This places a financial burden on families, as more than 12 million children are living in poverty. While public opinion supports government spending to provide health care to children and the elderly, both considered vulnerable populations, there is a large discrepancy between how much is spent on children and how much is spent on seniors. Annual public spending on health care amounts to $258 per child, as compared to $4,360 per senior.

Next, Dr. Crall reviewed the policy implications of recent trends in the Medicaid program. Medicaid is an entitlement program that covers about 25 million children and
includes the EPSDT component, which provides comprehensive medical coverage including dental benefits. Recent efforts to restrain the growth of Medicaid may place these dental benefits at risk. States are increasingly purchasing benefits through contracts with managed care organizations to serve as dental care managers. Although the Federal Government does establish a broad framework for Medicaid services, many of the programmatic and funding decisions are determined at the State level. In 2003, a Federal proposal was raised that would eliminate the entitlement component of the Medicaid program. Although the proposal was rejected, Medicaid costs continue to rise rapidly. Even though pharmaceuticals and long-term care are driving the increase in Medicaid expenditures, the dental benefits package for children is at risk for dissolution.

Children’s dental benefits may also be impacted by passage of the Deficit Reduction Act (DRA), enacted in 2005, which could allow States to offer “benchmark coverage” with “wrap-around benefits” to achieve EPSDT standards. The Kaiser Commission has reported that this change could result in less comprehensive Medicaid services that resemble those offered by SCHIP. There is also concern that the DRA may change the cost sharing structure or impose premiums, which could result in greater out-of-pocket expenses for families.

In the face of these changes to the Medicaid program, Dr. Crall concluded his presentation by encouraging States to adopt an EPSDT dental periodicity schedule. He pointed out that, even though there is legislation that mandates States adopt an EPSDT dental periodicity schedule, very few States have done so. Dr. Crall argued that having a periodicity schedule in place may strengthen the EPSDT component of the Medicaid program, making it less likely to be eliminated.

**Workforce Issues**

- Tara Lubin, Policy Associate, Forum for State Health Policy Leadership, National Conference of State Legislatures
- Jessica Lee, D.D.S., Ph.D., Department of Pediatric Dentistry, University of North Carolina at Chapel Hill
Tara Lubin, Policy Associate, Forum for State Health Policy Leadership, National Conference of State Legislatures

Ms. Lubin provided an overview of the issues that States are facing regarding the shortage in the dental workforce, and she shared information about the trends influencing the workforce composition. She began by reporting some of the problems that are affecting the dental workforce. The rate of retirement among dentists exceeds the graduation rate of new dentists. Additionally, fewer dentists are assuming teaching positions as dental faculty because of the lucrative opportunities in private practice. Of practicing dentists, the ethnic and racial composition of the workforce has not increased in diversity, with low percentages of Hispanic and Black dentists. This is relevant because research shows that patients prefer practitioners from their own demographic group.

Although some argue that dental shortages are due to a maldistribution of dentists, there are definite shortage areas, especially among rural and low-income communities. In fact, HRSA estimates that 31 million people live in Dental Health Professional Shortage Areas (HPSAs), which are defined as underserved.

Next, Ms. Lubin highlighted some of the strategies that are being used to address these workforce issues. She described the Federal loan repayment program, which encourages dentists to practice in underserved areas, and she added that at least 27 States have their own repayment programs. In an effort to expand the workforce, States are also reviewing their Practice Acts and expanding the scope of dental practice. Some States are now allowing dental hygienists to practice in some form of unsupervised practice (19 states), and three States (California, Colorado, New Mexico) permit dental hygienists to practice independently. These changes are not without controversy. Over the past year, Alaska has expanded the dental workforce through the use of mid-level dental health aides but has faced opposition from the American Dental Association (ADA).
Building on Ms. Lubin’s presentation, Dr. Lee presented technical information on the HPSAs and how dental shortage areas are defined. She explained that HRSA recently contracted with the Cecil G. Shep Center for Health Research at the University of North Carolina at Chapel Hill to examine the process used to define an area as a dental HPSA, a process that HRSA has not revised since 1978.

Dr. Lee and her colleagues formed a multidisciplinary team to approach this task. They began by identifying the parameters that would define an underserved area – dental workforce, population needs, and barriers to care. This process looked at each of these areas and adjusted for population needs, used ADA data on dental productivity, and examined various indicators of barriers to care (age, rural, Medicaid).

Next, Dr. Lee discussed the definition of a service area, which has been defined by county. Ultimately their team accepted this designation primarily because data are available by county and sub county for some areas.

When examining dental productivity levels, their formula needed to take into account large sparse areas as well as densely populated urban areas and adjust for supply. They incorporated data from a 2002 survey of dental practice and applied a regression model. Dr. Lee mentioned that there were limitations to this model, which did not account for the effect of water fluoridation because reliable data were not available on that community characteristic.

Next, Dr. Lee discussed the barriers to care that were considered in the model. She listed a number of indicators that have been associated with barriers to care. After compiling the list, the team conducted a simple logic test to determine which variables to include. Based on these results, the recommended variables included the following:

- Percentage of the population less than 5 years old
- Density
- Labor participation rate
- Percentage of families living below 100 percent of the Federal poverty level
- Percentage of the workforce commuting for more than 30 minutes.

HRSA has plans to automate this process so that any county can easily calculate its dental HPSA score. Although HRSA can change the Index Threshold each year, Dr. Lee and her colleagues recommended that the Index Threshold equal 7.34 or lower to indicate eligibility for the HPSA designation.

**Gerry Ferretti, D.D.S., M.S., M.P.H., Chair, Department of Pediatric Dentistry, Case Western Reserve University School of Dental Medicine**

Dr. Ferretti shared information about his work training nurses and physicians on issues of oral health. These training programs, funded by HRSA and the State of Kentucky, have focused on expanding access to oral health services for young children.

Through the *Kids Smile Program*, training was provided to more than 1,000 nurses to teach them how to conduct dental screenings and apply fluoride varnishes. Although there was agreement that this program was appropriate for the prevention of ECC in children ages 0–5, there was some resistance to this training initiative by the dental community. Dr. Ferretti and his colleagues worked with the Dental Society and local providers to address their concerns.

Next, Dr. Ferretti described the training and oral health education provided to physicians. Physicians were trained to perform oral health screenings and risk assessments and provide parents with education and anticipatory guidance. The strategy was to modify the forms used during the 18-month well-child exam to include an oral health component, which could be completed by a physician, nurse, or nurse practitioner. By modifying the form, they were successful at making an oral health screening a routine part of the well-child exam. The decision to target children at 18 months was informed by a survey.
conducted with 2- to 4-year-old children that showed that among 2-year-olds, 43 percent had severe ECC and 9 percent had urgent oral health needs. This program is still ongoing and was recently expanded.

After describing these training programs, Dr. Ferretti reported that the Kids Smile Program has resulted in higher rates of fluoride application. Data show that nurses have applied fluoride varnish at a rate of 3,000–4,000 applications per month over the past 3 years. They have found that fluoride varnish is most effective when applied three times a year and will be analyzing clinical data to see if increased applications have decreased white spot lesions and decreased children’s risk of developing ECC.

**Transforming Lives through Access to Oral Health Systems of Care**

- Ronald Hathaway, D.M.D., M.S., Associate Professor of Orthodontics, Indiana University School of Dentistry

The day concluded with an inspirational presentation by Dr. Hathaway, who works to address the needs of special children. He works with a multidisciplinary team to address the medical and dental needs of children who have been impacted by congenital defects and require craniofacial and orthodontic work, surgical procedures that few providers are able to perform.

Dr. Hathaway presented some of the research that influenced the procedures and techniques he uses on patients with various syndromes. He used slides to illustrate why some of these children struggle to breathe and eat. For the remainder of the presentation, he shared slides showing the results of his surgical procedures on his young patients and the very positive outcomes he was able to achieve. He stressed that performing these surgeries was important in helping to reduce the major burdens faced by these children and their families.
Day 2, May 16, 2006

Morning Plenary Sessions

Anne Hopewell, M.S.W., Senior Associate, HSR, Inc.

Ms. Hopewell provided an overview of the prior day’s activities. She also reminded the participants that the MCHB was interested in identifying collaborative activities that States could pursue.


Dr. Rossetti reviewed the purpose of the Institute, as well as the MCHB expectation that States address a majority of these oral health issues by working through a core group of individuals. He encouraged participants during the State Partners Breakout Session to think about what roles and responsibilities they could assume and to commit to follow-up once they returned home.

Serving Children with Special Health Care Needs

- Mark Wagner, D.M.D., Director, Health and Research Initiatives, Special Olympics
- Sanford Fenton, D.D.S., M.D.S., Professor and Chair, Pediatric Dentistry and Community Oral Health, College of Dentistry, University of Tennessee Health Science Center

Dr. Fenton opened the presentation by mentioning two landmark reports released by the Office of the Surgeon General, Oral Health in America (2000) and Closing the Gap (2002). Both of these reports, to different extents, addressed the health needs of children and adults with intellectual disabilities or neurodevelopmental disorders. The Closing the Gap report specifically resulted from the Surgeon General’s Conference on Health Disparities and Mental Retardation. He explained that of the more than 7 million individuals with intellectual disabilities, many are living longer and thus facing more
health challenges through different life stages. These populations are also more vulnerable because their oral health status can be compromised by underlying conditions.

Dr. Wagner followed with an overview of treating special needs populations, particularly children with intellectual disabilities. He explained that these children are susceptible to the same oral health problems that affect other children and that sometimes providers see these children and address the disability while overlooking other disease processes.

CSHCN are defined as children who “have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally.” Close to one-fifth (18 percent) of U.S. children and adolescents aged 18 and younger have a chronic condition or disability.

These children can exhibit a wide range of intellectual ability, motivation, cooperation, and communication skills, which can result in behavioral issues that may challenge their ability to receive care. In addition to behavioral issues, other barriers to oral health care also may include caregiver barriers, such as the limited ability to perform oral hygiene, lack of parental awareness, or reluctance to seek or accept care. Barriers also exist among health care professionals and systems of care, including lack of skill or training, low reimbursement rates, or poor attitudes.

Oral health care management for preschool and school age children requires integrated care and effective preventive and treatment strategies. Preventive oral health care can encompass diet monitoring, fluoride use, sealants, and the education of health professionals (nurses, therapists). Treatment strategies, such as allowing enough time for care, need to be developed for each child and require a friendly and supportive dental team.

Next, Dr. Fenton discussed the oral health data describing this population. Data such as the results from the 2001 National Survey of CSHCN show that dental service is the
biggest unmet need of CSHCN and is almost twice as prevalent as the need for mental health. A wealth of information has documented that persons with disabilities face barriers to accessing dental care and have unmet dental care needs. Although some have attempted to reduce this level of unmet need through pro bono work, Dr. Fenton argued that charity work is not a health care system. Furthermore, because most of those in the dental profession are general practitioners (80 percent), he contends that those in general dentistry practice have to assume some of the responsibility for treating these populations.

Dr. Fenton continued by highlighting some of the goals that were presented in the Closing the Gap report released by the Office of the Surgeon General.

Goal 3: Improve the quality of health care for people with intellectual disabilities.

Goal 4: Train health care providers in the care of adults and children with intellectual disabilities.

Goal 5: Ensure that health care financing produces good health outcomes for adults and children with intellectual disabilities.

Goal 6: Increase sources of health care services for adults, adolescents, and children with intellectual disabilities, ensuring that health care is easily accessible for them.

He discussed strategies that can support each of these goals. He emphasized that the training of health care providers in the care of adults and children with intellectual disabilities needs to be approached from an interdisciplinary perspective, and he questioned whether current training and instruction is adequate. Although schools of dentistry and dental hygiene must instruct students on the management of treating individuals with special needs, almost 75 percent of dental students report not feeling prepared to treat persons with mental retardation. Regarding the connection between
outcomes and financing, Dr. Fenton questioned whether the current system for health care financing produces good health outcomes for adults and children with intellectual disabilities.

He argued that the Index of Medical Underservice for this population meets the HRSA determination score to be considered medically underserved. By having this designation, certain incentives would apply, such as loan forgiveness programs for providers serving these populations.

Also mentioned were organizations such as the ADA and the Grottoes of North America that are trying to address the oral health needs of special needs populations. Dr. Fenton mentioned that he often works with the Grottoes of North America, which is a foundation that provides financial support for dental treatment for children with special needs.

Dr. Fenton and Dr. Wagner concluded their presentation by asking participants to think outside the box in addressing these unmet needs and, most importantly, to focus on creating a team approach to dental care.

**Building Public Awareness on Oral Health through Social Marketing and Policy Development**

- Connie Ginsberg, Executive Director, Family Connection
- Burton Edelstein, D.D.S., M.P.H., Professor of Dentistry and Health Policy and Management, School of Dental and Oral Surgery, Columbia University


Ms. Gallagher began her presentation by reminding the audience that policies can affect what we care about and what we do and often reflect the values and beliefs of the policy
makers. Her presentation focused on identifying strategies to influence beliefs and attitudes through education, persuasion, and motivation using social marketing principles. Although her presentation was focused on oral health, it was applicable to other areas of health promotion.

Next, she defined social marketing and distinguished it from public relations. Social marketing is defined as the adaptation of commercial marketing technologies to programs and is used to influence the voluntary behavior of a target audience. Social marketing can be used to educate target audiences, including decision makers and consumers, and can be effective in motivating action. She continued by presenting “rules” of social marketing.

**Rule 1: It is all about your audience.**
This rule refers to knowing your audience well and understanding their beliefs, values, and motivations. This allows you to identify the type of message that will influence them and motivate them to make the desired change.

**Rule 2: People buy into solutions, not into products.**
This rule is probably the most important concept when applying social marketing techniques. To illustrate this concept, Ms. Gallagher provided an example using policy makers as the target audience. If you are trying to convince policy makers to adopt a particular policy, you first must demonstrate that there is a problem, and then you must convince them that your proposed policy is a viable solution to the problem. If your audience doesn’t relate to the problem, then the perceived “cost” of the solution can outweigh the perceived benefits of the solution.

**Rule 3: The message must resonate with your audience.**

**Rule 4: Provide a solution to a problem your audience recognizes and values.**
These two rules require that the appropriate message be framed to resonate with the audience. An audience must understand both the message and the solution. An audience cannot act on a message they do not understand or value.
In conclusion, Ms. Gallagher summarized the key social marketing principles in the following points:

- Target and research your audience
- Help your audience to own the problem
- Present a solution to the problem
- Use messages that resonate with your audience
- Tip the balance in favor of perceived benefits over perceived costs.

**Connie Ginsberg, Executive Director, Family Connection**

Ms. Ginsberg shared her experiences in South Carolina, where she successfully utilized social marketing techniques to assist the State Dental Association in increasing the Medicaid reimbursement rates.

She described some of the decisions made early in the process. The Dental Association hired a lobbyist and began lobbying legislators using different strategies and carefully crafted messages. One strategy was to enlist all of the Dental Association members to lobby legislators in their private practices. They also convened a meeting to engage other partners, including insurance leaders, the Chamber of Commerce, the American Academy of Pediatrics, school officials, children’s hospitals, parents, and advocates.

In organizing this meeting, Ms. Ginsberg had to address the following planning questions:

1. Who will convene the meeting?
2. How are participants invited?
3. What information is shared prior to the meeting?
4. Is there any funding to bring parents and consumers?

A successful communication strategy was the use of personal stories. At different points, she had individuals representing different perspectives – medical professionals, advocates, and others – share their concerns and personal experiences. She plans to
expand on this strategy by using personal stories to connect a legislator with a family in his or her district.

Next, Ms. Ginsberg shared some of the follow-up activities that she and her organization, Family Connection, pursued after the meeting. They testified before the South Carolina House Ways and Means Committee, organized a follow-up meeting on patients with special needs, and presented at numerous conferences and meetings. They also continued to collaborate on a number of activities. They worked with the Alliance, a Statewide health coalition, to develop an oral health awareness campaign and organized the distribution of toothbrushes with the Dental Association.

Ms. Ginsberg concluded the presentation by sharing some of the victories that they were able to achieve, specifically with the State Medicaid Agency. As a result of their efforts, the Children’s Dental Bill passed, which raised reimbursement rates to 75 percent of the usual, customary, and reasonable rate. They were also successful in having funding set aside specifically to treat children with special needs, although she reports this was short-lived because funding was lost recently as a result of fraud. She noted that this success is just the beginning of what they can accomplish in South Carolina.

**Burton Edelstein, D.D.S., M.P.H., Professor of Dentistry and Health Policy and Management, School of Dental and Oral Surgery, Columbia University**

Dr. Edelstein spoke of his personal experiences advocating to Federal agencies. He described the government as responsive and willing to act when advocates are effective in delivering their messages. Although many actions occur at a local level and Congress members can be difficult to move on issues, advocacy at this level is important because changes in Federal legislation can filter down to State and local levels. For example, the Federal Government can mandate care, increase reimbursement rates, and provide tax incentives to expand care. These are all appropriate actions the government can take to expand access to patients.
He explained that when approaching policymakers, how you frame an issue is critical. The words must be chosen based on the frame of reference of the specific audience and the circumstances. He went on to describe the circumstances that surround an exchange with legislators. Dr. Edelstein described it as a uniquely balanced relationship, because they have all the control in the allocation of resources, but as voters, we have the final say at the ballot box, and legislators are always thinking about their next election.

For a message to be effective, it must be framed to consider the following areas:

- Opportunity
- Knowledge
- Attitude
- Relevance
- Utility.

You must establish early on what you are trying to accomplish during the exchange. Some background research will tell you what the legislator knows about a given topic and what he thinks of you, your organization, or your issue. If your message is considered relevant to his work or circumstance, you must also convince the legislator that he has the political opportunity to do something, and you must demonstrate how taking on your issue is useful and can advance his overall work and political agenda.

Having worked on Capitol Hill, Dr. Edelstein has the experience of the inside observer and shared some insight into the mindset of policymakers. Although they welcome your input, they typically have very little time to meet with you. When a policymaker is listening to you, she is considering how you relate to her reelection, whether your issue is relevant to her personally, and what opportunity cost will be incurred should she agree to take action on the issue. Dr. Edelstein explained that policymakers have the desire to agree, but you must be very clear about what it is you are requesting of them.

Dr. Edelstein ended his presentation with the following suggestions on framing messages:

1. Prepare by knowing who you are talking to and where they stand on the issue
2. Provide advanced material so as to provide enough background to get them oriented on the main issues
3. Acknowledge and thank them for their help
4. Establish your authority
5. Get past the small talk as quickly as you can
6. Provide them with information about how it is relevant to their constituents
7. Offer your support in this process
8. Make it clear that you are there to establish a relationship that you plan to pursue.

**Luncheon Plenary Session**

**Optimizing Oral Health in Rural Areas**

- Karen Yoder, Ph.D., SEAL Indiana, Indiana University
- Kiyoko Fiedler, M.P.H., Director, Planning and Development, Western Dairyland Economic Opportunity Council, Inc.

**Karen Yoder, Ph.D., SEAL INDIANA, Indiana University**

Dr. Yoder expressed her appreciation at being invited to the meeting. She began by presenting data on the rural and economic status of Indiana residents. She explained that economic factors, such as a decrease in manufacturing jobs and an increase in service sector jobs, have led to higher rates of uninsured. This economic downturn has hurt rural areas. As a result, enrollment in public assistance programs, like Food Stamps and Temporary Assistance for Needy Families, have nearly doubled in the past 5 years.

The Medicaid/Hoosier Healthwise program also has seen increased enrollment rates, although Dr. Yoder pointed out that only 21–30 percent of children receive dental care in a given year. The SEAL INDIANA program was started to help address the need for oral health services in parts of the State where these services are less accessible. Most of the children that are treated by this statewide mobile dental sealant program reside in rural areas of the State. The goals of the program are to:
1. Locate Indiana children who are not receiving dental care
2. Provide oral examination with parental consent and when indicated, apply
   sealants and fluoride varnish for prevention of dental caries
3. Help to find a local dental home to ensure restorative services and continuity of
care
4. Provide service-learning experiences for dental and dental hygiene students to
   foster greater understanding of issues related to community oral health and access
to dental care
5. Engage in research that will promote optimal oral health and more equitable
   access to care.

The mobile clinic is staffed by a faculty dentist, a dental assistant, and a driver. A
Program Manager handles scheduling sites and dental students, distributing consent
materials, and promoting the program in order to recruit new sites. In addition to the full-
time staff, they have 150 dental and dental hygiene students who rotate through the
mobile clinic. To provide services, they travel to schools that have predominantly low-
income children (Title I schools), HS programs, homeless centers, and community and
migrant health centers. The mobile clinic is child friendly and also accessible to children
with disabilities. The dental services provided include examinations, bitewing
radiographs, sealants, fluoride varnish, and education. Because they promote the concept
of the dental home, they do not provide restorative services, and instead try to link the
child with a provider in their community.

Dr. Yoder continued by sharing data that has been collected since the program began in
2003. Data are stratified by population density, whether a community is urban, rural, or
more than 75 percent farmland. Rates of enrollment in Medicaid/Hoosier Healthwise are
highest in urban areas and lowest in farmland areas. The prevalence of carious lesions is
highest among children living in rural and farmland areas.
Operating costs are $350,000 annually and about 60 percent of expenditures are covered through Medicaid, SCHIP, and sliding fee billing. Other funding sources include grants from foundations, HRSA, and the Indiana State Department of Health.

As one of the goals of the program, there is a lot of effort invested into locating dental homes for children. Dr. Yoder has the support of the State Dental Association and communicates with local dentists before providing services in a new community. The program works closely with the school nurses to help locate local providers. She explained that often the success in locating a dental home really rests on the cooperation of dental societies and the efforts of the school nurses.

There are some challenges in this process, one of which is the lack of providers. There are 11 counties in Indiana that do not have any Medicaid providers, and only seven Federally Qualified Health Centers have dental clinics. The other main challenge is locating follow up care for children who are undocumented and not eligible for Medicaid/Hoosier Healthwise. There is limited funding available to provide services for these children.

Dr. Yoder ended her presentation by sharing the following lessons she has learned through the program:

- Obtaining parental consent is challenging, and forms must be simply formatted and should be bilingual.
- Service learning is a beneficial experience for dental students and gives them an opportunity to spend some time in a rural community and observe the results of disparities in access to dental care.
- The cost of running such a program requires ongoing external funding sources. It will never be self sustaining.

She concluded by communicating that rural counties can benefit from a program like this, but it is essential that it be well-planned and adequately funded.
Kiyoko Fiedler, M.P.H., Director, Planning and Development, Western Dairyland Economic Opportunity Council, Inc.

Ms. Fiedler represents Western Dairyland Economic Opportunity Council, Inc., a community action agency and the largest nonprofit in the western Wisconsin area. The agency serves four counties, three of which are rural areas. The organizational mission is to (1) alleviate poverty-related conditions, and (2) help low-income families become self-sufficient.

In her work as director of planning and development, Ms. Fiedler has assisted HS programs in conducting needs assessments. She found that access to dental care services emerged as a major need and explored this further by speaking with HS staff members and conducting focus groups with HS parents and families. They were particularly proactive about involving parents in this process, especially their growing Latino and refugee populations.

With a planning grant from the HS Bureau, they created a Dental Advisory Committee consisting of two pediatric dentists, HS parents, public health nurses, regional Medicaid representatives, and representatives from the dental schools in Wisconsin and Minnesota. This core group designed the Shining Smiles program with the following four goals in mind:

- The program had to be replicable.
- The program had to be sustainable.
- It had to establish a dental home for children.
- It had to slow dental disease progression for young children coming to the program.

The program was designed to target low-income pregnant women, HS children, and families of HS children in a variety of settings, which could include HS programs, child care settings, and home-based programs. Western Dairyland was unable to secure funding for the entire model and scaled back its program to include treating HS children.
at HS sites only. Children are examined by dentists, who volunteer their time, and can be referred to pediatric dentists for restorative care if needed. Low-income pregnant women are being targeted through local county health departments.

Ms. Fiedler reported the successful implementation of the train-the-trainer educational model using the *Oral Health for Young Children Colgate, Oral Health for Young Children and Dental Fundamentals* curriculum. The groups that are being trained include HS staff; HS teachers and teacher assistants; HS family service specialists; county public health staff; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) staff; and local physicians (primary care providers, OB/GYN, pediatric practitioners). There are also plans to train pediatricians and nurses to provide fluoride varnish applications in public health settings, WIC centers, and physicians’ offices. She stressed that even though policies are important, solutions are locally based. Ms. Fiedler provided an example of their solution-oriented mindset. She and her colleagues inquired as to why so few dentists accept Medicaid and treat Medicaid clients. After speaking with dentists, they were able to identify some of the problems and then propose solutions to address them:

- **Reimbursement rates are too low and the paperwork too cumbersome.** Western Dairyland became a Medicaid provider and planned to contract with the dentists to provide these services at augmented rates and to complete the necessary paperwork as well. While Western Dairyland has not been able to find funding for augmented reimbursement as yet, the agency remains committed to fully implementing the *Shining Smiles* Project. They plan to find funding for this arrangement until community health centers open in the area.

- **Medicaid families often miss appointments.** Western Dairyland worked with HS parents to provide them with office etiquette and stress the importance of making appointments. The curriculum also addresses physicians and their resistance to seeing Medicaid clients and young children.
Looking to the future, Ms. Fiedler hopes to reach out to additional populations, such as the elderly and homeless populations, who currently are not being served. She recommended that participants partner with community action agencies to address oral health challenges in their communities jointly.

**Breakout Sessions**

**Overview of Purpose**

At the request of MCHB and the OHI Planning Committee, one of the key activities of the OHI was the convening of breakout sessions. Despite the fact that participating States were in different stages of planning, the product expected from the OHI was a completed chart detailing three future collaborative activities to promote the achievement of MCH-focused goals identified in existing State oral health plans or other planning documents. Ideally, these collaborative actions would be inspired by the plenary discussion or the lessons learned from other States regarding ways in which collaborative activities could strengthen the oral health component of MCH and CSHCN programs. In the process of identifying these activities, participants were also asked to consider what TA might be needed to accomplish them.

In addition to the State sessions, the agenda included time for participants to meet with their counterparts in other States during two peer-to-peer breakout sessions. The Planning Committee noted that MCH, CSHCN, and Medicaid/SCHIP Directors rarely have an opportunity to meet and share ideas with their counterparts in other States. Thus, the OHI agenda included two breakout sessions devoted to State Partner discussion and planning and two breakout sessions devoted to peer-to-peer sharing. The assignments for each breakout session can be found in Appendix C.

To facilitate the group process for all breakout sessions, participants were provided with worksheets to guide their discussions. Facilitators were provided to assist with the discussions. Expert faculty members rotated among these group discussions to assist with
planning questions. The substance of each breakout session is reviewed in the next section.

**Peer-to-peer Breakout Sessions**

Peer-to-peer breakout sessions were conducted on Days 1 and 2. The work sessions encouraged attendees to share successful strategies for enhancing the oral health of MCH populations. Attendees were asked to focus on collaborative oral health enhancing strategies, both large and small, that could be replicated in their State.

On Day 1, the worksheet directed participants to discuss with their peers from other States successful efforts to promote improved oral health among MCH populations, especially any lessons learned about maintaining services amid changes in State policies and funding priorities. Peers were also given the flexibility to discuss other topics relevant to emerging issues in their States if applicable. Peers were asked specifically to share their insights regarding creative or innovative uses of Medicaid/SCHIP/EPSDT and effective strategies for mitigating the impact of budget cuts or policy changes.

The second peer-to-peer session provided participants with an opportunity to discuss the specific challenges identified during the State Session and gain information regarding promising practices that could be used to address them. The discussion guidance suggested that peers discuss the following:

- Any challenges identified during the State Partners Breakout.
- Suggestions about how these challenges are addressed in other States.
- Promising practices that have been used to integrate State Dental Programs and MCH/CSHCN programs.

Although no official recordings were made during the peer discussions, the evaluation information gathered from participants at the conclusion of the meeting indicated that participants found the peer-to-peer sessions especially informative. For many of the peer groups, this was a unique opportunity to convene specifically to discuss the oral health
needs in their States. In combination with the contact information on the OHI Participants List, these sessions served as an opportunity to create connections between peers that can be used strengthen oral health outcomes among participating States.

**State Partner Sessions**

The purpose of the State partner sessions was to produce a document outlining collaborative activities that could be undertaken to improve the oral health of MCH populations in their States. Partners were asked to identify three challenges that could be addressed through collaborative activities among MCH, CSHCN, Medicaid/SCHIP, and State dental programs and brainstorm how partners within a State could work together to improve oral health outcomes for MCH populations. HS and WIC programs were identified as potential partners for these collaborative activities. During the two State partner sessions, participants were asked to share any relevant information gathered during the peer-to-peer sessions. To aid in the discussion, presenters and other experts attending the meeting were asked to circulate among the States to provide insight into specific State challenges. The States were also given the opportunity to identify specific faculty to meet with them regarding particular topics of concern.

During the first State session, participants were specifically asked to:

- Consider current planning activities and identify what MCH oral health outcomes could be achieved with new or enhanced collaborations
- Identify actions to be undertaken to address challenges
- Brainstorm other partners who should be at the table
- Discuss what information or outreach could be used to encourage these partners to collaborate.

During the second session on Day 2, States were provided with an action-planning grid that provided a framework for identifying the appropriate activities and the appropriate lead person or entity responsible for the conduct of these collaborative activities. States
were asked to assign specific tasks, expected outcomes, and a tentative timeline. The States were provided with the following guidelines for discussion:

- Evaluate which actions are feasible in the near future.
- Consider both large and small actions.
- Identify person(s) to take the lead on each action.
- Discuss what TA may be needed.

Altogether, the State partners had approximately 2 ½ hours to identify priorities, assign tasks, and review outcomes. Therefore, it was not expected that States would be able to complete the finer details of their proposed collaborations. Some States identified more than three possible collaborative strategies of a smaller scope; others spent time detailing many steps to address a single challenge. Due to the limited time allotted for this discussion, the expectation was that this was simply the start of a broader collaborative planning process among State MCH Directors, CSHCN, Medicaid Directors, HS leadership, and State dental programs. The State action-planning grids can be found in Appendix D. An overview of the areas chosen for collaboration follows.

**OHI Collaborative Planning Outcomes**

**Priority Strategies and Next Steps**

Prior to concluding the meeting, a representative from each State shared the priority strategies identified during the State Partners Sessions that can be pursued to expand access to oral health services. Five States mentioned the population of CSHCN as an area of priority. A few States planned to provide training and education to dentists to increase the number of dentists willing to treat these children. Other States will expand their emphasis on the oral health needs of CSHCN within existing programs, such as an ECC program.

A number of States mentioned collaboration in their priority strategies. Several planned to collaborate with the HS Program through Statewide forums or summits. Some States also mentioned collaborating with HS at the community level by promoting oral health
through community HS health teams. One State would like to integrate oral health activities into its State Maternal and Child Health Early Childhood Comprehensive Systems Grant. Three States discussed improving collaboration between medical and dental providers, such as by training nurses to conduct oral health screenings. Three States will place greater priority on the continuation of planning activities, either by developing a State Oral Health Plan or by working with a Statewide Oral Health Coalition to promote oral health activities.

Almost all States included a policy-related strategy. Five States specifically mentioned their interest in reviewing Medicaid and EPSDT guidelines and policies. Three States recognized the limitation of their current dental practice acts and planned to review the appropriate legislation. One State mentioned expanding the responsibilities of public health hygienists.

**Wrap-up and Conclusion**

During the closing plenary session, each State was asked to present a brief summary of their priorities, activities, and partners. They were also asked to identify any specific TA needs, if possible. MCHB will provide follow-up training and TA in the months following the OHI, especially TA that will enable them to move forward on activities that will integrate State Dental and MCH programs.

Participants were reminded that they have access to a number of resource documents on the CD-ROM that was included with the meeting materials, as well as a participants list that included the contact information for the expert faculty and all OHI attendees. They were encouraged to continue to communicate with their peer groups regarding common interests and concerns and to maintain momentum in implementing their collaborative activities upon returning to their States.

In his closing remarks, Dr. Rossetti expressed his pleasure with the meeting proceedings and credited the States for their high level of participation. He urged States to maintain the level of enthusiasm that was generated during the OHI and to not become discouraged.
once they return home. Dr. Rossetti concluded the meeting by imparting the lessons he has learned:

- People make programs work
- Face to face contact is important
- Good things happen incrementally
- Continue to follow up.

Dr. Rossetti concluded the meeting by thanking States for their participation.
Appendix A: Participants List
Maternal and Child Oral Health Institute

Atlanta, Georgia
May 15 – 16, 2006

Participant List

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Appendix B: Agenda
Maternal and Child Oral Health Institute

Atlanta, Georgia
May 15 – 16, 2006

Institute Goals and Objectives:
The overall goal of the Maternal and Child Oral Health Institute is to strategize ways in which States can better integrate oral health into their MCH and CSHCN programs in order to enhance their capacity to build public private partnerships to address unmet oral health needs of their MCH populations. In addition, States will identify the technical assistance needed post-Institute to achieve this goal. During this meeting State MCH and oral health directors, CSHCN directors, and other key oral health stakeholders will:

- Increase their understanding of how optimal oral health is integral to overall health and well-being,
- Learn about approaches for developing effective collaborative strategies to improve access to oral health services for underserved maternal and child populations,
- Participate in a process of strategic decision-making regarding future collaborative activities that will strengthen the oral health component of MCH and CSHCN programs in States,
- Discuss issues or areas of concern that may result in national or State public policy recommendations on increasing access to oral health care,
- Plan three future collaborative activities that will promote the achievement of MCH-focused goals identified in existing State oral health plans and the technical assistance needed to accomplish them.

Monday, May 15, 2006

11:00 a.m. Registration

11:30 a.m. – 12:15 p.m. Welcome, Introductions, and Overview of Institute Goals and Objectives and Overview of States’ Accomplishments and Challenges

Facilitator:
- Anne Hopewell, M.S.W., Senior Associate, Health Systems Research, Inc.

Speakers:
- Galo Torres, Region IV Head Start Migrant Dental Consultant
During this session, participants will be welcomed to the Institute and an overview of the meeting’s goal and objectives will be presented. An overview presentation will be made highlighting the successes and challenges of the oral health programs in each State in attendance. There will be an opportunity for introductions.

12:15 p.m. – 1:15 p.m.  The Realities of Establishing a Dental/Medical Home  
(Working Luncheon)

• Olson Huff, M.D., Fellow, North Carolina Child Advocacy Institute

Despite the release of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry policies on medical and dental homes, the debate continues around the multiple interpretations of the medical/dental home concepts. To add to the controversy, efforts to establish medical and dental homes for all children have encountered a variety of challenges, including the lack of reimbursement for services provided to a child in a medical/dental home. This session will provide the audience with an opportunity to discuss what constitutes a medical home, how oral health fits into the model, and some of the practical realities of establishing a medical/dental home.

1:15 p.m. – 1:45 p.m.  What’s Happening with Medicaid/SCHIP/EPSDT and Oral Health: An Update

• Jim Crall, D.D.S., M.P.H. Director, National Oral Health Policy Center

Medicaid is a significant source of financing for oral health services, particularly for children and adolescents. Almost universally, however, Medicaid programs identify access to dental care as a significant and persistent problem for persons with Medicaid. Recent changes in Federal and State reimbursement policies and benefit packages further add to the dilemma. To help State officials understand better how these changes will affect their ability to offer and deliver high quality oral health care to their residents,
an update on recent and pending policy changes affecting these and other relevant issues will be provided.

1:45 p.m. – 2:45 p.m.  Peer-to-Peer – Breakout Session #1

This session will begin with a review of Peer-to-Peer and State Breakout session processes. Participants then will meet with their peers to discuss successful efforts to promote oral health in the MCH population and lessons learned about maintaining oral health services amid changes in State policies and priorities.

2:45 p.m. – 3:45 p.m.  Workforce Issues

- Tara Lubin, Policy Associate, Forum for State Health Policy Leadership, National Conference of State Legislatures
- Jessica Lee, D.D.S., Ph.D., Department of Pediatric Dentistry, University of North Carolina at Chapel Hill
- Gerry Ferretti, D.D.S., M.S., M.P.H., Chair, Department of Pediatric Dentistry, Case Western Reserve University School of Dental Medicine

An adequate supply of well-prepared public health professionals is essential to an effective public health system in the United States. Despite efforts to increase the number of qualified health care providers in workforce shortage areas through loan forgiveness programs and other strategies, few providers elect to practice in urban underserved or rural areas. This has contributed to a maldistribution of the health care workforce, especially those engaged in specialty practices. In the oral health community, the problem is also compounded by an aging workforce and inadequate reimbursement rates under Medicaid/SCHIP. In this session, participants will have an opportunity to discuss proposed changes to the definition of a workforce shortage area and learn what initiatives States have taken to remedy this problem.

3:45 p.m. – 4:00 p.m.  Break

4:00 p.m. – 5:00 p.m.  State Partners – Breakout Session #2
Participants will share relevant information gathered during Breakout Session #1. Based on their current planning efforts, they will be asked to identify three challenges that could be addressed through collaborative activities with new and existing partners. Experts will circulate among the teams to provide insight into specific State challenges.

5:00 p.m. – 6:00 p.m.  Transforming Lives Through Access to Oral Health Systems of Care

• Ronald Hathaway, D.M.D., M.S., Associate Professor of Orthodontics, Indiana University School of Dentistry

This inspirational presentation will provide participants with insight into the impact of congenital defects on a child’s development. Dr. Hathaway will review some of the partners that are integral to the oral health infrastructure in Indiana.
Tuesday, May 16, 2006

7:00 a.m. – 8:00 a.m.  Breakfast Refreshments

8:00 a.m. – 8:15 a.m.  Review of Day One Activities

•  Anne Hopewell, M.S.W.

During this plenary session, participants will highlight the lessons learned on Day One during the plenary and breakout session discussions and review the process for identifying priority activities, responsible parties and timelines.

8:15 a.m. – 9:30 a.m.  Serving Children with Special Health Care Needs

•  Mark Wagner, D.M.D., Director, Health and Research Initiatives, Special Olympics
•  Sanford Fenton, D.D.S., M.D.S., Professor and Chair, Pediatric Dentistry and Community Oral Health, College of Dentistry, University of Tennessee Health Science Center

Health care providers, public health officials, and families face special challenges and obstacles in meeting all health needs of CSHCN. These presenters will provide an overview of the oral health issues facing CSHCN and address some of the obstacles faced in accessing care. They also will identify and discuss promising practices and models for increasing access to care for this population.

9:30 a.m. – 9:45 a.m.  Break

9:45 a.m. – 10:45 a.m.  Peer-to-Peer – Breakout Session #3

Participants will be asked to share and discuss some of the priority challenges they have identified during Breakout Session #2 including successes and lessons they may have learned regarding collaborative solutions. In addition, peers will discuss strategies for maximizing MCH focused oral health programs and building successful collaborations based on specific actions that may have been implemented in their States.
10:45 a.m. – 12:15 p.m.  Building Public Awareness on Oral Health Through Social Marketing and Policy Development

- Burton Edelstein, D.D.S., M.P.H., Professor of Dentistry and Health Policy and Management, School of Dental and Oral Surgery, Columbia University
- Connie Ginsberg, Executive Director, Family Connection

The challenge of promoting the oral health of children, women, and infants in a way that attracts the attention of both the public and policymakers is a daunting but important task. Issues for each audience must be framed in a way that is simple but compelling, has meaning for them, and offers ways in which the problem can be addressed. This session will provide attendees with an overview of how to frame and disseminate oral health messages to various stakeholder groups. Implications for policy development on both the Federal and State levels will also be discussed.

12:15 p.m. – 1:45 p.m.  Working Lunch and Presentation

Optimizing Oral Health in Rural Areas

- Karen Yoder, Ph.D., Seal Indiana, Indiana University
- Kiyoko Fiedler, M.P.H., Director, Planning and Development, Western Dairyland Economic Opportunity Council, Inc.

The National Advisory Committee on Rural Health has highlighted the fragile state of basic dental services available to the residents of rural communities in numerous reports. Geographic isolation, lack of adequate transportation, high poverty rates, inadequate supply of oral health providers, and lack of fluoridated water supplies are some of the myriad of factors that contribute to the problem. During this session, several programs that are working to address the oral health needs of rural communities will describe their program, discuss their
successes and challenges, and identify the lessons they have learned throughout the process.

1:45 p.m. – 3:00 p.m.  State Partners – Breakout Session #4

Using an action planning grid, each State will refine the priority collaborative activities identified during Breakout Session #2 and begin to outline actions that can be undertaken to achieve these outcomes. This information will be shared with the other teams in the closing plenary. Presenters and faculty will circulate to aid States to identify the technical assistance resources that can be used to enhance the ability of stakeholders to undertake future actions.

3:00 p.m. – 3:30 p.m.  Priority Strategies and Next Steps

During this session, each State will share their priority strategies to date, what they anticipate their technical assistance needs to be, and next steps with all of the participants. Dr. Rossetti will discuss how the individual State technical assistance needs will be addressed post-Institute.

3:30 p.m.  Meeting Adjourned
Appendix C: Peer Group Assignments
### Breakout Session Assignments

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<td>Joe Alderman</td>
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Appendix D: State Action Planning Grids