State Dental Summits: An Evaluation

Prepared for

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I. Introduction

In June 1998, the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS) (formally the Health Care Financing Administration) sponsored a landmark national conference, “Building Partnerships to Improve Children’s Access to Oral Health Services,” in Lake Tahoe, Nevada. The purpose of the conference was to discuss and seek solutions to barriers to dental access in the Medicaid program and in the State Children’s Health Insurance Program (SCHIP). These barriers had been highlighted for the Medicaid program in a report of the Office of the Inspector General of the federal Department of Health and Human Services, in April 1996, entitled, “Children’s Dental Services under Medicaid: Access and Utilization,” and in numerous other reports. While the national conference in Lake Tahoe was viewed by the two federal agencies as helping to stimulate dialogue between the public and private sectors and the dental community that eventually might lead to oral health improvement for children, the agencies also recognized that real change in removing dental access barriers and improving dental health was more likely to occur at the state and community levels.

In follow-up to the Lake Tahoe conference, and as part of an Oral Health Initiative (OHI) then underway within the two agencies, HRSA and CMS sought to assist the states in their efforts to stimulate change locally. One activity that they strongly encouraged was the convening of state-level “dental (or oral health) summits.” Although state dental summits had occurred in small numbers prior to the Lake Tahoe conference, after the conference they became increasingly popular. These dental summits were viewed as opportunities for key individuals and organizations concerned with oral and general health within a state to meet together, face-to-face, to explore local barriers to oral and dental health access for children and other populations, and to formulate state-specific solutions to address these barriers. It was hoped that the dental summits would foster statewide problem-solving that would result in development of collaborations between policymakers, the private dental community, state health programs, and safety-net providers, leading ultimately to long term strategies and actions for improving oral health and dental access.

In February 2001, the HRSA, through its Maternal and Child Health Bureau (MCHB), issued a Notice soliciting requests from states interested in obtaining funding support to

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conduct state dental summits (or conferences that might follow-up on prior dental summits). The Notice is reproduced at Appendix A. States making requests for funding support were asked to provide a justification of need for the summit, describe problems in oral health access for children and their families, and note steps already taken to address those problems, including any involvement with Oral Health Policy Academies then being conducted by the National Governors Association. States applying for funding support also were asked to describe the results expected to ensue from the summit, such as administrative or legislative action, or creation of stronger collaborations among stakeholders, and to indicate activities that might be undertaken subsequent to the summit. Applicants also were asked to describe the structure of the proposed summit (e.g., planned length, dates, location, use of facilitators, number of participants, etc.).

Applicants for dental summit support were to involve a broad array of partners in planning for the summit, with partnerships required to be formed with the federal agencies’ OHI staff in their regional offices, personnel of state Medicaid programs and SCHIP, dental and dental hygiene professional associations, academia, safety-net providers and state public health and dental programs. In addition to these planning partners, it was highly recommended that applicants indicate that they would invite to the summit other key stakeholder groups, including staff of the Governor’s office, state legislators, rural and primary care associations, practicing dentists, dental hygienists and physicians, health professional training institutions, foundations, Native American representatives and others. Lastly, applicants were required to describe the proposed budget for the summit, and to indicate the specific purposes for which the funds would be used. It was noted that MCHB funding would be limited in amount to about $5,000 per applicant. Costs of the summit above that amount would need to be supported through other sources. MCHB funds were to be used only for “conference logistics, travel expenditures (e.g. speakers, facilitators), registration, hotel meeting space and accommodations, or other support directly related to the convening of the summit/summit follow-up.”

In order to facilitate the dissemination and effective use of the funds to applicants, and to evaluate the summits’ outcomes and processes, the MCHB entered into an agreement with the Association of State and Territorial Dental Directors (ASTDD) as part of an existing formal cooperative agreement (i.e., a grant) between the two organizations. Under the agreement, ASTDD was heavily involved in the tracking, approval and disbursement of MCHB funds to successful state dental summit applicants.

Applicants were instructed to first send their requests for funding support to the federal agencies’ OHI staff in the regional offices. The OHI staff reviewed the proposals, and offered technical assistance. Subsequently, the OHI staff provided a numerical score and a funding priority recommendation to ASTDD. ASTDD then made the funding decision. Prior to funding a request, ASTDD also may have provided technical assistance to the applicants regarding summit format, content, collaborative planning and facilitation strategies, and ideas for leveraging other resources, and on the eventual publication and dissemination of individual state dental summit reports.
In addition, as part of the agreement between MCHB and ASTDD, ASTDD was to:
“Hire a contractor and convene a committee to design and implement a comprehensive evaluation strategy to determine summit impact and outcomes, need for follow-up meetings or summits, feedback on the technical assistance provided by ASTDD and Regional office staff and others.”

ASTDD would produce a report based on the findings of this evaluation. The evaluation and its report were to encompass several purposes, including:
- Enhancing understanding of whether or not oral health summits were successful in moving forward oral health agendas in the states.
- Helping to inform MCHB as to how its funds were utilized and how the funding eventually affected oral health activity in the states, and
- Providing assistance to oral health stakeholders in the states as they planned future dental summits. To that end, the report was to include tips and recommendations for achieving successful outcomes.

During the period March 2001 to May 2002, MCHB received responses from 22 states to its announcement of the availability of dental summit funding support. Seventeen states ultimately received funds and conducted state summits (or follow-up meetings to previous summits) during the period April 2001 to December 2002. Those 17 states (listed at Appendix B) are the subject of this evaluation of oral health summit results.

It should be noted that MCHB/HRSA had supported five additional state and regional dental summits (in conjunction with state primary health care associations) in the year preceding March 2001. In addition, MCHB and ASTDD also collaborated with the federal Head Start Program in supporting up to 37 additional state-level dental conferences, known as “Head Start Forums,” beginning in May 2002 and continuing up the time of this evaluation. Also, another Bureau within HRSA, the Bureau of Health Professions, has funded six state-level dental meetings that were similar in purpose to dental summits.

In addition to HRSA/ASTDD, an array of other agencies and organizations have supported a substantial number of other dental summits, conferences, task forces, work groups and other efforts designed to address state-level dental access and health issues since 1997-8. A collection of reports of MCHB/ASTDD dental summit reports, and of other similar, state-level efforts is maintained by the National Maternal and Child Oral Health Resource Center, Georgetown University, Washington, District of Columbia, and may be found on the Internet at http://www.mchoralhealth.org/conferences/index.html.
II. Methods

*Evaluation Committee*

In January 2003, one month after completion of the last of the 17 summits funded under this MCHB/ASTDD cooperative agreement, the ASTDD entered into a contract with a consultant to work with ASTDD staff and an Evaluation Advisory Committee to design and implement an evaluation of these dental summits. The Evaluation Advisory Committee consisted of seven individuals, chaired by Diane Brunson, R.D.H., M.P.H., Immediate Past President, ASTDD. Appendix C lists the Evaluation Advisory Committee membership and evaluation staff. In February 2003, the Evaluation Advisory Committee and staff members were convened by ASTDD by telephone conference call to discuss the process for conducting the evaluation review, and to begin to develop goals for the evaluation.

*Questionnaire Content*

It was agreed that the evaluation would consist of a written questionnaire which was to be distributed primarily by e-mail to individuals representing key stakeholder organizations in the 17 states. The Evaluation Advisory Committee discussed evaluation goals, and added, eliminated and revised “hypotheses” that described possible processes and outcomes of the state summits. After the conference call, additional revisions to the possible hypotheses were suggested by the Committee and the hypotheses then were used to generate questionnaire questions. A questionnaire was drafted, and specific questions underwent multiple reviews and revisions by Committee members over the next several months.

As the questions for inclusion in the questionnaire were being refined to assure clarity and brevity and to reduce redundancy, it was decided to create two separate questionnaires; one questionnaire would contain “opinion questions” for response by all key stakeholders, while a second, longer questionnaire would contain both the “opinion questions” and “logistic questions” and would be provided only to certain individuals believed to be most knowledgeable about the logistics, organization, and administrative processes of the summits.

Questionnaires were developed as “form documents” using Microsoft Word, Version 2002©. Questions usually were constructed to allow the respondent to select a response from among a limited array of “multiple-choice” type answers, some in Likert Scale format in which choices from favorable to unfavorable were arranged on a scale. Many questions were accompanied by space for individualized, but limited respondent comment.

Once the questions were finalized, the questionnaires were “locked” and password protected to prevent further modification. As a pre-test of the questionnaire, several Committee members completed the penultimate draft of the questionnaires, and, subsequently, a few additional modifications were made.
Identification of respondents.

Following the Advisory Committee conference call, a primary “Summit Contact” was identified in each state from MCHB and ASTDD records. This person had formal responsibility for the receipt of the MCHB/ASTDD dental summit funds in the state, and was considered as the individual most closely involved in the planning and development of the state’s summit. As such, the Summit Contact was critical to the Committee’s effort to understand the dental summit process, and most likely would be the only person in the state who could be queried about the logistic, organizational, and administrative processes involved in summit planning, development and implementation.

The Summit Contact was contacted, advised about the evaluation project and requested to provide the names and contact information for between six and 12 additional individuals—known henceforth in this report as “Key Stakeholders,”—who participated in the state’s summit and were perceived by the Summit Contact as representing key oral health stakeholder organizations in the state. The Summit Contact was asked to include among those Key Stakeholders at least one individual representing the dental profession and one from the state’s Medicaid program. Other Key Stakeholders were identified at the discretion of the Summit Contact. Key Stakeholders, as well as the Summit Contacts, would be asked to provide their opinions regarding the results and impact of the state’s dental summit.

Issues Explored

Through the questionnaire, a wide range of issues about the structure, process and outcomes of the dental summits were to be explored. Table 1 summarizes questions posed to the Summit Contacts that address the logistics and organization of the dental summits, and comprise questions 1-26 of the Summit Contact’s Questionnaire. A copy of the questionnaire for Summit Contacts, including instructions to respondents, is available at Appendix D.

<table>
<thead>
<tr>
<th>Table 1. Questions About Logistics and Organization of the Dental Summits</th>
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</thead>
<tbody>
<tr>
<td>What was the summit’s duration?</td>
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<tr>
<td>Was administrative support available?</td>
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<tr>
<td>How many persons participated?</td>
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<tr>
<td>Was the application process burdensome?</td>
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<tr>
<td>Was satellite/videoconferencing available?</td>
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<tr>
<td>Who provided “in-kind” assistance?</td>
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<tr>
<td>Was a Head Start Forum held concurrently?</td>
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<tr>
<td>What were the planned summit goals?</td>
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<tr>
<td>What organizations provided funding?</td>
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<tr>
<td>How did states evaluate their summits?</td>
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<tr>
<td>What was the budget?</td>
</tr>
<tr>
<td>How were summit results disseminated?</td>
</tr>
<tr>
<td>What barriers had to be overcome before, during and after the summit?</td>
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<tr>
<td>Did the state participate in NGA Oral Health Policy Academies?</td>
</tr>
<tr>
<td>How were funds expended?</td>
</tr>
<tr>
<td>Was this the first state summit?</td>
</tr>
<tr>
<td>Was funding adequate?</td>
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<tr>
<td>What notable events catalyzed the summit?</td>
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<tr>
<td>How was background material developed?</td>
</tr>
<tr>
<td>Was assistance of federal and ASTDD staff helpful?</td>
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<tr>
<td>Who participated in pre-summit planning meetings?</td>
</tr>
<tr>
<td>What advice may be offered to future summit planners?</td>
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</tbody>
</table>
Table 2 lists questions designed to explore the opinions and ideas of both Summit Contacts (questions 27-59 of the Summit Contact questionnaire) and Key Stakeholders about the processes and outcomes of the dental summits in their respective states. The Key Stakeholder questionnaire, including instructions to respondents, is attached at Appendix E.

### Table 2. Questions About Opinions of Summit Outcomes and Processes

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
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<tbody>
<tr>
<td>Was the summit dependent upon one or two people or organizations?</td>
<td>Did it affect Medicaid/SCHIP policies and procedures?</td>
</tr>
<tr>
<td>Were all critical stakeholders included?</td>
<td>Did it affect health professional licensure, training, loan programs or education?</td>
</tr>
<tr>
<td>Were any stakeholders unfairly represented?</td>
<td>Did it affect community-based or school-based oral health programs?</td>
</tr>
<tr>
<td>Was there a balance of plenary and small group sessions?</td>
<td>Did it affect analysis or collection of oral health data or research?</td>
</tr>
<tr>
<td>Were summit facilitators helpful?</td>
<td>Did it expand oral health promotion, prevention or treatment programs?</td>
</tr>
<tr>
<td>Did the Summit fit into a logical sequence of events in the state?</td>
<td>Did it affect state oral health infrastructure or strategic plans?</td>
</tr>
<tr>
<td>Was it held at an appropriate date/time?</td>
<td>Did certain topics receive too much, too little of the correct amount of attention at the summit?</td>
</tr>
<tr>
<td>Did it affect coalition development?</td>
<td>What were the most positive outcomes?</td>
</tr>
<tr>
<td>Did it affect work groups or committee formation?</td>
<td>What were the biggest disappointments?</td>
</tr>
<tr>
<td>Did it affect application to NGA Academies?</td>
<td>How would you improve the summit?</td>
</tr>
<tr>
<td>Did it affect visibility of oral health among the public, policymakers, news media?</td>
<td>Was the summit useful in furthering the state’s oral health agenda?</td>
</tr>
<tr>
<td>Did it effect state legislation?</td>
<td>What is your organizational affiliation?</td>
</tr>
</tbody>
</table>

**Questionnaire Distribution.**

Electronic distribution of the questionnaires began on June 20, 2003. The questionnaires were attached to an e-mail individualized either for the Summit Contact or the Key Stakeholder. The e-mail was signed by the Chair, ASTDD Summit Evaluation Committee. It introduced the evaluation project, identified (by date and location) the specific state dental summit that was the subject of the questionnaire, contained a description of the evaluation project, a rationale for the individual’s selection as a participant in the evaluation, information about the confidentiality of the responses being solicited, and instructions about the timeline for completing and returning the questionnaire. (The questionnaire itself also included a two-page section of “Introduction and Instructions” reiterating why the individual was selected to participate as a respondent, describing the purpose of the questionnaire, and containing hints for working with the electronic questionnaire). E-mail addresses of all individuals who were to receive the questionnaires were obtained from the Summit Contacts. The e-mails were sent from the computer of the contractor, on behalf of the Summit Evaluation Committee Chair. Examples of the Summit Contact and Key Stakeholders e-mails used for the initial distribution of the questionnaire are located, respectively, at Appendix F and G.
E-mail recipients were requested to open and read the questionnaire attached to the e-mail, complete the responses electronically using the checkboxes and comment spaces provided, save the completed responses to a newly named document, and return the questionnaire to the contractor by July 11, 2003, either as an e-mail attachment or by FAX. A number of e-mails were returned to the contractor as “undeliverable” during the days immediately following their initial transmittal to respondents. Subsequently, alternate e-mail addresses or a valid U.S. Postal Service address were identified (for those few individuals with no e-mail address or who indicated they were having difficulty using the electronic questionnaire). The questionnaires were then resent to these respondents either electronically, or by post, with a self-addressed, stamped return envelop enclosed.

By June 27, 156 individuals had been sent questionnaires, including 17 Summit Contacts and 139 Key Stakeholders. In each state, the number of individuals sent the questionnaire ranged from 6-13, with a mean and median of 9. When completed questionnaires were returned by the respondent they were cursorily reviewed for completeness and obvious errors of commission or omission. If errors were noted, the respondent was contacted and requested to correct them or supply responses unintentionally omitted.

By July 16, a week after the original date for receipt of responses had passed (July 11), completed questionnaires had been received from 58 of the 156 individuals, for an initial response rate of 37 percent. Individuals who had not yet returned completed questionnaires were then sent a new e-mail (or received a telephone call, in cases where no e-mail address was available) encouraging completion of the questionnaire and providing a new response date of July 25. Subsequent to this contact, an additional 42 responses were received. On July 27, telephone calls were made to all those from whom a response still had not been received. Additional telephone calls were made as needed until data analysis began on August 4, and inclusion of any data from additional questionnaires was halted. The final response rate is noted in the Results section.

Data tabulation and analysis

When questionnaires were received, each was identified by an individualized code that could be used to identify the respondent, if necessary, but otherwise, the questionnaires did not identify the respondent. Respondent’s answers to each question were recorded on collection forms and tallied on Excel or other spreadsheets.

“Logistic” Data
Responses from Summit Contacts (N=17) to “logistic” questions that only they received were recorded separately (i.e., questions 1-28 in Part A of the Summit Contact’s questionnaire). These logistic data are reported by number and percent of total responses to each question. All percentages in this report are rounded to the nearest whole number, and may not total 100% due to rounding error.

“Opinion” Data
A more difficult analysis challenge was presented by the “Opinion” questions (i.e., those contained in the Key Stakeholder Questionnaire, and Part B of the Summit Contact
Questionnaire) than for the “logistic” questions. Opinion data could be recorded analyzed “by respondents” or “by states.” Both options presented concerns.

In considering analysis “by respondents,” it was recognized, a priori, that outcomes of each state Summit would be distinct for that state and summit. Each state differs from every other state with regard to its oral health history and infrastructure, level of existing collaborations, array of summit participants, philosophical approaches to dental care delivery, summit atmosphere and logistics, and a myriad of other underlying factors. The opinion of an individual in one state about the outcome/results of a specific state summit may reflect the combination of underlying factors, and may not be compared easily with the opinion of another individual from a different state having a different set of experiences. This study was unable to control for these state-by-state variables.

In considering analysis “by state,” it was known that the number of stakeholders sent questionnaires in a particular state was small, and varied from 6 to 13 individuals. The small number of those individuals who would respondend in each state could easily result in opinion “ties” and split opinions. A system for recording opinions within each state had to be constructed.

For these reasons, it was decided to analyze the opinion data collected from the questionnaires in two ways:

1. The primary method for presenting and analyzing the opinion data recognizes the discrete nature of each summit and compiles state-based data based on achievement of a “state consensus.” For any given question, a “state consensus” is defined as having been achieved when more than 50 percent of the respondents in the state make the same response on a particular question. For example, if 5 of 8 (but not 4 of 8) respondents in a state “agreed strongly” with the statement that “summit facilitators were helpful in keeping the summit discussions on track,” then that state was reported as having achieved a consensus (“agreed strongly”) about this statement. In some cases, results also are described by combining categories such as “agreed strongly” and “agreed” into a single category that does not focus on the degree of agreement (or disagreement), but rather on the direction of the agreement.

2. For completeness and to observe trends—even if the trends did not reach the level of state consensus—the combined responses of all respondents to each opinion question also are presented. The individual respondent’s state is ignored in this analysis.
III. Results

A. Logistic Questions

All 17 of the individuals identified in each state as the Summit Contact returned a completed questionnaire for a response rate of 100 percent. These individuals identified themselves as being affiliated with the following organizations:

- State, local or regional public health agency: 10
- Rural, Minority or Primary Health Care Agency/association: 2
- Advocacy/consumer group: 1
- Dental practice/Dental association: 1
- Foundation: 1
- State Medicaid/SCHIP agency: 1
- Other (Workforce agency): 1

Summit Contacts’ responses to each of the logistic, organization and process questions posed (in Section A of the Summit Contacts’ Questionnaire, Appendix D) are described below:

Q1. What was the duration of the oral health summit?
   Eleven of the 17 Summit Contacts (65%) reported that their summits lasted one full day. Four state summits (36%) were 1.5 days in length, and two were completed over two continuous days.

Q2. Were summit participants also able to participate at satellite/videoconference locations and/or by teleconference?
   Only one of the 17 state Contacts reported that satellite/videoconferencing was used. Seven Contacts would not recommend that future summit planners use such alternative participation methods, while five viewed such methods positively, and five respondents answered “don’t know.”

Q3. How many individuals attended any part of the summit (including those participating by video- or teleconferencing)?
   Eight Contacts (47 percent) reported that summit attendance was 100-149 individuals, five states had 50-99 participants, two had 150-199, one had 200-249, and one had 250-299 participants.

Q4. Was the summit held in conjunction with, or as part of an ASTDD-funded “Head Start Oral Health Forum”?
   Only one of 17 states reported that its summit was affiliated with a Head Start Oral Health Forum.
Q5. What organizations and agencies provided funds to conduct the summit (in addition to fund provided through the MCHB/ASTDD)?

State Contacts reported that a mean of 3.5 other organizations/agencies also provided summit funding, with a range of 0-8 organizations per state. Many organizations were listed as sponsors, with the following most-frequently cited entities listed in order by number of citations; entities with only one citation are not listed:

State departments of public health/welfare (11)
Dental health insurance corporations/dental service foundations (9)
State dental associations (8)
National foundations/grant-makers (6)
State associations of primary/rural health care (5)
National dental product corporations (3)
State dental hygiene associations (3)
Universities/dental schools (2)
State oral health coalitions (2)
State community health associations (2)
Other units (not MCHB) of the Health Resources and Services Administration (2)

Q6. What was the total summit budget, considering all funding sources?

The average dental summit budget was $16,299, and the median was $10,000, with a low of $8,000 and a high of $54,598.

Q7. What percent of the total summit budget was expended in each of the following categories?

The 17 Summit Contacts provided a breakdown of the percent of their total dental summit budget expended in each of nine specified budget categories. The mean percentage expenditure for each of the budget categories is displayed in order, as follows:

a. Conference facilitators 23%
b. Food/Refreshments 18%
c. Logistics (supplies, materials, printing, postage, equipment) 14%
d. Summit report (writing, duplicating, distributing) 11%
e. Meeting space 11%
f. Travel/Lodging/Honoraria (speakers) 9%
g. Event planners and administrative support 8%
h. Other unspecified activities related to the summit 6%
i. Travel/Lodging (participants) 1%
Q8. In addition to MCHB/ASTDD, what other organizations provided “in-kind” assistance (e.g., supplies, materials, meeting rooms, staff, etc.) for the summit, and what was the type of assistance provided?

All but one Contact said that in-kind assistance was provided, and for those 16 states, an average of 2.4 organizations provided assistance. As in the case of direct funding support, many organizations were listed as providing in-kind assistance. The organizations/entities most frequently cited as providing in-kind assistance are listed in order by the number of citations; entities with only one citation are not listed:

a. State departments of public health/welfare (8)
b. Universities/dental schools (4)
c. State dental associations (4)
d. Dental health insurance corporations/dental service foundations (3)
e. Advocacy groups (3)
f. State associations of primary/rural health care (3)
g. Federal agencies (2)

Contacts also described the types of in-kind assistance provided. This type of assistance is categorized below and listed in order by the number of states citing the type of assistance received:

a. Logistic (supplies, materials, printing, postage, equipment) (9)
b. Planning assistance (unspecified) (7)
c. Travel/lodging/honoraria (speakers) (6)
d. Staff (unspecified) (4)
e. Meeting space (4)
f. Food/Refreshments (3)
g. Advertising/promotion (3)
h. Event planners and administrative support (2)
i. Conference facilitators (1)
j. Mementos for participants (1)

Q9. Were funds sufficient to include everything that you wanted to include in the summit?

All 17 Contacts reported that they had sufficient funds.

Q10. Were pre-summit planning meetings conducted, and, if so, which types of agencies/organizations participated in the planning meetings?

All 17 Summit Contacts reported that pre-summit planning meetings were conducted. States reported including an average of about eight organizations in their planning groups, with a range of 1-12 entities participating. The following agencies/organizations were reported as participating in the meetings. Results are listed in order by of the number of states citing participation by those organizations in pre-summit planning.

a. State public health agency 16
b. State dental association 15
c. State Medicaid Agency 14
d. State dental hygienists’ association 12
e. State primary care agency/association 11
f. Regional Office of HRSA or CMS 10
g. Non-profit organizations 10
h. Local/regional government agency(s) 8
i. Health professions Schools 8
j. State rural health agency/association 6
k. Head Start affiliated entities 6
l. Foundations 4
m. Industry/business groups 4
n. Governor’s Office 3
o. Educational institutions (K-12) 3
p. Faith-based organizations 3
q. Other entities
(“Other” entities mentioned included: a coalition, health insurance company, state board of dentistry, county level Medicaid agency, State SCHIP agency, and minority health commission, as well as legislators and other state health agencies).

Q11. How were background/source information and data for the summit obtained?
Sixteen of 17 state Contacts reported collecting written documents and materials prior to the summit. Eight states indicated that they surveyed prospective participants to obtain source information.

Q12. Were any of the following used in your summit: Event planners/administrative support; Unpaid and/or paid facilitators?
Ten of the 17 Contacts (59%) used event planners/administrative support. Nine states used unpaid facilitators, eight states used paid facilitators, and one of these states used both types of facilitators. The same out-of-state firm provided paid facilitators in five states; other facilitators were locally based companies (one of the states used a combination of paid out-of-state and paid local facilitators).

Q13. How would you describe the degree of difficulty or burden involved in the application process for obtaining summit funding from ASTDD/MCHB?
Fifteen of the 17 state Contacts said the application process was “not very difficult;” however, two Contacts indicated that the application process was “moderately difficult.”

Q14. Did you encounter any major financial, political or other barriers that had to be overcome before the summit could be conducted?
Ten of the 17 Contacts said they encountered problems before the summit began. Problems were noted in three areas: summit personnel, participation of state government, and relations with dental health professional associations.
Comments of respondents illustrate some of these problems:

- Coordination of volunteers presented a problem, but proved easy to overcome because of excitement about the project.
- Speakers cancelled at the last minute, causing the summit date to be changed.
- A key individual involved in planning and administrative support resigned shortly before the summit.
- Several months were wasted trying to get the Governor’s office to lend its name to the summit.
- The state’s budget crisis prevented participation by the Governor’s office.
- Getting buy-in from the Governor’s office and the Director of Department of Public Health took time.
- State agencies sponsoring a summit have contracting regulations that make it difficult to pay for speaker expenses and they prohibit use of any public funds for purchase of any food. Time had to be spent soliciting others to cover these expenses. The National Governors Association paid for speakers’ travel.
- There was some initial resistance from the state dental association, but once engaged, our having their involvement, support and participation was key to the success of the summit.
- There was friction between dentists and dental hygienists that caused two separate meetings to be planned. Shortly before the scheduled meetings, the problem was resolved through discussions.
- Friction between organized dentistry and dental hygiene limited participation of private dentists.

Q15. Did you encounter any problems during the summit that might be avoided by other summit planners?

Only three of the 17 Contacts noted any problems encountered during the summit.

Q16. Did you encounter any problems after the conclusion of the summit that might be avoided?

Five of the 17 Contacts listed problems that arose after the summit ended.

Q17. Were federal Regional Office staff members (i.e., staff of either HRSA or CMS) helpful in planning or implementing the summit?

Of the 17 state Contacts, 12 said the federal Regional Office staff were “very helpful,” four said they were “somewhat helpful” and one said “not applicable.” Comments generally were complimentary of individual Regional Office staff members or described their involvement in planning and/or participating in the summit.

Q18. How helpful was the technical guidance provided by ASTDD contacts in planning for or implementing the summit?

Of the 17 state contacts, seven (48%) indicated that ASTDD technical assistance was “very helpful,” three said “somewhat helpful,” two said “not helpful,” and five responded “not applicable.”
Q19. What method(s) of evaluation did you use for the summit?
Of 16 Contacts responding, 15 said “participant evaluation forms” were used, three said “post-conference surveys” were used, and nine used “follow-up meetings.”

Q20. How were summit results (e.g., written conference proceedings or summaries) disseminated in your state?
Sixteen Contacts responded to this question:
- 12 discussed results at subsequent meetings
- 12 posted results on the Internet or sent them by e-mail
- 11 disseminated results by mail
- 3 used press releases or a press conference
- 3 utilized radio, television, newspapers and other media

Q21. Did the state submit an application to participate in a NGA Oral Health Policy Academy? If so, did the state actually attend, and did the summit occur before or after the Academy?
Sixteen Contacts answered this question. Nine states (or 56% of those responding) made application to attend the NGA Academies; seven actually attended, with five of those attending before, and two attending after the summit.

Q22. Was this the first statewide oral health summit conducted in the state?
Thirteen of 17 Contacts said this was the first summit.

Q23. Were there any notable events (besides participation in a NGA Oral Health Policy Academy) that preceded the Summit and prepared the way, or served as a catalyst for this summit?
Fourteen of 17 Contacts said that there were events that facilitated the summit. Several such events were cited by individual states and are included (in no priority order) in the paraphrased statements that follow:
- Conduct by ASTDD of an on-site oral health review in one state, and in another, conduct of an oral health assessment conducted by the state primary care association.
- Establishment and/or on-going activities of an oral health coalition (three states).
- Beginning of a statewide oral health initiative (two states).
- Convening of a task force on oral health that produced recommendations.
- Receipt of a grant from the Robert Wood Johnson Foundation.
- The Surgeon General’s report on oral health (two states, one having previously conducted a conference on the report);
- Appointment of a state dental director in one state and, in another, initiation of a dental public health activity in state government after a long absence.
- A surveillance summit held in close proximity to the dental summit.
- Interest of individual legislators and policy makers.
- Receipt of a letter from CMS to the state Medicaid program about dental access and critical access issues catching the attention of the Governor.
• Not going to the NGA Academy generated momentum and buy-in among key stakeholders in one state; in another state, momentum was created by participation in a Milbank Memorial Fund/Reforming States Group oral health meeting, facilitated by a state legislator.
• Mentoring by the HRSA Regional Office staff who strongly advised the state to hold a summit.
• A meeting hosted by HRSA/CMS staff to discuss children’s oral health concerns resulted in oral health becoming a top priority issue.
• Identification of oral health as the number one unmet health issues in the state.
• Fee improvements in the state’s Medicaid program.

Q24. What were the planned goals of the summit?
   From a supplied list, 17 Contacts identified the goals of their state summits. In all but one state (which listed as its only goal “production of a document with specific recommendations for improving services to children”), state Contacts identified multiple summit goals which are listed in order of the number of states citing these goals for their summits:
   a. Raising awareness regarding oral health issues 16
   b. Coalition/partnership development 16
   c. Access to dental services (in general) 16
   d. Information sharing 15
   e. Access to Medicaid/SCHIP dental services 13
   f. Supply or distribution of the oral health workforce 12
   g. Prevention programs (topical fluorides, sealants) 12
   h. Safety-net dental services 11
   i. State or regional level activities 10
   j. Oral health surveillance and data collection 10
   k. Community level activities 8
   l. Head Start Program access to dental services 7
   m. Water fluoridation 7
   n. Other goals 4

Q25. What advice would you give to future summit planners regarding what they should do in planning or conducting a summit?
   Suggestions for future summit planners as to “what they should do” are provided at Table 3.
Table 3. What Future Summit Planners Should Do

- “Start as early as possible to pick a date that is convenient for the greatest number of potential participants. Include key stakeholders at the planning meetings.”
- “Start early, invite everyone from a variety of organizations including some that do not have an oral health agenda, get everyone involved. Give everyone a job. Make listening a good part of the agenda instead of lecturing, and maintain momentum by follow-up meetings via phone or teleconferencing.”
- “Allow at least six months for strategic planning and consensus building prior to establishing a meeting date.”
- “Have a participatory, inclusive planning process.”
- “(Seek the) maximum participation of partners and coalition members.”
- “Have representatives from all key stakeholder groups on the planning committee. Also, assure that facilitators understand their role and are impartial.”
- “Get dental professional organizations engaged early on in the planning stage. Host on a Friday (dentists’ usual day off in the state). Engage, inform and invite state legislators/policymakers and have a plan to keep them involved. Invite a wide spectrum of stakeholders, and offer various ways to participate (video, pre-summit calls or written correspondence). Offer refreshment breaks and have lunch on site for networking. Inform (the) media in advance, hire a professional facilitator who is familiar with the issues and can temper ‘turf issues’ and stay on track.”
- “Obtain help for a professional facilitator in planning your first summit.”
- “Convene a Steering Committee; hire a facilitator with expertise in community engagement and planning; use the forum to get buy-in to a collaboratively developed strategic plan.”
- “Make sure you plan enough time for work groups; one day is really pushing it.”
- “Get dynamic speakers (academics and dentists can be a little boring).”
- “Employ a professional facilitator, post all information relative to the summit on your institution’s web site, and be selective on who you invite to participate in (an) effort to meet the objectives of your summit.”
- “(Depending upon the goals of the summit), limit the summit agenda to one or two issues associated with a state oral health plan.”
- “Have as diverse a planning group as is possible. Do not rely on HRSA funds as (the) sole funding source. Use a paid facilitator.”
- “Encourage more legislators and policy makers to attend. Perhaps create incentives, like a speaking opportunity as part of the program.”
- “Make sure that you have state/local legislators who attend the conference, even if they have to ask one to give a short introduction.”
- “Depending upon the goals of the summit, planners should involve legislators. After completing the summit notes/proceedings, continue to have the core planning group meet to help carry out (the) ideas & plan generated at the meeting. (If you) don’t have a dental director in your state, the statewide planning has to occur through organizations/volunteers.”
- “When planning, make sure to survey potential summit attendees to find out the types of sessions they are interested in and the format of the meeting. Also, plan for a post-summit evaluation or mail survey.”
- “Seek funding for ongoing administration of a statewide Oral Health Coalition with full time staff so that the Summit could extend from the activities of the Coalition more effectively.”
Q26. What advice would you provide to future summit planners about what they should not do or not include in a summit?

Summit Contacts’ suggestions for future summit planners regarding what they should not do are provided in Table 4.

<table>
<thead>
<tr>
<th>Table 4. What Future Summit Planners Should Not Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Do not use the summit to spend a lot of time focusing on national oral health issues. Summarize those (issues) and spend the majority of the time on state specific issues.”</td>
</tr>
<tr>
<td>• “Don’t have too much time dedicated to ‘keynote’ presentations. Build in time for small group interactions (and) work planning.”</td>
</tr>
<tr>
<td>• “Don’t split the invitees into separate groups (based on profession) as it (won’t) allow for open and enlightened dialogue among participants (and so they can) hear different perspective on the issues. Don’t leave the meeting without a list of participants willing to work on the issues and possibly form a coalition.”</td>
</tr>
<tr>
<td>• “Do not have just lectures, make folks get involved, and listen for even what might seem to be silly solutions.”</td>
</tr>
<tr>
<td>• “Do not allow one interest group to dominate or derail the summit. Make sure that all bases are covered BEFORE the summit—you do not want surprises on summit day.”</td>
</tr>
<tr>
<td>• “Don’t try to do it all on your own.”</td>
</tr>
</tbody>
</table>

B. Opinion Questions

Response Rate

In addition to the 17 Summit Contacts who responded, 123 Key Stakeholders completed questionnaire—or a total of 140 of the 156 individuals sent questionnaires—for a response rate of just under 90 percent for the project overall. (One individual was named as a key stakeholder by two state Summit Contacts and completed a separate questionnaire for each state). In addition to those who responded, four Key Stakeholders formally declined to complete a questionnaire, citing their inability to remember details of the summit, or indicating that they did not attend the summit, or that they only participated for a very brief time. The response rate varied from state to state, ranging from 66-100 percent. Five states had response rates of 100%, five had rates of 90% or more, four had rates of 80% or more, two had rates of 77%, and one state had a 66 percent response rate. Each of the 140 respondents answered all or most of the opinion questions.

Respondent Affiliation

All respondents were asked to select from a list, the group, organization, or entity with which they perceived themselves to be most closely affiliated. The affiliation categories of the 140 respondents are shown in Table 5, in order by the number of respondents in that category.
Table 5. Respondent Affiliation (Summit Contact Questionnaire, Question 60, and Key Stakeholder Questionnaire, Question 34).

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>State, local or regional Public Health agency</td>
<td>33</td>
</tr>
<tr>
<td>Dental practice/dental association</td>
<td>22</td>
</tr>
<tr>
<td>Health professions education</td>
<td>13</td>
</tr>
<tr>
<td>State Medicaid agency/State SCHIP agency</td>
<td>12</td>
</tr>
<tr>
<td>Advocacy/consumers group</td>
<td>11</td>
</tr>
<tr>
<td>Community-based clinic</td>
<td>11</td>
</tr>
<tr>
<td>Dental hygiene practice/hygiene association</td>
<td>8</td>
</tr>
<tr>
<td>Rural, Minority or Primary Health Care agency/association</td>
<td>8</td>
</tr>
<tr>
<td>Foundation</td>
<td>7</td>
</tr>
<tr>
<td>Head Start, preschool or daycare programs</td>
<td>3</td>
</tr>
<tr>
<td>Legislator</td>
<td>2</td>
</tr>
<tr>
<td>Pre-health professions education (e.g., K-12, college)</td>
<td>1</td>
</tr>
<tr>
<td>Industry/business</td>
<td>1</td>
</tr>
<tr>
<td>Health professions (Physician, Nurse, etc.)</td>
<td>1</td>
</tr>
<tr>
<td>Faith-based organization</td>
<td>0</td>
</tr>
<tr>
<td>Governor’s Office</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>140</td>
</tr>
</tbody>
</table>

Six individuals indicated they were in “other” affiliation categories, including student, dental health coalition member, workforce agency, Indian health agency, and school-based health agency. In several instances, the “other” affiliation category specified by the respondent was revised, if it was determined from the response provided or from other information, that the respondent belonged more appropriately in one of the existing categories.

Respondent Comments on Opinion Questions

For most questions in the opinion section, opportunity was provided for respondents to write comments clarifying or expanding upon their responses. Respondent comments on the opinion questions were substantial and are included in Appendix H. The length of respondents’ comments were limited by the physical size of the electronic comment box imbedded in the questionnaire which allowed no more than 7-9 lines of prose. Only selected comments have been captured in this document. Comments were transcribed directly whenever possible, although no quotation marks are used in an effort to conserve space. Lengthy comments were edited, where possible, for brevity. Comments were not included if they duplicated other comments, were difficult to understand, or did not address the question being considered. When part of a comment was judged to be valuable for inclusion, but it lost clarity when separated from the unused portion, it was paraphrased, revised or otherwise altered so that the original, contextual meaning would be present.
Efforts were made to delete or generalize obvious references to specific entities, persons, or locations which might easily identify the state or the respondents.

**Opinion Questions 1-7.**
The first seven opinion questions (i.e., Key Stakeholder Questionnaire, Opinion Questions 1-7, and Summit Contact Questionnaire, Opinion Questions 27-33, as renumbered for this analysis), require respondents to agree or disagree with statements about: (1) those responsible for the summit, (2) the appropriate inclusion of critical stakeholders, (3) the correct balance of viewpoints, (4) the appropriate balance of plenary and small group sessions, (5) the utility of facilitators, (6) whether having the summit was the correct “next step,” given the events already occurring in the state, and (7) if the time of day and week of the summit were appropriate.

Respondents’ replies to Opinion Questions 1-7 are displayed in Table 6. This Table shows the consensus in each state when respondents were asked to indicate whether they agreed or disagreed with the seven statements (with “consensus” defined as more than 50% of the individuals in the state responding in the same manner). With the exception of four instances in which consensus was not reached on a particular question (three states did not reach consensus on Opinion Question 3, and one state did not reach it on Opinion Question 5), states achieved consensus for each statement, either in degree (i.e., when considering the choices “strongly agree, agree, disagree, or disagree strongly” independently of each other) or in direction (i.e., when considering together similar choices, such as “strongly agree/agree” versus “disagree/strongly disagree”). In other words, there was substantial agreement in the states that (1) the summit would not have occurred without the work of one or two individuals, (2) all critical stakeholder organizations were included at the summit, (3) there was no unfair representation nor imbalance of views, (4) plenary and small group discussion at the summit were in balance (4) summit facilitators were helpful, (6) the summit was an appropriate next step in the sequence of events in the state, and (7) the summit was held at an appropriate time and day of the week.
Table 6. Questions 1-7. Respondents’ Consensus by State

Key:
Consensus Achieved Independently on Agree Strongly (AS); Agree (A); Disagree (D); or Disagree Strongly (DS), Don’t Know/Not Applicable (DK), No Consensus (NC)
Consensus Achieved by Combining “Agree and Agree Strongly” (A/AS)
Consensus Achieved by Combining “Disagree and Disagree Strongly” (D/DS)

<table>
<thead>
<tr>
<th>States</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
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<tbody>
<tr>
<td>1</td>
<td>AS</td>
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<td>D/DS</td>
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<td>A/AS</td>
<td>AS</td>
<td>D</td>
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<td>D/DS</td>
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<td>A</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
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<td>AS</td>
<td>A</td>
<td>NC</td>
<td>A</td>
<td>A</td>
<td>A/AS</td>
<td>D</td>
</tr>
<tr>
<td>4</td>
<td>AS</td>
<td>AS</td>
<td>D/DS</td>
<td>D/DS</td>
<td>DK</td>
<td>NC</td>
<td>AS</td>
</tr>
<tr>
<td>5</td>
<td>A/AS</td>
<td>A/AS</td>
<td>D</td>
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<td>A</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>6</td>
<td>AS</td>
<td>A/AS</td>
<td>D</td>
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<td>A/AS</td>
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<tr>
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<td>A/AS</td>
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<td>10</td>
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<td>A/AS</td>
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<td>A/AS</td>
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<tr>
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<td>AS</td>
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<td>D</td>
<td>A</td>
<td>A</td>
<td>A/AS</td>
<td>DS</td>
</tr>
</tbody>
</table>

Respondents’ answers also are displayed without regard to the respondent’s state, as shown in Table 7. For most statements, the vast majority of respondents were in agreement in direction, if not in degree. The greatest “disagreement” occurred in response to the statement (Opinion Question 3) that “critical stakeholder organizations were unfairly represented (having too few or too many summit participants);” more than 20% of respondents said there was unfair representation among stakeholder groups. Twelve percent of respondents also disagreed with the statement (Opinion Question 2), that all critical stakeholder organizations were included in the summits.
Table 7. Questions 1-7. Respondents’ Answers (N=140)

<table>
<thead>
<tr>
<th>Opinion Question</th>
<th>Agree/Agree Strongly</th>
<th>Disagree/Disagree Strongly</th>
<th>Don’t Know</th>
<th>Missing/Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
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</tr>
<tr>
<td>1</td>
<td>127 (91)</td>
<td>12 (9)</td>
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<tr>
<td>2</td>
<td>120 (86)</td>
<td>17 (12)</td>
<td>3</td>
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<td>3</td>
<td>31 (23)</td>
<td>97 (69)</td>
<td>11 (8)</td>
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<tr>
<td>4</td>
<td>128 (91)</td>
<td>6 (9)</td>
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<td>5</td>
<td>132 (94)</td>
<td>4 (3)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>128 (91)</td>
<td>9 (6)</td>
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</tr>
<tr>
<td>7</td>
<td>8 (6)</td>
<td>128 (91)</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Opinion Questions 8-27

Opinion Questions 8-27 are directed at determining if respondents attributed to their state summits any of 19 oral health outcomes identified in the questionnaire. Table 8 displays whether or not respondents in each state achieved a consensus (more than 50% agreement) that the summit had “no” influence, or a “weak,” or “strong” influence on each of the outcomes. The greatest consensus was achieved for Opinion Question 8, in which 14 states agreed that their summits had strong influence on coalition development and/or broadening of stakeholder partnerships. Twelve states reached consensus that the summits heightened visibility of oral health among policymakers (Opinion Question 12), and 10 states agreed that the summits stimulated the development of oral health committees, work groups and task forces (Opinion Question 9). Seven states said that the summits had either a strong or weak impact on the development of state legislation regarding oral health. Six states reported that the summits had a weak influence on heightening visibility of oral health issues among the media, although one state indicated there was no influence. Respondents in 10 states agreed that they did not know if the summit influenced the state’s application to the NGA Oral Health Policy Academies. Little consensus was noted for the other Questions/outcomes in this group.

When the influence of the summits on outcomes in each state was observed, substantial state-by-state variation was found (Table 8). In the state with the most agreement (State number 1), a majority of respondents agreed that the summit strongly influenced 12 outcomes; however, in another state (State number 13), there was only agreement that the summit had no influence on five outcomes.
To examine if there were any trends about the influence of the summits on outcomes that might have been masked by the consensus methodology, individual opinions of all respondents were tabulated without regard to the respondent’s specific state. These data are shown in Table 9. A substantial majority of respondents, 73, 60 and 58 percent respectively, indicated that they believed that the summits had a strong influence on establishment of oral health coalitions, expansion of committees, and heightened visibility among policymakers. Fifty-two percent of respondents also believed that the summits had a strong influence on the development of state oral health strategic or action plans. A plurality of respondents said that the summits weakly influenced achievement of heightened awareness of oral health issues among the media; lesser pluralities (but above 33%) also were found for a number of other outcomes, i.e., visibility among the public (strong), development of state legislation (weak), creation/expansion of community-based clinical programs (strong), creation/expansion of school-based programs (strong), use of existing data (strong) and expansion of oral health prevention programs (strong).

On the other end of the influence spectrum, about a quarter or more of the respondents thought that the summit did not influence changes in Medicaid policies or procedures, oral health professional licensure, training and education, loan repayment or scholarship.

<table>
<thead>
<tr>
<th>QUESTIONS/OUTCOMES</th>
<th>STATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Coalitions</td>
<td>S S S S S S S S S S S S</td>
</tr>
<tr>
<td>9. Committees</td>
<td>S S S S S S S S S S S</td>
</tr>
<tr>
<td>10. NGA</td>
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</tr>
<tr>
<td>11. Public</td>
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</tr>
<tr>
<td>12. Policymakers</td>
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</tr>
<tr>
<td>13. Legislation</td>
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<tr>
<td>14. Media</td>
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<tr>
<td>15. Medicaid</td>
<td>S N S</td>
</tr>
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<td>16. Licensure</td>
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<td>17. Education</td>
<td>S S N</td>
</tr>
<tr>
<td>18. Loan Repay</td>
<td>S N S</td>
</tr>
<tr>
<td>20. School-based</td>
<td>S S S S N N N</td>
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<tr>
<td>21. Existing Data</td>
<td>S S S S S 6</td>
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<tr>
<td>22. New Data</td>
<td>S D S D S D D</td>
</tr>
<tr>
<td>23. He Promotion</td>
<td>S D S</td>
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<td>24. Dis. Prevention</td>
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</tr>
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<td>25. Treatment</td>
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</tr>
<tr>
<td>26. Infrastructure</td>
<td>D D S N N N</td>
</tr>
<tr>
<td>27. State Plan</td>
<td>S S S S S S S S</td>
</tr>
</tbody>
</table>

To examine if there were any trends about the influence of the summits on outcomes that might have been masked by the consensus methodology, individual opinions of all respondents were tabulated without regard to the respondent’s specific state. These data are shown in Table 9. A substantial majority of respondents, 73, 60 and 58 percent respectively, indicated that they believed that the summits had a strong influence on establishment of oral health coalitions, expansion of committees, and heightened visibility among policymakers. Fifty-two percent of respondents also believed that the summits had a strong influence on the development of state oral health strategic or action plans.

A plurality of respondents said that the summits weakly influenced achievement of heightened awareness of oral health issues among the media; lesser pluralities (but above 33%) also were found for a number of other outcomes, i.e., visibility among the public (strong), development of state legislation (weak), creation/expansion of community-based clinical programs (strong), creation/expansion of school-based programs (strong), use of existing data (strong) and expansion of oral health prevention programs (strong).

On the other end of the influence spectrum, about a quarter or more of the respondents thought that the summit did not influence changes in Medicaid policies or procedures, oral health professional licensure, training and education, loan repayment or scholarship.
programs, or the state government’s oral health program infrastructure. A strong majority of respondents (74%) said either that the summits had no influence, or they didn’t know about its influence on the state’s application to an NGA oral health policy academy.

Table 9. Questions 8-27. Respondent’s Answers (N = 140)

<table>
<thead>
<tr>
<th>QUESTIONS/ (OUTCOMES)</th>
<th>No Influence</th>
<th>Weak Influence</th>
<th>Strong Influence</th>
<th>Don’t Know</th>
<th>Missing/ Error</th>
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<tr>
<td>8. Coalitions</td>
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<td>18 (13)</td>
<td>102 (73)</td>
<td>13 (9)</td>
<td>2</td>
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<tr>
<td>9. Committees</td>
<td>5 (4)</td>
<td>21 (25)</td>
<td>84 (60)</td>
<td>27 (19)</td>
<td>3</td>
</tr>
<tr>
<td>10. NGA</td>
<td>23 (16)</td>
<td>7 (5)</td>
<td>25 (18)</td>
<td>81 (58)</td>
<td>4</td>
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<tr>
<td>11. Public</td>
<td>12 (9)</td>
<td>42 (30)</td>
<td>56 (40)</td>
<td>22 (16)</td>
<td>8 (6)</td>
</tr>
<tr>
<td>12. Policymakers</td>
<td>8 (6)</td>
<td>33 (34)</td>
<td>81 (58)</td>
<td>14 (10)</td>
<td>4</td>
</tr>
<tr>
<td>13. Legislation</td>
<td>25 (18)</td>
<td>55 (39)</td>
<td>45 (32)</td>
<td>2 (1)</td>
<td>13 (9)</td>
</tr>
<tr>
<td>14. Media</td>
<td>21 (15)</td>
<td>62 (44)</td>
<td>31 (22)</td>
<td>23 (16)</td>
<td>3</td>
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<td>15. Medicaid</td>
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<td>34 (24)</td>
<td>47 (33)</td>
<td>22 (16)</td>
<td>3</td>
</tr>
<tr>
<td>16. Licensure</td>
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<td>20 (4)</td>
<td>34 (24)</td>
<td>36 (26)</td>
<td>0</td>
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<td>17. Education</td>
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<td>24 (17)</td>
<td>37 (26)</td>
<td>38 (27)</td>
<td>2</td>
</tr>
<tr>
<td>18. Loan Repay</td>
<td>38 (27)</td>
<td>30 (21)</td>
<td>32 (23)</td>
<td>40 (29)</td>
<td>0</td>
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<tr>
<td>19. Comm. Clinical</td>
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<td>31 (22)</td>
<td>49 (35)</td>
<td>43 (31)</td>
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<tr>
<td>20. School-based</td>
<td>31 (22)</td>
<td>22 (16)</td>
<td>48 (34)</td>
<td>37 (26)</td>
<td>2</td>
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<tr>
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<td>57 (41)</td>
<td>46 (33)</td>
<td>0</td>
</tr>
<tr>
<td>22. New Data</td>
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<td>23 (16)</td>
<td>42 (30)</td>
<td>58 (41)</td>
<td>2</td>
</tr>
<tr>
<td>23. He Promotion</td>
<td>19 (14)</td>
<td>34 (24)</td>
<td>42 (30)</td>
<td>44 (31)</td>
<td>1</td>
</tr>
<tr>
<td>24. Dis. Prevention</td>
<td>17 (12)</td>
<td>31 (22)</td>
<td>53 (38)</td>
<td>38 (27)</td>
<td>1</td>
</tr>
<tr>
<td>25. Treatment</td>
<td>20 (4)</td>
<td>37 (26)</td>
<td>34 (24)</td>
<td>41 (29)</td>
<td>8 (6)</td>
</tr>
<tr>
<td>26. Infrastructure</td>
<td>36 (26)</td>
<td>24 (27)</td>
<td>31 (22)</td>
<td>47 (34)</td>
<td>2</td>
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<td>27. State Plan</td>
<td>21 (15)</td>
<td>20 (4)</td>
<td>73 (52)</td>
<td>23 (16)</td>
<td>3</td>
</tr>
</tbody>
</table>

Opinion Question 28, a.-i.

The objective of Opinion Question 28, which had nine subparts (questions a.-i.), was to determine if respondents thought topics that potentially could have been considered for discussion at the summit actually received too little, too much, or the correct amount of attention, or were not discussed at all. State consensus data for this question is displayed in Table 10. A consensus (more than 50%) of the state respondents in all states agreed that there was the correct amount of discussion about “access to services.” Slightly fewer states achieved consensus for the topics of “advocacy,” “workforce,” and “oral health promotion,” for which 16, 15, and 15 states, respectively, agreed that the amount of attention paid to the topic was correct. Fewer states agreed that the topics of “research” and “legislation” had the correct amount of attention paid, with several states having a majority of its respondents believing that there was too little discussion or no discussion at all of these two issues.
Table 10. Question 28, a.-i. State Respondent Consensus Data

“Please indicate if the following summit topics/issues received too little or too much attention, or were not discussed at all.”

Key: Too Much (M); Correct Amount (C); Too Little (L); Not Discussed (D)

<table>
<thead>
<tr>
<th>QUESTION/ISSUE</th>
<th>STATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Workforce</td>
<td>C C C C C C C C C C C C</td>
</tr>
<tr>
<td>b. Infrastructure</td>
<td>C C C C C C L C C C C</td>
</tr>
<tr>
<td>c. Financing</td>
<td>C C C C C C C L C C C</td>
</tr>
<tr>
<td>d. He. Promotion</td>
<td>C C C C C C C C L C C C</td>
</tr>
<tr>
<td>e. Surveillance</td>
<td>C C C C C C C C C C</td>
</tr>
<tr>
<td>f. Research</td>
<td>C L C L D D D C</td>
</tr>
<tr>
<td>g. Access to service</td>
<td>C C C C C C C C C C</td>
</tr>
<tr>
<td>h. Advocacy</td>
<td>C C C C C C C C C C</td>
</tr>
<tr>
<td>i. Legislation</td>
<td>C C C C C L L C C</td>
</tr>
</tbody>
</table>

When the responses of the total sample to Opinion Question 28 were reviewed without regard to respondents’ particular state (Table 11), similar trends were observed. More than 70 percent of respondents viewed the topics of health promotion, access to services, workforce, and advocacy as receiving the correct amount of summit attention. Lesser majorities stated that surveillance, legislation, financing and infrastructure received adequate attention, although 39 percent of respondents believed that state or local government infrastructure development received either too little attention, or was not discussed. Also, a majority of respondents (52%) believed that research issues were not discussed or received too little attention. Few respondents thought that any topic received too much attention, with financing and reimbursement of dental services perceived by 6 percent of respondents as having been discussed at too great a length.

Table 11. Question 28, a.-i. Respondent Answers (N=140)

“Please indicate if the following summit topics/issues received too little or too much attention, or were not discussed at all.”

<table>
<thead>
<tr>
<th>QUESTION/ISSUE</th>
<th>Too Much</th>
<th>Correct Amount</th>
<th>Too Little</th>
<th>Not Discussed</th>
<th>Missing/Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>a. Workforce</td>
<td>3 (74)</td>
<td>104 (72)</td>
<td>28 (20)</td>
<td>2 (3)</td>
<td>3</td>
</tr>
<tr>
<td>b. Infrastructure</td>
<td>3 (55)</td>
<td>77 (55)</td>
<td>40 (29)</td>
<td>15 (11)</td>
<td>5</td>
</tr>
<tr>
<td>c. Financing</td>
<td>9 (6)</td>
<td>84 (60)</td>
<td>35 (25)</td>
<td>9 (6)</td>
<td>3</td>
</tr>
<tr>
<td>d. He. Promotion</td>
<td>0 (78)</td>
<td>109 (78)</td>
<td>27 (19)</td>
<td>1 (3)</td>
<td>3</td>
</tr>
<tr>
<td>e. Surveillance</td>
<td>3 (64)</td>
<td>89 (64)</td>
<td>35 (25)</td>
<td>9 (6)</td>
<td>4</td>
</tr>
<tr>
<td>f. Research</td>
<td>2 (31)</td>
<td>44 (31)</td>
<td>45 (32)</td>
<td>39 (28)</td>
<td>10 (7)</td>
</tr>
<tr>
<td>g. Access to service</td>
<td>5 (76)</td>
<td>106 (76)</td>
<td>27 (19)</td>
<td>0 (2)</td>
<td>2</td>
</tr>
<tr>
<td>h. Advocacy</td>
<td>0 (74)</td>
<td>103 (74)</td>
<td>32 (23)</td>
<td>2 (3)</td>
<td>3</td>
</tr>
<tr>
<td>i. Legislation</td>
<td>1 (59)</td>
<td>82 (59)</td>
<td>48 (34)</td>
<td>6 (3)</td>
<td>3</td>
</tr>
</tbody>
</table>
Opinion Questions 29-33.

Opinion Questions 29, 30, 31 and 33 provided opportunity for respondents, respectively, to describe the most positive features or outcomes of the summit; indicate the biggest disappointments or “turn offs,” give their recommendations for improvement; and share any additional comments they wished to offer. Selected comments and recommendations are provided at Appendix H.

In Opinion Question 32, respondents were asked to indicate if they thought a follow-up summit would be useful in furthering their state’s oral health agenda; 108 (77%) said “Yes;” 9 (6%) said “No;” and 21(15%) said they “Didn’t know.” (Data was not available for 2 respondents). Respondents’ comments on this question are displayed in Appendix H.
IV. Discussion

This evaluation of 17 state dental summits funded by MCHB/ASTDD during the period April 2001-December 2002 focused on obtaining information from key stakeholder participants through an electronically distributed questionnaire. The questionnaire queried the key stakeholders about the logistics, administrative and organizational processes of the summits, and sought opinions of the stakeholders about the impact of the summits on various oral health outcomes.

Methodological Issues

A purposive, rather than random method of identifying potential respondents was elected for use in this project in an effort to assure strong respondent knowledge about the issues being evaluated. Selection of participants for inclusion in the project was determined first by identification in each state of a Summit Contact—those with responsibility in the state for administrative management of MCHB/ASTDD funds and planning, implementation and evaluation of the summit. Each Summit Contact, in turn, identified other Key Stakeholders—individuals who could best represent the opinions of important stakeholder organizations—to receive the summit questionnaire.

Self-reported organizational affiliations (Table 5), anecdotal information from the Summit Contacts, and review of respondent position titles suggest that many of those included in the study were agency policymakers or executives, or members of summit planning committees. As such, they might be more likely to have accurate information about events that transpired before, during and after the summits. An alternative methodology, in which a list of participants of all state summits would have been generated and potential respondents selected randomly, was rejected because of concerns that these individuals would be less likely to be aware of summit processes and outcomes, and because of perceived difficulty in locating, contacting and convincing them to participate. Funding for this evaluation project also was limited and played a role in methodological decisions, e.g., it suggested a small sample size and electronic transmission of questionnaires.

By purposely seeking knowledgeable study participants, rather than using a random selection of summit participants, there is potential that participants purposefully selected would demonstrate bias towards certain viewpoints and or questionnaire responses. For example, as a summit planning committee member, a study participant may be less inclined to describe the summit as minimally affecting oral health outcomes, or to point out flaws in the summit design or implementation. As a means of partially compensating for this potential bias, the questionnaire encouraged respondents to provide specific examples which demonstrate, for instance, the oral health outcomes they identified as having occurred as a result of the summit. Nevertheless, in interpreting the results of this study, readers should be aware of this potential bias.

An additional methodological challenge was presented by the likelihood that the opinions of respondents in any state, to some degree, are reflections of influences specific to their own states, rather than of dental summits in general. Since this study was unable to control
for state-specific variables, simple computation of percentages for the entire study cohort might be misleading, especially if this was the sole statistic used. State-by-state comparisons were also hampered by the small number of respondents in each state. To assist in evaluating the responses of study participants in a given state, a methodology was selected that reports on the “consensus” of respondents’ views in each state, where an “opinion” is recorded only if more than 50 percent of respondents made the same response on a particular question. The use of the consensus technique, however, also might mask minority opinion. Hence, results are reported for “opinion” questions using both the consensus, and more traditional “all respondents” formats.

The high response rate, which was just under 90 percent for the project as a whole, and 100% for the 17 Summit Contacts, may be attributable, in large measure, to the strong interest about the summits and oral health issues that may have characterized the individuals selected for participation in this project. It should be noted, however, that substantial efforts over several months were needed, including multiple reminder e-mails, letters and direct telephone contacts with respondents, before these high response rates were achieved.

**Logistics, Organization and Processes**

The great majority of Summit Contacts said that the application for funds from ASTDD/MCHB was not very difficult, although two Contacts had moderate difficulty. One Contact complimented the HRSA/CMS regional office staff for their guidance and support in the application process, but another Contact noted that he/she was required to submit several applications before receiving funding. A third responder noted that the amount of the ASTDD/MCHB award was less than the cost of the paid facilitator that ASTDD and federal staff had recommended, implying that the application process may not have been worth the effort. However, yet another comment noted that “in states with limited resources available for activities of this kind, the oral health summit (funding) is a godsend.” Summit Contacts said that technical assistance provided by federal Regional Office staff was slightly more helpful than guidance provided by ASTDD personnel in planning for and implementing the summits.

At about the same time that these ASTDD/MCHB summits were being planned or were occurring, the National Governors Association (NGA) was soliciting states to participate in NGA Oral Health Policy Academies (held in December 2000, and March and October 2001). These Academies were designed to help state policymakers to develop oral health action plans. Nine of the 17 Summit Contacts said that their states had made application to the NGA Academies. Seven states sent teams to the Academies, with five states attending prior to their summits.

When Key Stakeholders were asked to indicate if they thought that the summit influenced the state to apply to the NGA Academy, 58 percent said “don’t know,” and another 16 percent said “no.” Despite their status as knowledgeable oral health stakeholders, it is likely that many summit participants had not been involved with, and could not have had an opinion about the NGA application process. In addition, if the NGA application had
been made prior to the summit, as was the case for most of those responding states that had applied, the summit logically could not have impacted the NGA application. Although not asked the reverse question, a number of respondents who had knowledge of the NGA Academies volunteered comments that that the Academies generally had a positive impact on their summits, with Academy results sometimes guiding summit direction and Academy action plans morphing into state strategic plans. When asked to cite events that facilitated the summit, one Summit Contact noted, “Not going to the NGA Academy generated momentum and buy-in among key stakeholders.”

Summit Contacts also cited a number of other events that preceded and helped to catalyze the summit process. These events included, the prior work of an oral health coalition, task force, review team, or statewide oral health initiative; changes in the state’s oral health infrastructure, such as appointment of a new State Dental Director or Medicaid fee increases; participation in related conferences; the influence of federal initiatives; and the release of the Surgeon General’s report on oral health. When asked if the summits were an appropriate next step in a sequence of oral health-related state events, there was strong agreement that this was the case.

Stakeholders also agreed strongly that their summits would not have occurred without the work of one or two key individuals or organizations, yet often more that a couple of organizations or individuals were cited as critical initiators by Key Stakeholders. While at least one, and often several committed individuals and agencies were required to stimulate and push forward the process, all states used pre-summit planning groups to further mold the summits. Most states included a substantial number of organizations (average number was about eight) in pre-summit planning; however, a small number of states primarily used individuals internal to their own agencies for planning purposes.

The entities included in pre-summit planning by a majority of states were the state public health and Medicaid agencies, state dental and dental hygienist associations, state primary care agencies or associations, HRSA/CMS regional offices, and not-for-profit organizations. A number of comments suggested that it was especially important to “have a participatory, inclusive planning process,” with “all key stakeholder groups engaged early on in the planning stage.” A recommendation of one Summit Contact was to “get dental professional organizations engaged early in the planning process,” as a way of helping to assure their participation in and support for the summit.

Summit Contacts in 13 of the 17 states said that this was the first state summit. Most of the 17 summits lasted either one day (65%) or one-and-one-half days (36%). Although no questions were directed specifically at whether or not the amount of time available for the summit was sufficient to accomplish all summit goals, responses to a related questions suggest that the correct amount of attention was paid to most summit topics in the available time, with the possible exception of research and state government oral health infrastructure development. A number or respondents included “lack of adequate time” as one of the major disappointments of the summit, although others indicated that “one day was probably the right amount of time,” and still others noted that it was difficult for them to participate for more than a day because of their occupational commitments. One
respondent suggested that “a one day summit means it is difficult to fit everything in. There is a trade-off in getting good participation for one day, versus less participation if the summit is held over two days.”

The great majority of states and respondents indicated that they disagreed with the statement, “The summit was not held at an appropriate day and time.” However, to increase participation, several comments urged planners to consider holding the summit at least partly on a weekend when private sector employees and health care providers’ offices may be closed (e.g., in some states dentists routinely close their offices on Fridays).

Similar majorities agreed with the statement, “There was a good balance of presentation/plenary session and small group discussion sessions at the summit.” Here again, however, comments of respondents suggest that summit planners might considering limiting the amount of time devoted to keynote remarks or plenary remarks (especially if national oral health issues are reviewed, but are not well linked to specific state concerns), in order to maximize the time available for small group discussions that might lead to recommendations about improving oral health.

Most summits attracted a modest number of participants; in eight states attendance was 100-149 individuals and in five states 50-99 individuals attended. All the summits had budgets in excess of the amount ($5,000) usually provided by MCHB/ASTDD, with a range of $8,000-$54,000, and an average budget of $16,299. The state with the largest budget ($54,000) also had the most participants (250-299), but budgets for other states did not appear to correspond to attendance levels. In establishing these budgets, most states relied on several other organizations for funds, with one state receiving funds from eight additional entities. The organizations most often providing additional funds included state departments of public health/welfare, dental health insurance corporations/dental service foundations, state dental associations, and national foundations and grant-makers. All but one state also used “in-kind” assistance provided by an average of 2.4 organizations, with state departments of public health/welfare most frequently providing this assistance. All states said that their budgets were sufficient to include everything they wanted to include in their summits.

Paid conference facilitators and food/refreshments were the two highest summit expenditures, averaging 23 and 18 percent of summit costs, respectively. Eight states reported that they used paid conference facilitators. When the average percent expenditures of the states’ total budgets for facilitators were compared for those states using and not using paid facilitators, the percentages were 46 and 3 percent, respectively. States deciding to use paid facilitators should plan on expending a substantial part of their budgets on this option.

All states used either paid and/or unpaid facilitators. Respondents generally agreed that paid or non-paid facilitators were helpful in keeping summit discussions on track, although a number of comments indicated that facilitators were either unskilled, unfamiliar with the issues, or had their own biases in directing the discussion. Several respondents urged “hiring a facilitator with expertise in community engagement and planning” and one who
“is familiar with the issues and can temper ‘turf’ issues and (help summit discussions to) stay on track.” In addition to facilitators, a majority of the states used event planners and/or other administrative support in planning and implementing the summits.

Only one Summit Contact reported that his/her state utilized video- or teleconferencing in an effort to expand participation at the summit, although seven Contacts recommended against, and five for use of this technology. One Contact commented: “There are plusses and minuses to this idea. Plusses—more people have ability to see what is going on. Minuses: costly, less opportunity for networking and discourages attendance (at the primary summit site).” Planners should weigh factors such as those noted, as well as travel time in the state, the availability of convenient teleconferencing locations, and the goals of the summit, e.g., primarily information sharing vs. coalition building and group decision-making.

All but one of the 17 state Contacts indicated that written documents and other materials had been collected as background/source information for the summit. About half of the states surveyed prospective participants to obtain source information. One Summit Contact recommended that “when planning, make sure to survey potential summit attendees to find out the types of sessions they are interested in and the format of the meeting.”

A majority of state Summit Contacts indicated that they encountered problems during the pre-summit period. These problems appear to be wide ranging, and perhaps not easily anticipated or preventable; however, two problematic issues were mentioned by several states: difficulty in obtaining support from the Governor’s Office and friction between dentists and dental hygienists. Although perhaps more easily said than done, two Summit Contact recommendations may be relevant: “Allow at least six months for strategic planning and consensus building prior to establishing a (summit) meeting date,” and “Do not allow one interest group to dominate or derail the summit; make sure that all bases are covered BEFORE the summit—you do not want surprises on summit day.”

Two questions in the questionnaire focused on the issue of stakeholder representation at the summit, i.e., were all critical stakeholders represented at the summit and was this representation fair in comparison to other stakeholder groups? While there was consensus among respondents in all the states that critical stakeholders were at the table and appropriately represented, as much as 23 percent of respondents disagreed. Comments regarding this issue indicated, depending upon the state, that ethnic communities, seniors, and disability groups, legislators, policy level decision makers, the medical profession, and public school and dental hygienist educators were inadequately represented, if at all. In some states, groups cited as being over-represented included Head Start programs, dental hygienists, not-for-profit advocacy groups and state health agencies. Private sector dentists, generally, were viewed as under-represented, although in some states they were seen as appropriately present. In some states, unresolved conflict between the dental and dental hygiene professions, generally regarding scope of practice issues, may have influenced participation of these health providers, and perhaps more importantly, inhibited effective oral health collaboration and problem solving.
Summit Contacts noted fewer difficulties during and following the summit then prior to the summit. During the summit, one state observed problems with lack of impartiality and skill of the paid facilitator, another noted problems with meeting room size resulting from a last minute format change, and a third indicated that meetings with the media during the summit caused key players to miss parts of the session. Key Stakeholders commented about an array of other concerns, ranging from problems with the summit facility/site (too cold, too small for group discussions, not conducive to maintaining a “positive environment”), limited participation of critical groups and organizations, disagreements among stakeholder groups, failure to recommend concrete actions, and not enough time to complete the work of small group strategy sessions, to cite a few examples (see Appendix H, especially Question 30).

Following the summit, Summit Contacts cited additional problems such as, failure to establish clear timelines and explicit expectations for completion of summit reports; difficulty in keeping momentum going, especially in light of 9/11, the Iraq war, and the economic downturn, and difficulty in receiving payment from ASTDD/MCHB. Perhaps the most frequently expressed post-summit issue of Key Stakeholders was concern about a lack of follow-up on activities and minimal communication by summit planners about summit results and future steps and actions.

To address concerns about communication gaps and lack of follow through, suggestions made by respondents included: use a newsletter to keep stakeholders informed; post all summit information on an Internet web site; plan for a post-summit evaluation or mail survey; don’t leave the summit without a list of participants willing to work on issues, and, after completing and distributing summit proceedings, use the core planning group to help carry out summit ideas and actions.

Most Summit Contacts indicated their states used “participant evaluation forms” at the time of the summit, nine relied on “follow-up meetings,” but only three conducted “post-conference surveys” for evaluation purposes. All Summit Contacts said they disseminated results of the summit (e.g., written conference proceedings or other summaries) at subsequent meetings, on the Internet/by e-mail, or through the regular mail. A few states used radio, television or other media, or conducted press releases or news conferences. A majority of states used a combination of these dissemination techniques. One comment explained that the state had produced and widely disseminated a document that included the state oral health plan along with a description of the summit. Another comment noted that the state’s oral health plan (which evolved from the summit) rather than the summit summary, per se, was disseminated via the Internet.
Summit Outcomes

As stated in the questionnaires, it was considered difficult for respondents to attribute outcomes to a single event, such as an oral health summit. For this reason, there was speculation that few such attributions would be made. On the other hand, since many of the respondents were involved directly in planning and conducting the summits, they might be viewed as having a strong bias towards identifying positive influences, resulting in many attributions concerning summit impact.

Depending upon the reader’s preconception about attribution, it is perhaps surprising that of 20 possible outcomes only three were cited by a consensus of respondents (in more than 50 percent of states) as having been strongly influenced by the summits. These outcomes were:

- Enhanced coalition development and/or broadening or stakeholder partnerships.
- Heightened visibility of oral health among policymakers, and
- Stimulation of the development of oral health committees, work groups and task forces.

In addition, although consensus was not achieved in a majority of states, more than 50 percent of respondents said that the summits strongly influenced development of state oral health or strategic action plans.

Respondents viewed other outcomes as having been influenced by the summits, but fewer states achieved consensus and only a plurality of respondents were in agreement. These outcomes included, achievement of heightened awareness of oral health issues among the media (weak); enhanced visibility or oral health among the public (strong), development of state legislation (weak), creation/expansion of community-based clinical programs (strong), creation/expansion of school-based programs (strong), use of existing data (strong) and expansion of oral health prevention programs (strong).

At the same time, about one fourth of respondents thought that the summit did not influence changes in Medicaid policies or procedures, oral health professional licensure, training and education, loan repayment or scholarship programs, or the state government’s oral health program infrastructure. As noted previously, a strong majority of respondents (74%) said either that the summits had no influence, or they didn’t know about its influence on the state’s application to an NGA oral health policy academy.

When the outcomes of the summits, as reported by Key Stakeholders, were compared to the goals established for the summits, as reported by the Summit Contacts, some concordance was noted. Two of the most frequently cited goals—coalition or partnership development, and raising awareness about oral health issues—are closely related to the outcomes that a majority of states and respondents said were strongly influenced by the summits. Also, a plurality of respondents agreed that the summits had an influence on expanding school-based oral health and community-based clinical programs, suggesting that another widely shared summit goal—increasing access to dental services in general—may have been at least partly achieved. The goal of enhancing access to Medicaid/SCHIP services, however, appears generally not to have been influenced by the summits. The lack
of general consensus among the states about the summits’ influence on other outcomes suggests that other goals were not affected, although on an individual, state-by-state basis, some goal achievement surely occurred.

A number of respondents stated that they could not remember the summits in sufficient detail to enable them to comment accurately on their impact on some outcomes (and, for that matter, other questions posed in the questionnaires). It should be noted that the gap between the first summit supported by ASTDD/MCHB and this evaluation was more than two years, and about six months for those attending the last summit in the series. This difficulty in recalling details over an extended period may account for the high percentage of individuals who responded “don’t know” for many of the outcome questions. In contrast, other respondents remarked that they could not accurately judge the affect of the summits on oral health outcomes because the passage of time since the summit was insufficient for legislative or regulatory changes to have occurred. Accuracy in assessing a summit’s impact on outcomes may be enhanced if future evaluations are begun within six months of completion of each summit and repeated periodically over several years.

Alternately, failure to know about outcomes resulting from the summit—especially when an outcome was documented by other respondents with a specific example, such as passage of important legislation—may indicate that many respondents were less informed about events in their states than might have implied by their status as a key representative of an important stakeholder group. This knowledge failure may lend credence to the expressed concern of several respondents that follow-up and information flow to summit participant after the summit was inadequate.

More than 75 percent of respondents said that a follow-up summit would be useful in furthering a state’s oral health agenda. They noted that such follow-up summits would enable the state to continue its momentum for progress, further solidify relationships forged at the summit, and allow reporting back of action steps underway and accomplished. Many respondents, however, also placed qualifiers on this view. Some said that the timing of a follow-up summit was important. While a one-year interval between summits was often suggested, others said that an 18-24 month gap would better allow for work begun at the summit to be accomplished, and would reduce the cost and effort needed in planning for and implementing another summit. Others agreed that another summit would be useful, but only if perceived problems with the prior summit were corrected, such as improving participation of policymakers, or focusing on action planning rather than rehashing problems.
V. Recommendations

Based on the results of this evaluation—especially the comments of the respondents—and the experiences and insights of its members, the ASTDD Summit Evaluation Committee provides the following recommendations for future dental summit planners and MCHB, as appropriate:

1. Utilize an inclusive and diverse pre-summit planning process to try to gain support for the summit from as many key stakeholder groups as possible.

2. Obtain consensus about summit goals. For example, is the summit directed at information transfer, coalition building and sharing views, or is it directed at strategic planning and establishing action steps? A combination of the two goals may be too ambitious for the available time and expertise of those in attendance. A clear goal may help inform the planning committee about the appropriate summit format and the number and types of participants to be invited.

3. Spend as much time as necessary—as much as 6-12 months—in strategic planning and consensus building before setting an actual summit date.

4. When a consensus about a controversial issue cannot be achieved during the pre-summit phase, e.g., scope of practice for dental hygienists, and it appears that the issue may be sufficiently divisive to disrupt progress on other issues, consider requesting that the leaders of the groups advocating one position or the other agree to defer or defuse the issue during the summit. Try to not allow those with one track agendas from derailing the summit.

5. Facilitators can help keep focus participants on tasks, assist in defusing divisive discussions, vetting recommendations for plausibility, and advising on methods for developing consensus and prioritizing strategic planning and action steps. Professional facilitators are useful, but need to be knowledgeable about oral health, and are expensive; consider orienting facilitators to your state’s oral health issues. A combination of non-professional issue experts and facilitators may be useful in directing small group sessions.

6. Unless the day of the week for the summit is selected carefully, it may be difficult for non-public employees, especially private sector health professionals to participate in the summit. Planners should determine if there is a day of the week that many private sector providers are not in the office and may participate in the summit more easily. Also, consider holding the summit on a Saturday.

7. Experience from other summits suggests that the length of the summit and attendance at the summit may be inversely related. Most summits are scheduled for one or one-and-a-half days in length.
8. Devote as much summit time as possible to discussions of state specific, rather than national oral health issues. If a national focus is desired, ask speakers to relate their broader remarks to your state’s issues.

9. Carefully balance plenary and small group breakout sessions. If your goal is to develop strategic plans or action steps, for example, devote as much time as feasible to small group discussions.

10. While MCHB funding support (about $5,000) has been critical in stimulating dental summits and in leveraging other funding contributions, no state found MCHB support to be sufficient for meeting all summit expenses. All states required additional funding support and needed a budget, on average, of about $15,000, or more. Use “in-kind” support when possible.

11. Paid professional facilitators (recommended with the caveats above) and refreshments/food (recommended) will most likely be the most costly items in the summit budget.

12. When deciding on site location for the summit, consider if the available space will enhance both plenary and small group discussions, and pay careful attention to environmental details (acoustics, room temperature, etc). Consider using an “event planner” to assist in managing logistics, participant registration, and securing speakers’ accommodations and travel arrangements, etc.

13. Use of video- and teleconferencing may increase the number of stakeholders able to participate, especially in large, rural states, but may hinder group decision making, priority setting, and networking.

14. Do not leave the summit without offering participants a view of “what comes next.” At a minimum, this might include collecting names of participants wishing to continue to work on certain issues, or, for example, a description of committees or work groups to address next steps. Send participants a summary of the proceedings as soon as possible. Consider posting a summary of the summit on an Internet site, using a newsletter or developing an electronic listserv to continue dialogue among participants about summit-related issues. If you say you will follow through on something, do it.

15. Evaluation of the “quality” of your summit may be enhanced by using a survey of participants (by e-mail to reduce costs) sent shortly after the summit is concluded. Use the survey to solicit additional ideas which participants may not have had a chance to express during the summit, or which occurred to them after the summit.

16. Evaluation of long term summit outcomes may require conducting an assessment six months after the summit, then again at intervals over a period of several years to accommodate the lengthy timeframe needed for passage of legislation and promulgation of regulations.
APPENDIX A
MCHB NOTICE SOLICITING REQUESTS FOR DENTAL SUMMIT SUPPORT
February 2001

State Dental Summits

The HRSA/HCFA Oral Health Initiative (OHI) is soliciting requests from states to support funding of State Dental Summits. Each state approved for funding will receive up to $5,000, pending availability of funds, to assist in convening a statewide dental summit/summit follow-up to develop a State oral health strategy. It is anticipated that up to 20 State Dental Summits may be approved for funding during this fiscal year. Requests should be received by April 2, 2001, to receive priority for funding. Requests received after April 2, may be funded in the order they are received, assuming funds remain available. Those states approved for funding may use funds for conference logistics, travel expenditures (e.g. speakers, facilitators), registration, hotel meeting space and accommodations, or other support directly related to the convening of the summit/summit follow-up.

Background and Purpose

In June 1998, HRSA and HCFA sponsored the landmark “Building Partnerships to Improve Children’s Access to Oral Health Services” national conference at Lake Tahoe, Nevada. The purpose of the conference was to respond to the April 1996 Department of Health and Human Services, Office of the Inspector General Report: “Children’s Dental Services Under Medicaid: Access and Utilization,” to identify barriers to dental access in Medicaid and the State Children’s Health Insurance Program (SCHIP), and to begin discussion of potential solutions states could use to respond to the access crisis.

While the national conference did much to initiate dialogue between the public sector, private sector and the Medicaid program around the critical access problems that confront the underserved, HRSA and HCFA recognize that real change must take place at the state and community levels. To this end, HRSA and HCFA are attempting to assist states in their efforts to make local changes through a number of activities. One such activity is the support of statewide “dental summits.”

The summits are conceived as an opportunity for state and local level stakeholders in oral health access to meet with each other face-to-face. These summits should address solutions to oral health access problems in states for the purpose of developing state specific strategies and implementation plans for overcoming access barriers. The statewide problem solving fostered by the summits may assist states in developing broad based collaboration between policy makers, the private practice dental community, state health programs and safety-net providers. Summit outcomes will vary from state to state and may include the development of administrative and legislative action plans, stakeholder collaboration strategies, and coordinated implementation activities, among others.
In each of the summits, key Medicaid and SCHIP staff, private and public sector providers, academics, state health agencies, Primary Care Associations, state legislators and other stakeholders will convene to develop strategy and implementation plans to address access to oral health services for children and their families within their states.

Proceedings describing activities and discussion occurring during the summit meeting, are the required deliverable from the state following funding. The proceedings are to be delivered to the Regional OHI team (see Attachment A) within 2 months following the meeting.

Request Process

The attached Funding Request for State Dental Summit or Summit Follow-up document suggests how states may apply for funding to support a meeting. The degree of importance applied to topical areas of information is indicated by an associated point value. Please address each topical area in making your request. Within the topical areas, every bulleted item does not need to be addressed, rather the bullets are intended to stimulate your thinking as you identify descriptive information appropriate for your funding request. Please limit your application to no more than three pages and submit your request to a HRSA/HCFA OHI regional team member for your state (see Attachment A).

Be sure to identify in your written request a point of contact regarding your request for funding:

1) Contact Person’s Name
2) Title/Organization
3) Address
4) Phone
5) Fax
6) Email

Please do not make commitments for the use of funds until you have received written approval and notice of the availability of funds.
APPENDIX B
STATES THAT CONDUCTED DENTAL SUMMITS UNDER
MCHB/ASTDD COOPERATIVE AGREEMENT

<table>
<thead>
<tr>
<th>State</th>
<th>City</th>
<th>Federal Region</th>
<th>Summit Date(s)</th>
</tr>
</thead>
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<td>4</td>
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</tr>
<tr>
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<td>Boise</td>
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<td>11/16/01</td>
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<td>4</td>
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<td>12/6/02</td>
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<td>7</td>
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<td>Las Cruces</td>
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APPENDIX C
DENTAL SUMMIT EVALUATION COMMITTEE AND STAFF

Evaluation Committee
Diane Brunson, R.D.H., M.P.H.  Chair, ASTDD Summit Evaluation Committee and Immediate Past President, Association of State and Territorial Dental Directors, Denver Colorado.

Julie Allen, Manager, Legislative and Regulatory Policy, American Dental Association, Washington, D.C.


Christine M. Farrell.  State Medicaid Dental Program Manager, Medical Services Administration, Michigan Department of Community Health, Lansing Michigan.


Greta Shepard Stewart, M.P.H., Executive Director, Oklahoma Primary Care Association, Oklahoma City, Oklahoma.

James Sutherland, D.D.S., M.P.H., Regional Dental Consultant, Region VIII, Health Resources and Services Administration, Denver, Colorado.

Evaluation Staff
Beverly Isman, R.D.H., M.P.H.  Project Officer, Dental Summit Evaluation, Association of State and Territorial Dental Directors, California.

Donald A Schneider, D.D.S., M.P.H.  Consultant in Dental Health and Health Policy, Sarasota, Florida.
APPENDIX D
“SUMMIT CONTACT” QUESTIONNAIRE
ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS
(ASTDD)
EVALUATION OF ORAL HEALTH SUMMITS

INTRODUCTION & INSTRUCTIONS

Why have I been selected to complete the questionnaire?
• You have been identified as the Primary Contact person for the Oral Health Summit funded by the ASTDD, in partnership with the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). The specific Oral Health Summit that is the focus of this questionnaire is identified in the e-mail cover letter you received from ASTDD. As the Primary Contact for this Summit, you have critical information about the logistics, organization and processes used in planning and conducting the Summit.
• No more than a dozen individuals in your state have been selected to complete the survey, and you are the only individual selected to complete the entire questionnaire. Without your assistance, we will be unable to adequately describe the oral health summit process in your state, or understand the summit process from the perspective of the stakeholder group whom you represent.

What is the purpose of the questionnaire?
• To better understand if oral health summits were successful in moving forward your state’s and other states’ oral health agendas.
• To help inform the MCHB/HRSA how grant funds were utilized and how the grant affected oral health activity in the states.
• To provide assistance to oral health stakeholders in other states as they plan future dental summits.

Which parts of the questionnaire should I complete?
• As the “ASTDD Primary Contact,” we request you complete the entire questionnaire, that is, both Section A, “Summit Logistics, Organization, and Processes,” and Section B, “Opinions and Ideas.” All other survey participants will complete only Section B. Since a few questions in Section A may request details that you may not have immediately at hand, please feel free to contact other individuals in your state who may be able to assist in answering those questions.

Hints for working with the electronic questionnaire:
• The questionnaire is in the “locked” position, so you will be able to write only in the designated spaces.
• The designated spaces are of three types:
  o Check boxes look like this □
  o Regular text spaces look like this _______ , and
  o Comment:
• For Check boxes, Use your cursor or the “Tab” key to move from question to question. “Right click” with your mouse, or use your keyboard space bar to mark or clear your response (i.e., “[□]”). Check boxes are independent of each other. You need to manually mark or clear each check box. One check mark is not cleared automatically when another box is selected.

• Regular text spaces (i.e., “________”) can accommodate as many words as you want, but lengthy responses may “push” the next question forward. We have used regular text spaces to indicate that only a very brief response of no more than a few words is requested.

• Framed text spaces can be used to insert several lines of text; usually 5 or 6 lines of text. We have used this space to indicate that the response we are requesting may be more than a few words in length, but not longer than a few lines of text. Use your mouse cursor to enter the framed text space and right click to begin to enter text.

• When you have completed answering all the questions, you must “save” the document to your computer’s hard drive (Drive C). When you save the document, we suggest you rename it using your last name, followed by your state’s two-letter initials (e.g., SchneiderFL). After saving your responses, please send the document as an e-mail attachment to Dr. Don Schneider, at DonsDDS@comcast.net, or print it and then fax it to Dr. Schneider at (941) 925-2901.

------------------------END OF INTRODUCTION & INSTRUCTIONS------------------------
QUESTIONNAIRE: SECTION A

SUMMIT LOGISTICS, ORGANIZATION, AND PROCESSES.

All questions relate to the specific Oral Health Summit identified in the e-mail cover letter you received from ASTDD.

1. What was the duration of the Oral Health Summit? Please check the best answer.
   a. One full day. □
   b. One and ½ days. □
   c. Two full days. □
   d. Two non-continuous days. □

2. In addition to participation at the main Summit site, were individuals also able to participate at satellite/videoconference locations and/or by teleconference?
   No □ Yes □
   Would you recommend that future Summit planners use either of these methods?
   No □ Yes □ Don’t know □

   What is the reason for your recommendation?

3. How many individuals attended any part of the Summit (including those participating by video- or teleconference)? Please check one.
   0-49 □
   50-99 □
   100-149 □
   150-199 □
   200-249 □
   250-299 □
   300+ □

4. Was the Summit held in conjunction with, or as part of an ASTDD-funded “Head Start Oral Health Forum?”
   No □ Yes □
5. The Association of State and Territorial Dental Directors (ASTDD), in partnership with the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration, provided about $5,000 to help fund this Summit. What organizations and agencies, in addition to the ASTDD/MCHB, provided funds to conduct the Summit? Please list no more than five.

Names of organizations/agencies:

a. 

b. 

c. 

d. 

e. 

Comment:

6. Considering all funding sources (including ASTDD and MCHB), plus conference registration fees, what was the total Summit budget? $________

7. Approximately what percent of the total Summit budget was expended in each of the following categories? Please check to make sure that the sum of the percentages for the categories totals 100 percent. Do not include "in-kind" assistance.

   a. Logistics (supplies, materials, printing, postage, equipment). ________% 
   b. Travel/Lodging/Honoraria (speakers). __________% 
   c. Travel/Lodging (participants). __________% 
   d. Meeting space. __________% 
   e. Conference facilitators. __________% 
   f. Event planners and administrative support. __________% 
   g. Summit report (writing, duplicating, distributing). __________% 
   h. Food/Refreshments. __________% 
   i. Other activities related to the Summit. __________% 

Total = 100%
8. In addition to ASTDD and MCHB, did other organizations provide “in-kind” assistance (e.g., supplies, materials, meeting rooms, staff, etc.) for the Summit?

No □ Yes □

If “Yes,” please note the in-kind assistance provided by up to three agencies:

a. Organization Name: __________
   Assistance provided: __________

b. Organization Name: __________
   Assistance provided: __________

c. Organization Name: __________
   Assistance provided: __________

9. Were funds in the Summit budget sufficient to include everything that you wanted to include? Yes □ No □

If “No,” what potential activities were you unable to undertake because of insufficient funds?

10. Were pre-Summit planning meetings conducted? No □ Yes □

If “Yes,” which agencies/organizations participated in planning meetings?

a. State Public Health Agency □
b. State Medicaid Agency □
c. State SCHIP Agency (if different) □
d. State Rural Health Agency/Association □
e. State Primary Care Agency/Association □
f. State Dental Association □
g. State Dental Hygienists’ Association □
h. Governor’s Office □
i. Local/regional government agency(s) □
j. Regional Office of HRSA or CMS □
k. Head Start affiliated entities □
l. Educational Institutions (K-12) □
m. Health Professions Schools □
n. Faith-based organizations □
o. Non-profit organizations □
p. Foundations □
q. Industry/business groups □
r. Other entities (Specify): ________
11. How was background/source information or data for the Summit obtained?
   a. Written documents/materials were collected.  
      No ☐  Yes ☐
   b. Prospective participants were surveyed.  
      No ☐  Yes ☐
   c. Other (Please specify): __________

12. Were any of the following used for your Summit?
   a. Event planners/administrative support. No ☐  Yes ☐
   b. Unpaid facilitators. No ☐  Yes ☐
   c. Paid facilitators. No ☐  Yes ☐
      If you answered “Yes” to “c,” what was the name of the paid facilitator and his/her organization?
      Name of Facilitator: __________
      Name of Organization: __________
      Address (city/state only): __________

13. How would you describe the degree of difficulty or burden involved in the application process for obtaining Summit funding from ASTDD/MCHB?
   Not very difficult ☐
   Moderately difficult ☐
   Very difficult ☐

   If “Moderately difficult” or “Very difficult,” please identify any problems you encountered in the application process:

14. Did you encounter any major financial, political, logistic or other barriers that had to be overcome before the Summit could be conducted?
   No ☐  Yes ☐

   If “Yes,” please note the key barrier(s) encountered before the Summit:
15. Did you encounter any problems during the Summit that might be avoided by other Summit planners?  
   No [ ]  Yes [ ]

   If “Yes,” please note the key problem(s) encountered during the Summit:

   [Blank space for comment]

16. Did you encounter any problems after the Summit concluded that might be avoided by other Summit planners?  
   No [ ]  Yes [ ]

   If “Yes,” please note the key barrier(s) encountered:

   [Blank space for comment]

17. Were federal Regional Office staff members (i.e., staff of either HRSA or the Centers for Medicare and Medicaid Services-CMS) helpful in planning or implementing the Summit? Please check only one.

   Very Helpful [ ]
   Somewhat Helpful [ ]
   Not Helpful [ ]
   Not Applicable [ ]

   Comment:

   [Blank space for comment]

18. How helpful was technical guidance provided by your ASTDD contacts in planning for or implementing the Summit? Please check only one.

   Very Helpful [ ]
   Somewhat Helpful [ ]
   Not Helpful [ ]
   Not Applicable [ ]

   Comment:

   [Blank space for comment]
19. What method(s) of evaluation did you use for the Summit?
   a. Participant evaluation form.  
      Yes [ ]  No [ ]
   b. Post-conference survey.  
      Yes [ ]  No [ ]
   c. Follow-up meeting.  
      Yes [ ]  No [ ]
   d. Other (Please specify): ______

20. How were summit results (e.g., written conference proceedings or summaries) disseminated in your state? Please check all that apply.
   a. By mail (US Postal Service, UPS, etc.)  
      [ ]
   b. Results were posted on the Internet, or sent by e-mail.  
      [ ]
   c. By press release, or a press conference.  
      [ ]
   d. Through discussion of results at subsequent meetings.  
      [ ]
   e. Through radio, television, newspaper or other media coverage.  
      [ ]
   f. Other (Please specify): ______

21. Did the state submit an application to participate in a NGA Oral Health Policy Academy?
   Yes [ ]  No [ ]
   a. If yes, did the state participate in a NGA Oral Health Policy Academy?
      Yes [ ]  No [ ]
   b. If Yes” to question “a” or “b,” did the NGA Oral Health Policy Academy occur before or after the Summit?
      Before the Summit. [ ]  After the Summit. [ ]

22. Was this the first statewide oral health Summit conducted in the state?
   Yes [ ]  No [ ]
   If “No,” when was the prior Summit held? Date (month and year): 

23. Where there any notable events (besides participation in a NGA Oral Health Policy Academy) that preceded the Summit and prepared the way, or served as a catalyst for this Summit?
   No [ ]  Yes [ ]

If “Yes,” please specify the notable event(s):
24. What were the planned goals of the Summit? *Please check all that apply.*
   a. Information sharing.
   b. Raising awareness regarding oral health issues.
   c. Coalition/partnership development.
   d. Community level activities.
   e. State or regional level activities.
   f. Access to dental services (in general).
   g. Access to Medicaid/SCHIP dental service.
   h. Head Start Program access to dental services.
   i. Safety-net dental services.
   j. Supply or distribution of the oral health workforce.
   k. Water fluoridation
   l. Prevention programs (topical fluorides, sealants).
   m. Oral health surveillance and data collection.
   n. Other *(Please specify):__________

25. If you were asked to provide advice to other Summit planners, what would you suggest they *should* do or include in planning or conducting a Summit?

   **Should do or include:**

26. What advice would you provide to future Summit planners about what they *should not* do or *not* include in a Summit?

   **Should not include or do:**
INSTRUCTIONS: For the following questions, please indicate the degree to which you agree or disagree with the statement. Please check only one response for each question.

27. The Summit would not have occurred except for the work of one or two key individuals or organizations.
   Agree Strongly □
   Agree □
   Disagree □
   Disagree Strongly □
   Don’t Know/Not Applicable □

   If you said “Agree” or “Agree Strongly,” please identify the individual(s) or organization(s) primarily responsible for enabling the Summit to Proceed:

28. All critical stakeholder organizations in the state were included at the Summit.
   Agree Strongly □
   Agree □
   Disagree □
   Disagree Strongly □
   Don’t Know/Not Applicable □

   If you said “Disagree” or “Disagree Strongly,” which organization(s) were left out at the Summit:
29. Some critical stakeholder organizations were unfairly represented (having either too few or too many Summit participants) and created an imbalance of viewpoints.
   Agree Strongly  
   Agree  
   Disagree  
   Disagree Strongly  
   Don’t Know/Not Applicable  

*If you said “Agree” or “Agree Strongly,” please identify any organizations that you thought were unfairly represented:*

30. There was a good balance of presentation/plenary sessions and small group discussion sessions at the Summit.
   Agree Strongly  
   Agree  
   Disagree  
   Disagree Strongly  
   Don’t Know/Not Applicable  

*If you said “Disagree” or “Disagree Strongly,” please describe the imbalance:*

31. Summit facilitators were helpful in keeping the Summit discussions on track.
   Agree Strongly  
   Agree  
   Disagree  
   Disagree Strongly  
   Don’t Know/Not Applicable  

*If you said “Disagree” or “Disagree Strongly,” please indicate why you thought the facilitators were not helpful:*
32. The Summit was an appropriate next step in a sequence of oral health activities and events which had already taken place in the state.

<table>
<thead>
<tr>
<th>Agree Strongly</th>
<th>Agree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
<th>Don’t Know/Not Applicable</th>
</tr>
</thead>
</table>

*If you said “Disagree” or “Disagree Strongly,” please indicate why you thought that the Summit did not occur in the appropriate sequence:*

---

33. This Summit was not held at an appropriate time of day or week.

<table>
<thead>
<tr>
<th>Agree Strongly</th>
<th>Agree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
<th>Don’t Know/Not Applicable</th>
</tr>
</thead>
</table>

*If you said “Agree” or “Agree Strongly,” please indicate why you believe the Summit did not occur at an appropriate time of day or week:*

---

**INSTRUCTIONS: Although it is difficult to attribute outcomes to a single event such as an Oral Health Summit, for the next questions, indicate the degree to which you think the Oral Health Summit may have influenced or stimulated each of the following possible oral health-related outcomes. Check only one answer for each possible outcome.**

34. Increase in coalition development and/or broadening of partnerships.

Summit’s influence: None □ Weak □ Strong □ Don’t know □

*Please provide example(s):*
35. Development of oral health committees, work groups, task forces.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   
   Please provide example(s):

   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   
   Please provide example(s):

37. Heightened visibility about oral health issues among the public.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   
   Please provide example(s):

38. Heightened visibility about oral health issues among policymakers.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   
   Please provide example(s):

   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   
   Please provide example(s):
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<td>40. Heightened visibility about oral health issues in the <em>news media.</em></td>
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<td>Summit’s influence: None □ Weak □ Strong □ Don’t know □</td>
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<td>41. Changes in policies or procedures of the Medicaid program or SCHIP, either by the programs themselves or by the state legislature.</td>
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<td>Summit’s influence: None □ Weak □ Strong □ Don’t know □</td>
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<td>42. Changes in oral health professional <em>licensure.</em></td>
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<td>43. Changes in oral health professional <em>training or education.</em></td>
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<td>Summit’s influence: None □ Weak □ Strong □ Don’t know □</td>
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<td><em>Please provide example(s):</em></td>
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44. Creation or expansion of oral health professional loan forgiveness or scholarship programs.
   Summit’s influence: None □  Weak □ Strong □  Don’t know □
   Please provide example(s):

45. Creation or expansion of community-based clinical oral health programs.
   Summit’s influence: None □  Weak □ Strong □  Don’t know □
   Please provide example(s):

46. Creation or expansion of school-based oral health programs.
   Summit’s influence: None □  Weak □ Strong □  Don’t know □
   Please provide example(s):

47. Use or analysis of existing oral health-related data.
   Summit’s influence: None □  Weak □ Strong □  Don’t know □
   Please provide example(s):
48. Collection or development of new oral health data, research, or reports.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   Please provide example(s):

49. Creation or expansion of oral health promotion programs aimed at the public?
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   Please provide example(s):

50. Creation or expansion of oral health prevention programs.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   Please provide example(s):

51. Creation or expansion of oral health treatment programs.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   Please provide example(s):

52. Changes that occurred subsequently in the state government’s oral health program infrastructure (e.g., the office of the State Dental Director), such as in its organization, staffing, or budget.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □
   Please provide example(s):

53. Development of an oral health strategic plan or action plan for the state.
Summit’s influence: None □ Weak □ Strong □ Don’t know □

*Please provide example(s):*

54. In this question, please indicate if the following Summit topics/issues received too little or too much attention, or were not discussed at all. Please check only one box for each topic/issue.

a. Oral health professional workforce.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

b. State or local government’s oral health infrastructure.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

c. Financing and reimbursement of dental services.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

d. Oral disease prevention and health promotion.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

e. Oral health surveillance and data collection.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

f. Oral health research.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

g. Access to oral health services.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

h. Advocacy for oral health.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □

i. Oral health legislation.
   Attention: Too much □ Correct amount □ Too little □ Not Discussed □
55. What were the most positive features or outcomes of the Summit?  
*Please specify:*

56. What were the biggest disappointments or “turn-offs” of the Summit?  
*Please specify:*

57. What changes would you have made to improve the Summit?  
*Recommendations:*

58. Would a follow-up Summit be useful in furthering your state’s oral health agenda?  
Yes [ ]  No [ ]  Don’t know [ ]  
*Comments:*

59. Please share any additional comments about the oral health Summit:  
*Comments:*
60. With which one of the following groups/organizations/entities are you affiliated most closely? Check only one.
   a. Advocacy/consumers group  
   b. Community-based clinic  
   c. Dental practice/dental association  
   d. Dental hygiene practice/hygiene association  
   e. Faith-based organization  
   f. Foundation  
   g. Health Professions education  
   h. Pre-health Professions education (e.g., K-12, college)  
   i. Head Start, preschool or daycare programs  
   j. Governor’s Office  
   k. Industry/business  
   l. Legislator  
   m. Health professions (Physician, Nurse, etc.)  
   n. Rural, Minority or Primary Health Care agency/association  
   o. State Medicaid agency/State SCHIP agency  
   p. State, local or regional Public Health agency  
   q. Other (Specify):  

------------------------END OF QUESTIONNAIRE------------------------
APPENDIX E
“KEY STAKEHOLDER” QUESTIONNAIRE
ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS
(ASTDD)
EVALUATION OF ORAL HEALTH SUMMITS

INTRODUCTION & INSTRUCTIONS

Why have I been selected to complete the questionnaire?
• You have been identified as a representative of an important oral health stakeholder group in your state—someone who can provide an informed and fair appraisal of the process and impact of an Oral Health Summit conducted in your state. The specific Oral Health Summit that is the focus of this survey is identified in the e-mail cover letter that you received from ASTDD.
• You are one of not more than a dozen individuals in your state who have been selected to complete this questionnaire. Without your assistance, we will be unable to adequately describe the oral health summit process in your state, or understand the summit process from the perspective of the stakeholder group that you represent.

What is the purpose of the questionnaire?
• To better understand if oral health summits were successful in moving forward your state’s and other states’ oral health agendas.
• To help inform the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) how grant funds were utilized and how the grant affected oral health activity in the states.
• To provide assistance to oral health stakeholders in other states as they plan future dental summits.

Hints for working with the electronic questionnaire:
• The questionnaire is in the “locked” position, so you will be able to write only in the designated spaces.
• The designated spaces are of three types:
  o Check boxes look like this □
  o Regular text spaces look like this ________, and
  o Framed text spaces look like this [Comment: ________]

• For Check boxes, Use your cursor or the “Tab” key to move from question to question. “Right click” with your mouse, or use your keyboard space bar to mark or clear your response (i.e., “[ ]”). Check boxes are independent of each other. You need to manually mark or clear each check box. One check mark is not cleared automatically when another box is selected.
• Regular text spaces (i.e., “________”) can accommodate as many words as you want, but lengthy responses may “push” the next question forward. We have used regular text spaces to indicate that only a very brief response of no more than a few words is requested.
• *Framed text spaces* can be used to insert several lines of text; usually 5 or 6 lines of text. We have used this space to indicate that the response we are requesting may be *more than a few words* in length, **but not longer than a few lines** of text. Use your mouse cursor to enter the framed text space and right click to begin to enter text.

• When you have completed answering all the questions, you *must* “save” the document to your computer’s hard drive (Drive C). When you save the document, we suggest you rename it using your last name, followed by your state’s two-letter initials (e.g., SchneiderFL). After saving your responses, please send the document as an e-mail attachment to Dr. Don Schneider, at DonsDDS@comcast.net, or print it and then fax it to Dr. Schneider at (941) 925-2901.

-------------------------END OF INTRODUCTION & INSTRUCTIONS--------------------------
QUESTIONNAIRE: ASTDD EVALUATION OF ORAL HEALTH SUMMITS

INSTRUCTIONS: All questions relate to the specific Oral Health Summit identified in the e-mail cover letter you received from ASTDD. For the following questions, please indicate the degree to which you agree or disagree with the statement. Please check only one response for each question.

1. The Summit would not have occurred except for the work of one or two key individuals or organizations.
   - Agree Strongly ☐
   - Agree ☐
   - Disagree ☐
   - Disagree Strongly ☐
   - Don’t Know/Not Applicable ☐

   If you said “Agree” or “Agree Strongly,” please identify the individual(s) or organization(s) primarily responsible for enabling the Summit to Proceed:

2. All critical stakeholder organizations in the state were included at the Summit.
   - Agree Strongly ☐
   - Agree ☐
   - Disagree ☐
   - Disagree Strongly ☐
   - Don’t Know/Not Applicable ☐

   If you said “Disagree” or “Disagree Strongly,” which organization(s) were left out at the Summit:
3. Some critical stakeholder organizations were unfairly represented (having either too few or too many Summit participants) and created an imbalance of viewpoints.

   Agree Strongly □
   Agree □
   Disagree □
   Disagree Strongly □
   Don’t Know/Not Applicable □

   If you said “Agree” or “Agree Strongly,” please identify any organizations that you thought were unfairly represented:

4. There was a good balance of presentation/plenary sessions and small group discussion sessions at the Summit.

   Agree Strongly □
   Agree □
   Disagree □
   Disagree Strongly □
   Don’t Know/Not Applicable □

   If you said “Disagree” or “Disagree Strongly,” please describe the imbalance:

5. Summit facilitators were helpful in keeping the Summit discussions on track.

   Agree Strongly □
   Agree □
   Disagree □
   Disagree Strongly □
   Don’t Know/Not Applicable □

   If you said “Disagree” or “Disagree Strongly,” please indicate why you thought the facilitators were not helpful:

65
6. The Summit was an appropriate next step in a sequence of oral health activities and events which had already taken place in the state.

   Agree Strongly
   Agree
   Disagree
   Disagree Strongly
   Don’t Know/Not Applicable

   If you said “Disagree” or “Disagree Strongly,” please indicate why you thought that the Summit did not occur in the appropriate sequence:

7. This Summit was not held at an appropriate time of day or week.

   Agree Strongly
   Agree
   Disagree
   Disagree Strongly
   Don’t Know/Not Applicable

   If you said “Agree” or “Agree Strongly,” please indicate why you believe the Summit did not occur at an appropriate time of day or week:

INSTRUCTIONS: Although it is difficult to attribute outcomes to a single event such as an Oral Health Summit, for the next questions, indicate the degree to which you think the Oral Health Summit may have influenced or stimulated each of the following possible oral health-related outcomes. Check only one answer for each possible outcome.

8. Increase in coalition development and/or broadening of partnerships.

   Summit’s influence: None Weak Strong Don’t know

   Please provide example(s):
9. Development of oral health committees, work groups, task forces.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □

   Please provide example(s):

10. Application to a National Governors Association Oral Health Policy Academy.
    Summit’s influence: None □ Weak □ Strong □ Don’t know □

    Please provide example(s):

11. Heightened visibility about oral health issues among the public.
    Summit’s influence: None □ Weak □ Strong □ Don’t know □

    Please provide example(s):

12. Heightened visibility about oral health issues among policymakers.
    Summit’s influence: None □ Weak □ Strong □ Don’t know □

    Please provide example(s):

    Summit’s influence: None □ Weak □ Strong □ Don’t know

    Please provide example(s):
14. Heightened visibility about oral health issues in the *news media*.
   Summit’s influence:  None □  Weak □  Strong □  Don’t know □

   *Please provide example(s):*

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15. Changes in policies or procedures of the Medicaid program or SCHIP, either by the programs themselves or by the state legislature.
   Summit’s influence:  None □  Weak □  Strong □  Don’t know □

   *Please provide example(s):*

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16. Changes in oral health professional *licensure*.
   Summit’s influence:  None □  Weak □  Strong □  Don’t know □

   *Please provide example(s):*

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17. Changes in oral health professional *training or education*.
   Summit’s influence:  None □  Weak □  Strong □  Don’t know □

   *Please provide example(s):*

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18. Creation or expansion of oral health professional *loan forgiveness or scholarship programs.*

   Summit’s influence:  None □  Weak □  Strong □ Don’t know □

*Please provide example(s):*

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19. Creation or expansion of *community-based clinical* oral health programs.

   Summit’s influence:  None □  Weak □  Strong □ Don’t know □

*Please provide example(s):*

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20. Creation or expansion of *school-based* oral health programs.

   Summit’s influence:  None □  Weak □  Strong □ Don’t know □

*Please provide example(s):*

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21. Use or analysis of *existing* oral health-related data.

   Summit’s influence:  None □  Weak □  Strong □ Don’t know □

*Please provide example(s):*
22. Collection or development of *new* oral health data, research, or reports.
   Summit’s influence:  None  Weak  Strong  Don’t know
   
   Please provide example(s):

23. Creation or expansion of *oral health promotion* programs aimed at the public?
   Summit’s influence:  None  Weak  Strong  Don’t know
   
   Please provide example(s):

24. Creation or expansion of oral health *prevention* programs.
   Summit’s influence:  None  Weak  Strong  Don’t know
   
   Please provide example(s):

25. Creation or expansion of oral health *treatment* programs.
   Summit’s influence:  None  Weak  Strong  Don’t know
   
   Please provide example(s):

26. Changes that occurred subsequently in the *state government’s oral health program* infrastructure (e.g., the office of the State Dental Director), such as in its organization, staffing, or budget.
   Summit’s influence:  None  Weak  Strong  Don’t know
   
   Please provide example(s):
27. Development of an oral health strategic plan or action plan for the state.
   Summit’s influence: None □ Weak □ Strong □ Don’t know □

28. In this question, please indicate if the following Summit topics/issues received too little or too much attention, or were not discussed at all. Please check only one box for each topic/issue.

   j. Oral health professional workforce.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   k. State or local government’s oral health infrastructure.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   l. Financing and reimbursement of dental services.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   m. Oral disease prevention and health promotion.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   n. Oral health surveillance and data collection.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   o. Oral health research.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   p. Access to oral health services.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   q. Advocacy for oral health.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □

   r. Oral health legislation.
      Attention: Too much □ Correct amount □ Too little □ Not Discussed □
29. What were the most positive features or outcomes of the Summit?

Please specify:

30. What were the biggest disappointments or “turn-offs” of the Summit?

Please specify:

31. What changes would you have made to improve the Summit?

Recommendations:

32. Would a follow-up Summit be useful in furthering your state’s oral health agenda?

Yes ☐  No ☐  Don’t know ☐

Comments:

33. Please share any additional comments about the oral health Summit:

Comments:
34. With which one of the following groupsorganizations/entities are you affiliated most closely? Check only one.
   r. Advocacy/consumers group
   s. Community-based clinic
   t. Dental practice/dental association
   u. Dental hygiene practice/hygiene association
   v. Faith-based organization
   w. Foundation
   x. Health Professions education
   y. Pre-health Professions education (e.g., K-12, college)
   z. Head Start, preschool or daycare programs
   aa. Governor’s Office
   bb. Industry/business
   cc. Legislator
   dd. Health professions (Physician, Nurse, etc.)
   ee. Rural, Minority or Primary Health Care agency/association
   ff. State Medicaid agency/State SCHIP agency
   gg. State, local or regional Public Health agency
   hh. Other (Specify): ________

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END OF QUESTIONNAIRE-------------------------
APPENDIX F
E-MAIL FORWARDING “SUMMIT CONTACT’S” QUESTIONNAIRE

This e-mail is from Ms. Diane Brunson, Chair, ASTDD Summit Evaluation Committee, and is being forwarded to you by Dr. Don Schneider, ASTDD Consultant).

Association of State and Territorial Dental Directors

Dear Ms.______:

On behalf of the Association of State and Territorial Dental Directors (ASTDD), I am requesting your assistance in conducting a national evaluation of state oral health “summits.” These summits were sponsored, in part, by ASTDD, with funding support made available from the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). It is our understanding that you are the ASTDD Summit Contact for one of those summits, as noted in the box below:

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<tr>
<th>ORAL HEALTH SUMMIT</th>
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<td>STATE: MO</td>
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Through this evaluation—which is being conducted by questionnaire—we hope to better understand if the dental summits were successful in moving forward your state’s and other states’ oral health agendas. The evaluation also will help to inform the MCHB/HRSA about how funds were used and how those funds affected oral health activity in the states. In addition, we hope the information obtained through this evaluation will be of assistance to other states as they plan future dental summits.

As the ASTDD Primary Contact for your state Summit, you have critical information about the logistics, organization and processes used for planning, conducting, and evaluating the Summit. As such, you are the only person in the state who is requested to complete the entire questionnaire. No more than a dozen other individuals (whom you helped us select) will be asked to participate in the evaluation by completing Section B of the questionnaire.

Information collected as part of this evaluation will be reported primarily as national data. If state-to-state comparisons are made, no individual state will be identified in the comparison. Although you are asked to identify yourself on the questionnaire for tracking purposes, your responses to this survey are confidential; you will not be identified in any report.

The survey questionnaire consists of about 60 multiple choice questions, with your additional comments requested. Since you are the only person in the state receiving the entire survey questionnaire, it is very important for the success of the
evaluation that you **complete and return the questionnaire by Friday, July 11, 2003.**

For your convenience, we have formatted the questionnaire so that it may be completed electronically. The survey questionnaire is attached to this e-mail as a MS Word 2000 document. Simply open the document and complete the questionnaire, then save it to your computer’s hard drive and return the questionnaire by e-mail to our consultant for this evaluation, Dr. Don Schneider. You may also print out the questionnaire, complete it in hard copy and return it to Dr. Schneider by FAX. Dr. Schneider’s contact information is:

- Don Schneider, DDS, MPH
- Telephone number/FAX (941) 925-2901
- e-mail address: donsDDS@comcast.net

**Please contact Dr. Schneider immediately if you have any problems in using the electronic questionnaire,** or if you have questions or comments about any items. Thank you in advance for your assistance in conducting this evaluation. After the evaluation report has been completed, probably in late summer of early fall, we will post it on the ASTDD’s Web site (http://www.astdd.org).

Sincerely,

/signed/

Diane Brunson, RDH, MPH
Chair, ASTDD Summit Evaluation Committee

(Sent by:)

Donald A. Schneider, D.D.S., M.P.H.
Consultant in Health Policy and Dental Health
7149 Wainscott Court
Sarasota, Florida 34238
Phone/FAX (941) 925-2901
E-mail: DonSDDS@comcast.net
(This e-mail is from Ms. Diane Brunson, Chair, ASTDD Summit Evaluation Committee, and is being forwarded to you by Don Schneider, ASTDD Contractor).

Association of State and Territorial Dental Directors

Dear Ms. _____:

On behalf of the Association of State and Territorial Dental Directors (ASTDD), your assistance is requested in conducting a national evaluation of state oral health “summits.” These summits were sponsored, in part, by ASTDD, with funding support made available by the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). It is our understanding that you participated in one of those summits, as noted in the box below.

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<th>ORAL HEALTH SUMMIT</th>
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<tr>
<td>CITY: New Orleans</td>
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<td>DATE: 12/6/2002</td>
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Through this evaluation--which is being conducted using a survey questionnaire--we hope to better understand whether or not the dental summits were successful in moving forward your state’s and other states’ oral health agendas. The evaluation also will help to inform the MCHB/HRSA about how its funds were used and how those funds affected oral health activity in the states. In addition, we hope the information obtained through this evaluation will be of assistance to oral health stakeholders as they plan future dental summits.

You were selected to participate in this oral health summit evaluation by the individual in your state who received the ASTDD summit award. Only 6-12 individuals in your state have been selected to participate. The ASTDD summit award recipient indicated that you were a key representative of an important state stakeholder group, and would be able to provide an informed and fair appraisal of the state’s oral health summit process and impact.

Please note that information collected as part of this evaluation will be reported primarily as national data. If state-to-state comparisons are made, no individual state will be identified in the comparison. Although you are asked to identify yourself on the questionnaire for survey tracking purposes, your responses to this survey are confidential; you will not be identified in any survey report.

The survey questionnaire consists of 34 multiple choice questions, although your additional comments are requested. Since only a handful of individuals in each state have been selected to participate in this evaluation, it is very important for the
success of the evaluation that you complete and return the survey by Friday, July 11, 2003.

For your convenience, we have formatted the questionnaire so that it may be completed electronically. The survey questionnaire is attached to this e-mail as a MS Word 2000 document. Simply open the document and complete the questionnaire, then save the questionnaire with your responses to your computer’s hard drive and return the questionnaire by e-mail to our contractor for this evaluation, Dr. Don Schneider. You may also print out the questionnaire, complete it in hard copy and return it to Dr. Schneider by FAX, or through the regular postal service. Dr. Schneider’s contact information is:

Don Schneider, D.D.S., M.P.H.
7149 Wainscott Court
Sarasota Florida, 34238
Telephone number/FAX (941) 925-2901
e-mail address: donsDDS@comcast.net

Please contact Dr. Schneider immediately if you have any problems in using the electronic questionnaire or if you have questions or comments about this survey. Thank you in advance for your assistance in conducting this evaluation. After the evaluation report has been completed, we will post it on the ASTDD’s Internet site (http://www.astdd.org).

Sincerely,

/signed/

Diane Brunson, RDH, MPH
Chair, ASTDD Summit Evaluation Committee

(Sent by:)

Donald A. Schneider, D.D.S., M.P.H.
Consultant in Health Policy and Dental Health
7149 Wainscott Court
Sarasota, Florida 34238
Phone/FAX (941) 925-2901
E-mail: DonSDDS@comcast.net
APPENDIX H
COMMENTS OF GRANT CONTACTS AND KEY STAKEHOLDERS
TO OPINION QUESTIONS

Respondent comments to “Opinion Questions” have been collated by question number, with a “bullet” (●) used to separate comments respondents in one state from those of another state. Comments of different respondents within a given state are separated by “triple asterisks” (***) Comments from different states are not listed in any particular pattern; they are listed randomly. The question numbers used here are those in the Key Stakeholder questionnaire, and are identical to those in Section B, Summit Contact Questionnaire, Questions 27-60.

Q1. The summit would not have occurred except for the work of one or two key individuals and organizations. (Agree Strongly to Disagree Strongly)
Respondents listed an array of individuals and organizations perceived as having substantial responsibility for facilitating the summit. Confidentiality issues prevent these comments from being displayed here.

Q2. All Critical stakeholder organizations were included in the summit. (Agree Strongly to Disagree Strongly)
- Ethnic communities and disability groups not represented well, if at all.
- Left out Public School organizations and the Foundation of Dentistry for the Handicapped (donated Dental Services program). Also, legislators had been invited, but none were there.
- I do wish there was more representation of legislators at the meeting. *** The state Medicaid agency and managed care did not have policy level or administration representation present.
- The medical profession was left out.
- We forgot a few folks—seniors and developmentally disabled representatives—however, we involved them in a second summit. *** It would be good to include people with little or no access to dental care. Need to get their perspectives
- Left out consumer organizations and family-based organizations.
- Dental hygiene education programs were not represented well. I found out about the summit 5 days before the actual date. *** Should have been a louder voice from the state health agency and legislators *** Head Start programs outside the summit city were not invited.
- The dental hygiene educator’s association was not included.

Q3. Some critical stakeholder organization were unfairly represented (having either too few of too many summit participants) and created an imbalance of viewpoints. (Agree Strongly to Disagree Strongly)
- The dental hygienists association had a push on for a large contingent of dental hygienists to be there to present their views. *** The dental association should always be at such meetings.
- The hygienists had an agenda that was good, but not shared by all participants. *** There were quite a few dental hygienists present because they were particularly concerned with access to care. The dentists were invited but they just didn’t choose to participate in as great numbers. *** Legislators, local policy makers, consumers and medical health professionals were under-represented.
- State agencies were unfairly represented. *** While private sector medical/dental professionals, representatives from faith-based organizations, private sector business representatives and consumers were present, many of them could not participate for the entire conference, resulting in workgroups that were less diverse than we would have liked. *** One organization took charge of this summit and developed it, but there was no real planning committee and virtually no one was asked about planning or implementing the summit.
• Too many not-for-profit advocacy groups just wanted everyone getting care and did not care who would provide for it or pay for it. This was not (supposed to be) a forum for “universal health care.” *** More representatives for adult dental services would have enhanced the meeting. *** There was poor attendance by the private dental community, i.e., non-public health dentists and dental hygienists.

• All stakeholders had equal representation and opportunity to participate as members of four workgroups. *** Probably Head Start was over represented. *** Not enough dentists present, but that seems to be more of a problem of disinterest rather than not getting an invitation.

• The state dental association was well represented, but the viewpoints of the educator’s of allied dental personnel program were not adequately represented.

• The state dental association was invited and was a listed sponsor; I would have liked to have seen more participation from all the associations.

• Dentists were invited, but chose not to attend. *** The dental hygienist association used the forum as a way to lobby; definitely the wrong place for that type of presentation. *** Too many dental hygienists. *** Dental directors from FQHCs were not included.

• Should have had more private dentists *** Possible over-represented by members of the hygienist’s association.

Q4. There was a good balance of presentation/plenary session and small group discussions at the summit. (Agree Strongly to Disagree Strongly)

• While the national presentations were good, there was not a sense of how they contributed to any theme of the meeting, or to the goals of the existing Coalition.

• The HRSA central office speaker did an incredible job—very dynamic and did an excellent job in setting the conference tone.

• Possibly could have shortened the speakers’ times in order to have more time at the end of the day to review what the breakout groups had discussed.

• There was some opportunity for interchange at the various summits, but the groups did not communicate between sessions: there was no participation by the Governor’s Office, and little from legislators even though they were always invited and sessions were held when they would not interfere with their official duties.

• At the first summit, speakers were not balanced; it appeared to be just a forum for advancing the hygienist’s legislative agenda. In the second summit planners worked to see this did not happen. *** Plenary presentation had numerous people presenting and not enough time for them all. Small groups had plenty of time to brainstorm.

Q5. Summit facilitators were helpful in keeping the summit discussions on track. (Agree Strongly to Disagree Strongly)

• Many of the facilitators were effective, but a few were not trained well enough to keep everyone on task.

• I found the facilitators to be helpful, although I think some members of the audience perceived them to have a political agenda.

• We had a good facilitator, but he had no clue of the legislative climate and deferred to the dentists…We had much too little time.

• The facilitator in the workforce session concentrated too much on Medicaid.

• Facilitator seemed unfamiliar with oral health to the extent that she was unable to focus the group; consequently, everything was considered a priority.

Q6. The summit was an appropriate next step in a sequence of oral health activities and events which had already taken place in the state. (Agree Strongly to Disagree Strongly)
• Activities have expanded since the summit with identification of dental providers who accept Medicaid patients, and more educational activities geared towards prevention. *** There was a lack of consensus building first (before the summit).
• It is important to keep coalition members informed and to continue to include new members. State funding is becoming difficult to obtain so it is imperative to seek other funds to keep the agenda on the table.
• It was a step was in the wrong direction. Summit created no consensus on priorities.

Q7. The summit was not held at an appropriate time of day or week. (Agree Strongly to Disagree Strongly).
• The summit start time could have been later as a consideration to out-of-town participants.
• The morning of Sept 11, 2001, turned out not to be the best time to convene a dental summit. *** Much of the actual meeting was cancelled.
• Although we held the summit on a Thursday, it may have been more convenient to get additional private practitioners to attend on a Friday.
• You can never find a convenient time for everyone, but that did not seem to be an issue for most people.
• Weekdays are difficult for the private sector, especially for those of us who are employees.
• The individuals that work for State Agencies don’t care which days the meetings are held. For those of us in clinical practice with schedules that extend for months, it is difficult to move patients in order to attend on a work day without a lot of advance notice. A Friday or Saturday would draw a lot more clinicians from dental offices.

Q8. The summit influenced: Increase in coalition development and/or broadening of partnerships. (None, Weak, Strong, Don’t Know)
• Of most importance was the involvement of the state legislature…which resulted in some important outcomes to benefit oral health *** Groups continued to work together in succeeding legislative sessions. *** Created a broad base of support for legislation, started momentum for local coalitions to model their local summits on the statewide summit; beginning of a much closer relationship between state entities and the state dental association which has resulted in regularly scheduled meetings/collaborative projects. *** The summit represented the first time that Head Start was involved in the oral health initiative. This has resulted in a strong partnership with this group.
• Planning meetings are consistently held. *** Head Start involvement strengthened health education for parents *** Bringing all the players together at the meeting. *** The School of Dentistry and the Office of Rural Health partnered to offer the community placements for 4th year dental students. *** No new partners were identified—just existing Coalition members—it was an invitation only event. *** Legislators were invited, but none came as the Governor had called a special session. *** Working relationships between governmental agencies, the dental school, private practitioners, and advocacy groups improved.
• Several key stakeholders got together for the first time and learned about each other’s programs, services and resources, and how they could work cooperatively to address the state’s oral health needs. This ‘eye-opening’ experience has resulted in formal and informal partnerships to improve and expand dental health services. *** The summit had representation from the Governor’s office and a state legislator was present at the table. *** I do not know for sure what the continued relationships have been, but I know that our organization linked with another at the summit to work on oral health advocacy issues. *** It strengthened partnerships between school nurses and oral health prevention efforts.
• True coalition development requires more concentrated effort than what the summit alone was able to provide *** But, whenever key stakeholders are present there is the opportunity for networking which can potentially strengthen everyone’s programs. *** Everyone was able to
find out what the current issues and struggles are, and to share ideas for planning and improvement. *** Academicians, practitioners and advocates had an opportunity to engage in meaningful dialogue.

- Great networking opportunity for key leaders, policymakers, stakeholders and advocates. Especially good to see public and private working in closer cooperation. *** Some pediatric dentists and primary care physicians are beginning to collaborate on varnish and sealant placement in primary care settings and developing referral sources for Medicaid cases needing immediate attention.*** Not helpful—it increased animosity between dentists and hygienists

- The summit and the development of the state oral health plan influenced many activities. *** The NDA, ADA and the Medicaid program partnered in the state’s oral health campaign.

- We saw a revitalization of statewide oral health coalition and regional coalitions in the part of the state; the dental schools are cooperating more; private-public cooperation has been enhanced (dental association and the Department of Public Health have stronger ties); local health department and dental societies are partnering to have local sealant programs and education programs. *** Key stakeholders at the summit also played key roles in the legislative changes that occurred. *** A link was established with the state agricultural network! *** Our state already had a strong dental health coalition, but the summit established stronger ties to other stakeholders, allowing the coalition to broaden its membership and outreach.

- Results of the summit were presented to many organizations in the state. They are working to increase oral health awareness in their areas. Several collaborations are functioning in the state. *** (We could) match names with faces; develop common points of reference. *** The relationship among Head Start, advocates, and the dental school was strengthened and, in some locations, begun as a result of the summit. *** Most participating organizations had good existing partnerships. *** Many of the other organizations were not aware of FQHCs—we exchanged business card and made contact with several of these organizations since. *** As a representative from a (local) oral health coalition, I was able to share our information and research with over 100 potential coalition members in the area of advocacy…

- Brought together stakeholders in an organized fashion and provided a forum for the oral health agenda in several areas, including a state oral health plan. *** There were many stakeholders that joined the coalition for oral health access and were sincerely interested and some even became very active in their communities, but a lack of a trained facilitator, (caused) interaction and idea transfer (to be) weak.

- We included areas of the state not previously involved and professionals and educators and auxiliary dental personnel. *** The summit allowed stakeholders to get together prior to the legislative session. The presence of non-dental providers allowed for a broader view of the issues. *** It was helpful to learn what oral health programs were in existence and how we could coordinate our efforts. *** We had not had much contact with Head Start programs and primary care groups; they have proved to be very helpful in getting initiatives noticed. *** Many of the key participants have retired or changed positions, thus the impetus for progress has been lost. Organized dentistry continues to be a non-player.

- A state dental coalition has been formed. *** The summit provided an opportunity to meet and interact with varied organizations, some outside of oral health. This gives us all a firm base of supporters and advocates. *** Two agencies from the summit organized an Advocacy Day for legislators that included many other organizations that participated in the summit. *** Other examples: an Oral Health Surveillance Partnership promoting a survey of 3rd grade children. *** Since the summit, our coalition has broadened its partnerships at the regional and state level.

- Provided opportunity for oral health folks from around the state to network and develop relationships. *** The networking was obvious. *** The state oral health coalition formed as a result of the summit. The coalition played an instrumental role in the successful grassroots effort to keep adult dental care covered in Medicaid. The Coalition meets quarterly and has
established a listserv. The initial list of Coalition partners was gathered from a sign up sheet at the summit.

Participants now see a need to collaborate. Hygienists discussed independent practice at the summit and legislation was passed in 2003 to allow them to practice outside a dental office with various levels of supervision. As a direct result of this meeting, individuals from several communities are working together on a grant for oral health promotion. An oral health partnership group has been formed as an arm of our child health Institute. Coalition development increased more as a result of the 2003 summit than this one. Weak, because of “turf guardianship.”

Great networking and learning from other states—a jump start for us in development of the oral health plan. The same people are always at the table. It further expanded and strengthened the state Coalition. Led to the eventual formation of the state oral health Coalition which has become a powerful voice for oral health.

Workgroups that resulted from the summit brought together many partners. The Coalition has continued to strengthen since the summit. It is broadening now by adding physicians, nurses and advocacy groups. Brought together the dental association with advocates on Medicaid and fluoridation. We are still feeding off the momentum.

Coalition was fairly strong prior to summit. Many participants have not worked together as individuals or as agencies, and more are reaching out to others based upon contacts made at the summit. The medical-dental link was strong. I am not convinced that the summit will produce significant momentum for better oral health in the state, though it was a valid attempt. Since the summit, the Coalition has spent some time discussing outcomes and next steps, but it hasn’t been a priority. Leadership of the Coalition transitioned about the time of the summit.

Q9. The summit influenced: Development of oral health committees, work groups, task forces. (None, Weak, Strong, Don’t Know)

- The summit generated enthusiasm that carried over to the state’s oral health Coalition which subsequently created new, expanded sub-committees to continue the work begun at the summit. We formed a Dental Task Force, State dental Coalition and other committees of interested/concerned residents. Ten health districts received planning funds for systems integration to address access to oral health issues. Implementation of recommendations from the summit was assigned to the district Dental Directors who will serve as the State Oral Health Coordinating Committee. Programs will be developed at the district level by committees and work groups of local people most familiar with local/district needs.
- Within my county, it brought together funders and agencies interested in improving access to oral health services. Some participants are working on a foundation grant to accomplish some of the goal of the summit.
- The dental summit resulted in forming four workgroups…which made up the (state) Dental Access Coalition… A second summit was called soon after the original summit to address issues that had arisen between a small group of dental hygienists and the dentist community. Differences were addressed and a “wreck” in front of the legislature was avoided. The State Minority Health Office now participates in policy development on the task force.
- The State Dental Board appointed an ad hoc committee to research and make recommendations about defining and expanding the role of dental hygienists. The dental hygienist association worked to help formulate rule and statute changes to allow hygienists to work with less restrictions. The taskforce still continues to meet and continues to move its role to the private sector from the health department
- The summit produced legislative and educational coalitions. Work groups were created to develop prevention based initiative for the state Early Childhood Development program and a steering committee was created to develop ongoing oral health surveillance in the state.
have an ongoing summit follow-up committee that functions within our coalition that meets via teleconference.

- Jury is still out on this. Many wanted to continue work, but we have not had a lot of interest in getting meetings planned. *** Some follow-up meetings were held to discuss the summit and action steps needed. *** I am not sure about the progress made by many of the committees, but the energy was undeniable and there is little doubt that meaningful relationships were built and progress made. *** Resulted in a Head Start Oral Health meeting.

- Work groups were developed and they provided much information to the coalition, it just didn’t get the legislative impact that was desired. *** The Oral Health Coalition was strengthened as a result of the summit. *** The prevention workgroup greatly increased membership and the level of activity post-summit. Increased awareness of the oral health shortages helped to clarify the work of the dental education community. *** Workgroups supported continued re-introduction of legislation to include dental health providers in the state Health Service Corps—this was one of the strongest recommendations to come out of the 2002 summit. Getting this legislation took us three years to accomplish. *** Although there were good ideas and action items identified, the Department of Health, which was designated to follow-up post summit, did not. 10.8

- The State Public Health Association, as a direct result of interaction of people at the summit and during its planning phase, has implemented an oral health section. *** Statewide fluoridation workshops and school oral health surveillance program have been initiated by the Department of Health.

- The coalition developed at the summit meets quarterly. *** The summit validated the efforts of the State Dental Director to bring folks together to discuss the state’s Task Force on Oral Health Access. *** Five summit attendees returned to their communities and developed local coalitions.

- Although not directly related to the summit, I was asked to be on a workgroup that contacted me only because I was on the summit planning group. *** Until now, I had not been contacted for any follow-up. *** Until this summit, none of the groups were effectively communicating. *** This was a very basic starting place which laid a foundation for beginning work. A state coalition was established only this year. *** The oral health coalition has several committees. *** We had two summits, but we just keep hashing the problem, not working towards change.

- Summit follow-up is discussed to some degree by the Coalition. *** The Coalition used the impetus of the summit to move forward in the area of adult oral health advocacy. *** Adult dental received more attention than anticipated, resulting in continuation of the adult Medicaid program when cuts (appeared) inevitable.

- Several workgroups have evolved from the alliances begun at the summit and have been instrumental in securing oral health grants for the state. *** It provided valuable input to the advisory council overseeing implementation of the state plan.

- As a result of the summit, a steering committee and three different workgroups were established. *** Several participants noted that the coalition is one of the most active groups in which they’ve ever participated. *** The summit ran out of time and momentum; the steering committee will have to assume additional leadership in making assignments or developing new work groups.

- Three major workgroups were formed with representatives from many organizations. *** The summit was needed to enroll new organizations in the Coalition; committee members come and go so it is important to conduct annual summits.

Q10. *The summit influenced: Application to a National Governors Association Oral Health Policy Academy. (None, Weak, Strong, Don’t Know)*

- The NGA Academy team was already in place at the time of the summit. *** The Summit was a continuation of previous NGA activities. *** NGA was very effective. Committees meet
quarterly to continue the work of the summit. Group consists of state policy makers, medical personnel and consumers.

- The state summit, to a large extent, was patterned after the NGA meeting. The main planning group for the summit was the NGA Policy Academy Team.
- The Governor’s Office asked that an application to the NGA academy be submitted, but the state dental association refused to participate, so the process was aborted.
- I honestly can’t recall whether a formal application was submitted. There was serious discussion about doing so.
- Attendance at the NGA Academy was prior to the summit. An oral health policy was developed (at the NGA meeting) and many of the same outcomes used at summit. Participation in the NGA academy allowed our coalition to establish stronger relations with other stakeholders in the state.
- We didn’t have the summit until after we attended the NGA Academy. The coalition had formed prior to the attendance at the Academy and key stakeholders attended, but legislative and executive branch representatives failed to show up. The summit strengthened the team that attended the NGA Policy Academy.
- The Academy developed a draft of the oral health state plan, and the summit provided a forum for feedback on the draft. The feedback was all positive. The NGA academy also allowed states to learn from each other. Dental hygiene was excluded from the NGA.
- I participated in the NGA Academy which was a direct result of the first summit. Attendance at the Academy and planning for this (second) summit occurred concurrently. Most who participated in the NGA Team were also at the Summit.
- Although the state did not attend an academy, two representatives of the Coalition did attend. (One attendee) reported out (about the Academy) at the summit.

Q11. The summit influenced: Heightened visibility about oral health issues among the public. (None, Weak, Strong, Don’t Know)

- No data is available to measure this, but we had some excellent newspaper articles following the summit. There was good coverage at the time of the summit, plus (oral health) is now on the radar screen at state and local levels. The issue had media interest long before the summit.
- This invitation-only summit focused more on internal stakeholders. Public awareness is being generated by other outreach efforts within the state. The summit report has generated interest from outside parties not involved in the summit itself, e.g. a non-dental agency, citing the summit report as an example of what can be done, is determining if a similar approach could work for their interest area. Through brochures, posters, education materials, media blitzes and other conferences, visibility had been heightened. Medicaid workers are visiting Head Start Centers across the state, providing training and leaving resource materials, but the summit did not receive much media attention or involve the general public. There was a press release as the summit began, but I am not aware of anything following the meeting. The development of an oral health fact sheet in the state increased visibility.
- Some newspaper coverage. A compact disk of major summit papers and information was given to participants at a large state meeting. Increased visibility of school sealant programs.
- Word didn’t get out to the general public very well. Issues addressed and further fleshed out in small groups have the potential to greatly impact the public in general. Leadership of the State Dental Director is key to placing the spotlight on oral health as a priority.
- Unusual advocacy groups are now interested in oral health, e.g., the city water company is sponsoring Healthy Smiles, Head Start programs are now promoting oral health and follow-up care; there is an emphasis on pediatric oral health education by the dental schools; regional Area Health Education Centers have given greater emphasis to oral health issues among all health professionals (dentists, hygienists, nurses, physicians). Fundraising has begun for
statewide oral health (public) announcements on radio. *** Strong press coverage. *** Not much public visibility outside of health officials. *** A disappointment of the summit was the lack of participation by the public.

• A strength of the summit was the number of organizations that participated, but involvement of a Church Mission brought a greater visibility to the program.

• Development and dissemination of a PowerPoint presentation and a statewide oral health position paper (have heightened visibility). *** Strong: News media coverage, major television stations and newspaper articles. *** There was excellent media coverage of the event. *** Minimal media coverage of the summit, though it may have stimulated some increased outreach efforts by groups on specific issues, e.g., fluoridation. *** More publicity is needed.

• Inclusion of primary care association participants improved visibility. *** The conference was attended by the media. With the efforts of participants and a US Senator, oral health is an active issue in the state. *** Key players are no longer holding positions of influence. Some policy is taking a giant step backwards (dental Medicaid). *** Policy recommendation from the summit resulted in successful legislation passed in the next legislative session. *** Newspapers are addressing this.

• The summit’s report is available to the public on the Internet. *** The summit resulted in an advocacy day to promote children’s oral health. *** This area requires both professional and monetary attention... it is one of our greatest shortcomings.

• There was some press *** Most attendees were providers or involved in healthcare. The public was not targeted at this first summit.

• The goal of the summit was to reach key decision makers from organizations, not to focus on increasing the public’s awareness about oral health. *** Press sheet, fact sheets and information papers have been developed by the Coalition. *** The summit alone did not produce much awareness, although individual participants have continued to make awareness a priority.

• The key stakeholder groups at the summit had potential to increase visibility. *** I think it’s a problem, but not anyone’s fault—it’s hard to make it visible to the public. *** Would have been neat to have had a major PR blitz about the summit—unaware of any press. *** The grants that evolved are working to raise public awareness.

• I think it heightened awareness for those in the “field,” but the focus was not on marketing to the broader community. *** Better media coverage could have greatly improved the impact on the public.

• Public awareness is increasing gradually as a result of the summit. *** The workgroups provide visibility. *** Most of our work has focused, so far, on advocacy groups and policymakers. *** We’ve held an oral health day for the legislature and press conferences. *** Based on voter decision, fluoridation will occur in our more populated counties. *** We had a strong presence in the legislature last year; as a result, in large part to the Coalition’s effort, we increased money for dental CHIP.

Q12. The summit influenced: Heightened visibility about oral health issues among policymakers. (None, Weak, Strong, Don’t Know)

• Legislative and executive branches failed to participate. *** Policymakers were invited to the sessions and spoke about oral health issues. *** With the election of a new Governor, many of the faces changed and our issues did not make it into this year’s legislative agenda. We did get inclusion of dentists and hygienists into the state Health Services Corps.

• Summit planners had initially involved Legislative staff and worked closely with the legislature on oral health strategies.

• Dissemination of the summit report to legislators and policy makers provided greater visibility for oral health issues. It also provided a valuable reference document for all involved due to the data included in the report. *** Legislators, the Governor and the Medicaid Commissioner
worked to increase reimbursement to dentists…and it passed! ***E.g.: changes in how dentists are licensed in the state and Medicaid outreach to increase participation by dentists. *** Poor participation by policymakers. They were invited and encouraged to attend, but did not. *** A State legislator serves as a member of the state’s Coalition, and an oral health fact sheet has been developed and disbursed to each legislator.

- Too soon to document. *** The state dental association significantly increased its effort to educate legislators about oral health issues, hiring a high powered lobbyist and meeting one-on-one with legislators. The result was reinstatement of Medicaid adult dental benefits. *** Good attendance at the summit by policymakers and their staffs. *** Participants improved relationships with policy makers, communication improved and opportunities to communicate increased. *** Having the Lt. Governor as the keynote speaker was a great choice. *** The summit has never been mentioned by state legislators.

- Legislators and other state executives (education, families and children, Medicaid) request periodic updates on the oral health status and program needs. *** Policy movers are being targeted for legislative changes. *** Good advocacy by the Governor’s staff and several state house and senate leaders. *** Several legislators involved in the summit have become advocates for our oral health legislation. The Lt. Governor was a participant and has established a task force which has pushed for legislation to remove junk food from the schools. *** No ELECTED officials attended, and most health officials in attendance were already pretty well-versed on oral health issues.

- Heightened visibility about oral health can be partially attributed to summit planning activities—every legislator in the state has received copies of the oral health plan.

- Weak—it’s very difficult to maintain the urgent focus on oral health issues with policymakers in the midst of competition with matters such as budget deficits.

- The key decision makers were present, including the state Medicaid director and the Secretary of the state Health Department. *** The summit position paper disseminated at the summit has been given to legislators. *** Input made to state legislators by summit committee members related to possible Medicaid cuts.

- There was heightened visibility among policymakers within state health agencies and in the offices of a US Senator whose representative spoke at the summit on national oral health access. *** Inclusion of legislators, review of legislative agenda and rule and regulatory changes. *** Although a couple of legislators were present, it does not appear that oral health issues are a priority in the state.

- Papers distributed to staff of elected officials at the summit have been used in follow-up meetings and activities. *** A very firm relationship has developed among stakeholders and legislators, especially with the Commission on Rural Resources.

- Many policymakers were present, but still, too few were reached. *** Influence was not strong even though a panel of state policymakers was present at the Summit town hall meeting. *** The coalition played a strong role in saving adult Medicaid dental services. *** It helped in the sense of lighting a fire under others who took issues to the policymakers later. *** The coalition executive committee kept the coalition listserv members updated regarding issue (mostly Medicaid).

- Several legislators joined us for the day. *** Good attendance and participation of policymakers. *** I think this was one of the main positive outcomes of the summit. *** Limited legislative participation was a (not unexpected) disappointment. Legislators gave luncheon presentations about the bleak budgetary outlook, then left before the breakout sessions. *** After the summit, participants spoke more realistically about possible support from the legislature.

- Only a few legislators attended. *** One legislator attended, but stayed only one hour. *** Policymakers are neither informed nor encouraged to attend these summits.
• Representatives from the Governor’s office were present—would have liked a couple of key legislators or senior staff. *** State agency representatives were there, legislators were not.
• Only a few policymakers were present, but visibility is increasing gradually since the summit.

Q13. The summit influenced: Development of state legislation on oral health issues. (None, Weak, Strong, Don’t Know)
• Too soon to document. *** Legislative response probably will await some improvement in the state’s economy. All recommendations from the summit relate to the need for funding which will not be available as long as the state is threatened by budget deficits.
• (The summit resulted in) support for a dental hygiene school, rule changes through the Board of Dental Examiners allowing retired dentists to participate as volunteers in public health settings, limited access permits for dental hygienists to practice in public health settings, and dental student rotation programs in rural areas. *** Plus, income tax reductions for loan repayers serving in underserved areas, increase in Medicaid reimbursement, which since has suffered cutbacks due to budget situation.
• Increased awareness on oral health issues may have helped improve support for licensure by credentials legislation which passed in 2002. *** There was news media coverage in three of our largest cities.
• None to date. When the fiscal climate is right, the dental association will ask the legislature for funds for a statewide comprehensive preventive dental public health program. This year, their effort is to educate legislators about the need for early prevention and improving oral health and access through the public health system. *** The Board of dentistry is drafting legislation to improve the ability of retired dentists to practice for charity and to allow certain endorsed dental hygienists to practice under general supervision in underserved areas.***Weak. Need to be more visible to the average citizen and legislative policymakers.
• Strong: Indirect supervision of hygienists passed last session; mandatory oral exams prior to entering school is being proposed again; anesthesia for children by third party payers passed last session; limiting kids access to vending machine snacks will be resubmitted next session, and a statute to loosen requirements for visiting dentists to provide charitable dental care passed. *** Also coronal polishing regulations for dental assistants approved. *** Also local anesthesia by hygienists.
• We did not have any dental Medicaid cuts this fiscal year with a very tight and deficit state budget. *** The emphasis of the legislative session was not on new legislation, but on maintaining the programs already in existence.
• Resulted in legislation that allowed hygienists to provide preventive services in public health settings, unsupervised. *** Weak because of state budget woes and not much legislative participation among coalition members.
• We had policy discussion of new oral health legislation and successful inclusion of hygienists and dentists in the state’s Health Service Corps. *** Several appropriation bills were introduced to fund several programs, such as an early childhood caries program, sealant and community dental services, but they did not pass. *** Other than the Health Service Corps funding, oral health legislation has been stagnant.
• Strong: A bill to provide licensure for qualified non-US citizen dentists and hygienists was enacted to address the shortage of dental professionals. *** Other oral health related legislation is pending, such as permitting the use of school buildings to establish dental clinics and mandating dental examination as part of a physical exams. *** And bills on loan forgiveness were all recommended in the summit report. *** We need a comprehensive approach to legislations on oral heath issues.
• Although the summit did not specifically generate legislation, the legislative attendees did come away with a strong sense of support for oral health. *** A few bills were introduced on dentist and hygienist practice, but these probably resulted from the professional associations
rather than from the summit directly. *** This session was for maintaining and expanding oral health. Medicaid coverage for adult dental care survived the toughest legislative session in decades with only a small cut, rather than total elimination as had been predicted.

- The summit, per se, did not have a measurable effect. The Task Force on access, that preceded the summit, did; e.g., a bill that addresses some access issues awaits the Governors signature. *** The state dental association, after participating on this Task Force, formed an access committee that resulted in the access legislation. *** The summit helped bring the dental association to the table and, as a result, the legislation they proposed and won, though somewhat weak, has positioned the association to be on the side of improving access. *** The Coalition’s work on keeping adult dental Medicaid was significant.

- Loan forgiveness programs did not pass. *** The dental hygiene access laws were passed, but much more needs to be accomplished to improve access to care. *** There is no collaboration between the state dental association, the dental school, or the primary care association to affect change.

- The Access to Baby and Child Dentistry program was implemented by Medicaid in 2002.
- Strong: Coalition members actively and successfully worked to restore the CHIP dental benefit which had been cut the prior year. *** The legislature created an oral health Task Force. *** Dentists were included in state loan repayment programs. *** Budget constraints limited the level of our strength. *** We are developing a PowerPoint presentation to educate legislators about the Coalition’s strategy this year.

Q14. *The summit influenced: Heightened visibility in the news media. (None, Weak, Strong, Don’t Know)*

- The Summit had excellent media coverage and oral health issues have been highlighted continuously. *** Sparked new interest in dental issues, including need for care providers, promoting better oral hygiene and the need for community, non-profit dental care clinics.
- I’m not sure if it was the summit, but I think it had some influence because of the newly formed relationships and all of us harping on legislators to reinstate adult dental. It was a complete surprise to me that it was reinstated, particularly since our state is in a budget crisis.
- Print and radio messages are now airing. *** But, not much print or TV/Radio coverage at the time of the summit.
- Two major and several minor newspapers had stories about dental issues; “Meet the Press”-like TV news shows, requests by advocacy groups for presentation on oral health issues have increased since the summit, the NGA Academy, surveillance conferences and the publication of the children’s oral health survey.
- We had media coverage during and immediately after the summit, and national exposure through American Dental Association news coverage and through presentation at a national meeting. *** Coverage was too numerous to count. *** Weak: not much publicity. *** Media was invited and just didn’t participate much.
- We had great news coverage and articles in large cities in the state. *** There was minimal media coverage of the event and no significant increase in coverage since.
- Little to no interest shown by the media. *** Many articles regarding inaccessibility of oral health quoting various members of the Coalition.
- Some came from the conference, but most has occurred due to participants going to the media and to having a US Senator as an advocate. *** This area needs improvement and continues to be a challenge. *** Developed a plan for oral health visibility to be implemented in conjunction with the University and the local public broadcasting station (to be rolled out with the changeover to digital broadcasting).
- The Coalition’s work, and that of the state dental association and primary care association, resulted in two televised press conferences, several op-ed pieces and news articles. *** More could have been done to raise media awareness.
• This summit was not widely publicized. ***I have heard nothing.
• In spite of numerous press releases and media invites, media response is dismal. *** Need to focus more on how to make dental more news worthy.
• The summit focused on reaching a wide array of oral health providers and advocates; Summit planners left the task of raising visibility of oral health issues in the community-at-large to another, ongoing project.*** Individuals/organizations participating in the summit have been very successful in getting extensive coverage.

Q15. The summit influenced: Changes in policies or procedures of the Medicaid Program or SCHIP, either by the programs themselves or by the state legislature. (None, Weak, Strong, Don’t Know)
• No effect. The state, through the legislative appropriation process had just approved an increase in payment of fees to dentists when the state budget crisis occurred. To balance the budget this year, all state programs suffered cuts, including dental services to Medicaid and SCHIP patients. ***Unfortunately, due to the state’s economic condition, cuts have been made in Medicaid procedures covered. However, it is my belief that the summit helped to keep these cuts from being more significant than they were.
• SCHIP provider application form was simplified from 7 to 1 page and eliminated preauthorization requirements for Medicaid, except orthodontics. *** New reimbursement methodology using relative values, and universal and abbreviated application forms. *** Increased reimbursement, easier-to-read materials, easier (for providers) to enroll in Medicaid and SCHIP, plus increased number of dentists participating.*** Developing CE courses to be given in conjunction with Medicaid seminars to enhance general dentists’ skills in managing pediatric patients, and to increase knowledge of the benefit of sealants.
• Adult dental benefits were reinstated by the legislature, having been reduced to emergency-only in 2002 to help balance the state budget. Medicaid and the State Dental Association worked together to define covered benefits.
• Community involvement in the Dental Policy Advisory Committee and no (adverse) change in the Medicaid program this fiscal year can be partially attributed to the summit activities.
• Weak. Adult Medicaid benefits have been cut to meet the state budget crunch.
• Medicaid has begun to put personnel resource into the dental program and is recruiting dentists to the Medicaid program; utilization of dental services has significantly increased since the summit occurred.
• Nothing has been done regarding Medicaid and SCHIP, although it is a subject to put on our agenda. ***There is continued input by the Dental Technical Advisory Committee to review and make policy recommendations. *** Weak effect. Previous slight fee increase was maintained and adult benefits maintained in tough budgetary times.
• Medicaid is very supportive of providing dental coverage for pregnant women, but we are still working on this. Maybe next year. *** We continue to see modest reimbursement rate increases and ongoing dialogue about other reforms, but that is much more attributable to the highly visible governmental relations work of the state dental association. ***Adult dental Medicaid continued.
• Resulted in the Deputy Director of the agency managing the Medicaid program becoming very involved in oral health issues. *** (Medicaid policy) changed to allow FQHCs to contract with private providers to increase access.*** Much of the change had already been accomplished prior to the summit.*** I said “weak” only because the coalition has been unsuccessful in raising Medicaid reimbursement for private providers, however, the coalition has been influential in advocating for continued dental benefits.
• The Medicaid program did not participate, though asked. *** The Medicaid program made changes to their rules to allow dental hygienists to become Medicaid providers and a dental director for the Medicaid program was hired a few months after the summit. *** But, now we
are going backwards. *** We are in survival mode to keep the Medicaid dental benefit; however, there were no changes in eligibility or the Adult dental program this year. *** Support for the dental programs was significant and sufficient to hold the program harmless from proposed legislative cuts. *** We have been effective in this area. Legislators look to this group for credible information.

- Through the efforts of a regional coalition, dental reimbursement rates for a regional SCHIP provider are the highest in the state.
- Daily the coalition listserv members are given updates and assignments to contact policymakers regarding Medicaid and SCHIP. *** And the dental association lobbied very hard to save Medicaid in the state budget. It worked! *** Medicaid has committed to hiring additional staff to work solely with dental providers. *** The Medicaid folks have provided not much more than lip service to date. They convinced the Governor to line item veto what would have made “optional” services under Medicaid “mandatory.”
- None: Adult dental Medicaid services actually were cut in 2002.
- Certainly presented an opportunity to explore possibilities and strengthen the partnership with Medicaid representatives. *** The state had been unable to find funds for the SCHIP, thereby denying oral health access to numerous children.
- Biggest change has been in Medicaid finally acknowledging that reimbursement has been a barrier to access. *** We were successful in getting dental SCHIP reinstated and a slight increase for children’s Medicaid dental services, but we lost adult dental in the process.
- There was strong advocacy with political leaders for continuation of adult dental Medicaid coverage. *** The adult dental program was continued and children’s services sustained, but this may not be as a result of the summit, per se.

Q16. The summit influenced: Changes in professional licensure. (None, Weak, Strong, Don’t Know)
- In process, e.g., the state Board of Dentistry has proposed several changes to dental hygiene and dental assistant practice to improve access. *** There was excitement generated by the idea of expanding roles auxiliary dental personnel. Whether “father dentist” is ready to hear or entertain this concept is an entire other matter.
- Changes have occurred in dental hygienist supervision, and in allowing nurses to screen and apply fluoride varnish (through a change in interpretation, not statute).
- A workgroup was convened six months prior to the summit to make recommendations regarding licensure issues. *** Summit contributed to increased interest in hygienist collaborative practice opportunities and public health licensure. *** We gave testimony to the state dental Board which then made a change granting temporary licenses to dentists willing to work in high need areas. *** We facilitated licensing by credentials. *** The state dental Board now accepts more than the Western Region Boards for licensing.
- A bill to allow licensure of non citizens meeting educational and examination criteria was passed with the efforts expended by members of the coalition.
- The dental association has been instrumental in increasing the scope of practice for dental assistants and for changing the size and composition of the dental Board. *** A series of meeting were held (as a result more of the Task Force then the summit) between the Board and organized dentistry to review potential practice act changes.
- Since the summit took place, hygienists are now allowed to practice in schools and nursing home under general supervision, but this change was already in progress before the summit, so there was no connection. *** None that I am aware of.
- The state dental and dental hygiene associations are collaborating on the possibility of expanding the services provided by hygienists. *** The state dental Board has not received proposals, but they are aware they are coming and they may be supportive.
• The dental association successfully carried a bill to knock down barriers to dental licensing, but this was initiated internally and not connected to the coalition.*** The legislature enacted a bill for licensure by credentials, but bills on dental hygienist scope of practice did not pass. It is difficult to demonstrate that the summit itself influenced either the introduction of disposition of these bills.

Q17. **The summit influenced: Changes in oral health professional training and education.** *(None, Weak, Strong, Don’t Know)*

• The prevention/education workgroup is developing a lesson plan for Head Start educators. *** The coalition played a role in helping the University dental residency program to include rotations in rural shortage areas. *** Pediatric medical residents now have oral health as part of their training.

• Hasn’t happened yet, but there is a move towards involving dental student in the community. We had our first dental student working in our public health clinic.

• Increased activity for medical professionals in the University curriculum. *** The new dental school Dean and other educators attended the summit which coincided with the University receiving an RWJ pipeline grant.

• Progress continues to be made on increasing dental students’ awareness of access issues, and improving education in areas of prevention and early childhood care.

• HPSSA designations have been assigned to a majority of counties in since the summit.

• The dental school participates in the state’s program which recruits 4th year dental students to participate in community rotations in shortage areas. The number of students increased from 10-18 this past year. *** Forty students have participated and 5 graduates have chosen to practice in a community health center.

• The Associate Dean of the dental school was a member of our oral health committee and worked on increasing the number of pediatric dental residencies.

• Training requirements were outlined for expanded practice opportunities for hygienists.

• Groups or physicians and nurses are being trained in oral health screening, application of varnish, providing oral disease prevention and health promotion messages and making proper referrals to oral health professionals. *** Dental professional licensure not addressed.

• Strengthened the dental school’s outreach to vulnerable populations, thereby increasing student exposure to the underserved. *** The dental school increased enrollment; 70% of admissions to the school will be state residents. The position was solidified by the summit, but the direction for change had begun prior. *** Head Start programs and school nurses brought the new information back to their programs.

• The summit discussed training of dentists and hygienists, non-dental health providers and others. *** Summit recommendations led to the formation of a legislative resolution to develop a statewide dental education plan; a dental education summit will occur this summer. *** Subsequent to the 2002 summit, the school of medicine began a major initiative to establish a dental education component. We also had successful application for a dental residency program and an Oral Health Institute.

• The state now substitutes one year of dental residency training in lieu of clinical board examination. *** But, I don’t know if the summit influenced that decision.

• It increased education for professionals working with the public. *** The summit should have included someone from the school of dentistry. *** Dental has found its way back into health books in schools and school nurses have been trained to recognize dental problems.

• There was considerable discussion about training and education. Premature to know about the final outcome.

Q18. **The summit influenced: Creation or expansion of oral health professional loan forgiveness or scholarship programs.** *(None, Weak, Strong, Don’t Know)*
• An increased awareness of access to care issues created by the summit has opened the communication lines regarding loan repayment programs for dentists.
• The summit led to legislation that added dentistry to a state loan repayment program for medical professionals. *** But, I am not sure if more money was appropriated. Legislation now provides incentives for doctors to relocate in rural and urban areas.
• We were able to get a state income tax deduction of up to $5,000 for providers receiving loan repayment who are serving in shortage areas.
• The dental profession’s participation in the loan payment program has resulted in 5 dental graduates being place in underserved areas of the state.
• The legislator who participated in the Summit got legislation adding dentists and hygienists to those primary care health providers eligible for rural access grants.
• There has been continued discussion about the need for loan forgiveness and scholarship programs in the state, but I am not aware of the effect of the summit on these activities. *** Delta Dental created a loan repayment program for dentists.
• The state loan repayment program has added dentists to the list of those eligible; the appropriate representative from that program is a member of the oral health Coalition
• As a result of summit recommendations, dentists and hygienists are now included in the states Health Services Corps and are eligible for a $20,000 in return for providing year-for-year service in underserved areas. *** It is my hope that this program has been expanded, but there has been great confusion and misdirection in the past.
• The state dental association recently promoted legislation to assess dentists’ $10/year on their license fee to create a loan repayment program. Result of the summit or simply a generalized awareness of oral health issues? *** This was not a result of the summit; it was a result of the Task Force that preceded it.
• Legislation was introduced in 2002, but I don’t know if it was a result of the summit. The governor vetoed the bill that included this section. *** Veto was due to opposition from the dental association. *** The collation said they would support loan forgiveness legislation, if the dental association introduces it this year.
• The state has had a loan forgiveness/scholarship program for years, with dental receiving priority. *** The summit gathered anecdotal evidence that loan forgiveness may be one of the few viable means of quickly adding providers to rural areas.
• A dental tuition reimbursement program passed, but it is unclear if the summit had any role in this. *** A loan forgiveness program is in planning stages.

Q19. The summit influenced: Creation or expansion of community-based clinical oral health programs. (None, Weak, Strong, Don’t Know)
• Summit participants were instrumental in submitting two successful grant applications to establish community health center (CHC) dental clinics.
• Several community groups are partnering with the state Medicaid office to provide dental screenings and treatment to low income families.
• Both summits really helped gain acceptance by the dental community of community-based clinics. Dentists had been suing the health centers and submitting comments against shortage area designation, but now the state has several health centers with dentists on staff and they are expanding.
• Over the past years, the school of Dentistry has expanded from 1 community-based clinical site (for extramural training of senior dental students and pediatric dentistry residents) to 8 sites. Plans are to have 11 sites by the end of 2004.
• CHC participation in the summit and its recommendations encouraged CHCs to proceed as fast as possible to help meet the area’s dental needs.
• One foundation developed an initiative with a Health Center to provide mobile services which is now being reviewed by others for potential replication. *** We are seeing an increase in the number of community-based clinical oral health programs.

• At least three new CHC’s have been opened and existing primary care centers are adding oral health components. The school of dentistry has expanded its mobile program for children to include migrant and rural populations.

• Many applicants (for community-based programs) have used the information from the summit to write grant expansion proposals. *** More stirrings in the direction (of community-based programs), but hard to establish causality with the summit.

• Increased the number of community-based clinics in FQHCs and opened new sites. Increased FQHC collaboration with the state dental association. *** Mobile units are available by corporate and community efforts. *** Some participants attended to gain knowledge to assist them in developing local (community-based clinical) programs.

• The support from the coalition for collaborative dental hygiene practice has been appreciated. The hygienists still work within their scope of practice, but if a dentist isn’t available, they do assessments and help get patients into the treatment phase.

• The state has awarded $3 million over three years to 8 health agencies to develop innovative dental service delivery systems and to provide assistance to organizations interested in developing innovative systems in their communities.

• The state is educating WIC employees about early childhood caries and the importance of oral hygiene, and is designing a xylitol gum/prophy program for pregnant women. *** There has been an expansion of CHC clinics across the state.

• The increased focus and attention has resulted in grant funding for new and expanded clinical and case management dental programs. *** The dental school received a grant for their students to go out into the community, but I don’t know if this is a result of the summit. *** The Director’s Task Force (preceding the summit) led to Tobacco settlement dollars that went to safety net clinics.

• The greatest impact has been from an out-of-state organization that has built three pediatric Medicaid clinics. *** Another organization has two dental clinics at two schools—the summit set the stage for later expansion of these clinics.

• A mobile dental clinic program, in conjunction with Delta Dental, will be implemented. CHC’s are expanding services in many of their newly funded clinics. Plans include the possibility of contracting with private sector dentists.

Q20. The summit influenced: Creation or expansion of school-based oral health programs.
   (None, Weak, Strong, Don’t Know)
   • School-based preventive dental clinics were established in two school districts.
   • By allowing hygienists to practice unsupervised in public health settings, such as schools, the number of school-based sealant programs increased.
   • School nurses have received training on doing dental screenings and are now authorized to conduct school-based screenings.
   • Strong—expansion of the school-based dental sealant program and the Access to Baby and Child Dentistry Programs. *** Much discussion in the break-out sessions about school based and linked services. *** The primary care association has funded school-based research, which has resulted in the addition of dental sealant and varnish programs.
   • 19 of 56 local health departments have begun school-based sealant programs using volunteer dentists and hygienists, with additional funding from the state health department. *** Expansion of sealant, Mobile and fixed clinic programs.
   • The state currently has fully funded program of school-based oral health with both public and independent dental hygienists***I’m not aware of any changes directly related to the summit.
• The summit facilitated easing of differences between the state department of health and non- and for-profit school base providers who offer preventive care and referrals in schools. The not-for profit has hired dentists to give restorative care for Medicaid children. *** The University has opened a three chair clinic in middle school in a dramatically underserved area of the city. *** Since the summit, the state has experienced an increase in the number of school-based providers and expansion in the scope of preventive services offered.
• The state is substantially increasing the budget for the dental sealant program. *** School based dental services will be expanded by the new “Innovative Dental Services Delivery System” grant made by the state.
• The school based programs have increased and some of this can be attributed to alliances built during the summit. *** Discussions post-summit eventually led to a public-private partnership to expand school-based dental prevention programs.
• There is a new school-based CHC funded in 2003 with five school clinics that are required to provide oral health services.
• Summit networking resulted in expanded school-based programs in a county.

Q21. The summit influenced: Use or analysis of existing oral health-related data. (None, Weak, Strong, Don’t Know)
• The presentation of the needs assessment data was fantastic. The legislators really understood the report card data on oral health.
• The web-site for the state’s Oral Health Program has become very sophisticated and offers a comprehensive needs assessment of current oral health issues. *** Relevant oral health–related data was compiled for each public health district and distributed at the summit. The data has been used for school health site visits to provide information regarding local measures.
• There is now a research analyst to support the state MCH Oral health Program who is working on analyzing and compiling all relevant data for a state oral health report.
• Summit provided impetus for development of a statewide dental survey and other surveillance activities. *** The state went through a long period without a state dental director. One has been hired and data is being updated. *** At the summit, information was provided on Head Start children across the state, including numbers screened and treated. Working to collect this information on all children. *** Info is now readily available on fluoride water systems, number of dentists seeing Medicaid and CHIP children, shortage areas, etc. ***
• We saw publication of the children’s oral health survey and use of 1987 data for trending. *** The summit provided the impetus to collect new data.
• Many agencies are using data presented at the summit to write grant proposals. *** The presentations were nail-biters; the statistics were enough to motivate everyone to listen. *** I regularly use the oral health data I received at the summit.
• Increased the support for existing oral health surveillance systems and used data for policy decisions regarding the state oral health plan. *** Several reports have been prepared using data collected by the coalition.
• Data was presented from the survey of third grade children as well as other existing data to identify gaps, target areas of greatest need, and identify/discuss the extent of oral health problems. *** Data was used to compare our state to others. *** There are other data collected by the Licensing Board, but is not useful yet; I am trying to get that corrected. *** There was no useful data provided, and since the Medicaid program did not participate, no Medicaid data were provided.
• More people were exposed to oral health data as a result of the summit and there has been extensive distribution of that info in the past months.
• The state Department of Health is developing a network of existing county health agencies to collect and analyze existing and develop new oral health.
• Data from a joint report by the state Health and Medicaid agencies were shared at the summit and released on the Internet. *** The increased focus and attention have heightened the need for and use of data. *** We have the data, yet I don’t know how we have used it, other than to make it available to individuals.
• There were little data available at the time of this conference. 14.6
• There are good data from Delta Dental and the state Medicaid agency on utilization of dental services. *** We’ve used the Medicaid data in grants and with the legislature.
• A statewide survey of 6-8 year old children conducted around the time of the summit has been widely distributed. *** These data need to be made available in a more timely fashion so that stakeholders can make good use of them. *** We used the data in all our presentations to legislators and at media functions.

Q22. The summit influenced: Collection or development of new oral health data. (None, Weak, Strong, Don’t Know)
• The Department of Health had just completed a statewide survey of third graders that usually occurs on a five year cycle. *** The lack of data for other populations was recognized as a problem. As a first step, acquisition of data from studies and scientific research was recommended.
• Regular data updates are being made for news releases, brochures, and educational materials. *** New State Dental Director has begun surveillance and is providing policy-makers and public with data.
• A university dental student interned with a state legislator who was on the summit panel. The student researched adult Medicaid issues in the state and wrote a position paper that was disseminated. *** In one area of the state we plan to survey dentists on their willingness to participate in an early childhood prevention program.
• Surveys of children and adult oral health status have been completed and published, and an elder survey is being completed. *** Two or these had begun prior to the summit. *** A surveillance program is being developed to monitor yearly progress.
• A county surveillance system is being developed. Data on 7000 children have been gathered.
• One of the actions in the oral health plan supported at the summit was the updating of the oral health needs assessment, which resulted in the 2002 statewide basic screening survey. *** Due to the summit raising awareness, the state has acquired grants to develop an infrastructure which is the major source of oral health data.
• A statewide survey of elementary school children has recently been completed by the Department of Health.
• Summit workgroups helped to initiate collection of data on ER use and hospitalizations related to oral health. *** New surveys of fluoride tablet use are underway, though this may be only weakly related to the summit, and focus groups of consumers are identifying dental access barriers. *** We should have tried to pinpoint research needs presented by our new objectives.
• Summit action steps could lead to better oral health reporting. *** We had more discussion of the importance of oral health data, especially specific local health jurisdiction data, rather than state data.

Q23. The summit influenced: Creation or expansion of oral health promotion programs aimed at the public. (None, Weak, Strong, Don’t Know)
• Hiring of a health educator by the state has promoted the oral health agenda for a variety of organizations. *** Grant funds are being sought to finance a state-wide public health and health education program.
• At a 2003 meeting of the state’s oral health alliance, conducting a media campaign was identified as a priority next step.
• Public awareness was a very strong theme of the summit, though I am unaware of any specific programs that were developed as a result.
• Many recommendation were made, but are not yet implemented.
• The state will soon establish an oral health newsletter and will soon start a web page.
• Oral health promotion activities had been created and funded by the Medicaid agency through a RWJ grant.
• Several foundations who provided support and attended the summit have allocated monies for projects that have an oral health promotion component aimed at the public. *** We had the greatest participation of dental personnel in the Nation for the ADA’s Give Kids a Smile program. *** While it would be a great project…there has not been an organized effort in this regard.
• This is an area that needs to be developed.
• There are many oral health promotion plans underway in the state—most were occurring before the summit. ***The summit was a steppingstone of sorts for oral health promotion programs, creating an opportunity for these program managers to swap field validities. *** Not related to the summit.

Q24. The summit influenced: Creation or expansion of oral health prevention programs.
(None, Weak, Strong, Don’t Know)
• Dental professionals are becoming more involved with tobacco prevention programs/counseling, better nutritional choices in vending machines in schools.
• Delta Dental made water fluoridation a priority, hired a project director and is actively working to implement fluoridation in two high need areas.*** Title V Block Grant Funds were provided to fund and evaluate a 3-year early childhood caries prevention projects for children to age, focusing on screening, education and fluoride varnish application.
• Increased number of school-based sealant programs, increased number of fluoride varnish programs, increased research activities in prevention.
• Summit input led to development of an early childhood outreach project with Head Start. *** An example is the Medicaid Agency’s Smile Alabama! campaign.
• Strong: Oral cancer screenings for at-risk groups; fluoride varnish program statewide, sealant programs in local health departments; a state “Quit Spit” tobacco program and an oral cancer self-exam program directed at high risk groups; revitalization of fluoride supplement and fluoridation programs, and expansion of funds for local health departments for education and health promotion.***As a direct result of the summit, a partnership was created with corporate sponsors and the state dental association to begin a statewide prevention/sealant program at the State Fair.*** We participated in the ADA’s Give Kids a Smile program, and our coalition is active in the Special Olympics Special Smiles state games.
• Trying to develop a sealant program in the school based health centers in areas with poor Medicaid provider participation.
• The Department of Health’s effort to include more oral health activities in local health jurisdictions was supported and accelerated by the summit.
• Two of the Coalition partners have sponsored well-child based fluoride varnish programs.
• Pediatric residents and nurses are exposed to fluoride varnish application during training. *** There is an initiative in a community based coalition to promote oral health for pre-school children.
• Since the summit, the state has seen an expansion of school-based private providers and expansion of preventive services offered. ***We have school-based sealant programs and fluoride programs, but they don’t reach all in need.
• Only what private individuals and public health clinics do on their own. *** All prevention programs are done by the few community health centers. *** The state health department does prevention.

Q25. The summit influenced: Creation or expansion of oral health treatment programs. (None, Weak, Strong, Don’t Know)

• We have had some influence in encouraging care for patients with developmental disabilities. Members of the coalition have been successful in recruiting dentists to underserved areas, thus providing treatment. *** Private organizations are now offering restorative services in the schools.
• The identification of Medicaid providers increased access. *** Medicaid increased reimbursement which resulted in strong increase in the number of dentists participating and therefore providing treatment.
• Increase in number of communities organizing free dental clinics; development of new mobile clinic serving low income schools in one large city.
• Three treatment programs in communities have begun since the summit. *** The dental schools have expanded mobile and outreach programs throughout the state.
• The Innovative Dental Services Delivery grant will promote innovative dental service program—case management, mobile vans, portable equipment.
• Three coalition partners (foundations) have used their funds to develop safety-net clinics.
• One additional school-based and three pediatric dental clinic have been opened.
• Our dentists participated in the ADA’s Give Kids a Smile program and we are working with a dental school to conduct outreach clinics for underserved patients.
• Currently just have sealant programs. *** The Craniofacial program provided fluoride varnish application as part of its services.

Q26. The summit influenced: Changes that occurred subsequently in the state government’s oral health program. (None, Weak, Strong, Don’t Know)

• The Medicaid dental program officer now has taken on additional program responsibilities…SCHIP program has a dental coordinator who also has additional responsibilities, but the effect has been altered by current budget woes.
• Laid important groundwork for the ASTDD Site review which resulted in FTE’s for the State Dental Director position.
• We now have a .25 FTE research analyst and have received MCH funds to support a 3-year early childhood caries project.
• A new state Dental Director, with increased budget, personnel and influence among policy makers, politicians and legislators. *** We maintained office of the Dental Director in the face of budget cuts.
• The new state dental director is aggressive in leveraging state dollars by seeking extramural revenues from grants.
• The state oral health program has been de-emphasized/reduced in staffing and budget.
• The appointment of a new state dental director was announced during the summit, and then another dentist was hired for the Office of Dental Health. Reorganization of program activities/functions followed, to include vision and mission statements, and planning and performance measures. *** With the change of (state) administration, all of the suggested changes made at the summit were tabled (by the legislature). Also, six months prior to the summit, a very active dental program director retired and left a leadership void—strong leadership within the oral health program will be necessary to allow significant changes to occur. *** Key players in Medicaid seem intent upon discouraging its success—these people were not at the summit and carry no credentials in public health. The state’s pay scale is too
weak to increase initiatives in the State Dental Director’s Office. *** I understand that funding for the state dental program has been cut.

- None yet, though I know that summit participants will continue to work in this area. *** Our state does not have a dental director and establishing this position is a long term goal of the coalition. *** Upon departure of the Medicaid dental incumbent, the position was not refilled and the incumbent’s duties were absorbed by other positions.
- The state’s dental health program is very under-funded and the infrastructure lacks staff to meet the needs of the state. *** Our budget is up by $2.5 million *** There is strong support for the dental program at the Health Department.
- The summit continued efforts to validate the need to expand state oral health infrastructure. *** Began the process for later expansion of the state oral health program. *** One new salaried person was added to support the state dental director.
- An oral health coordinator has been hired, but the summit’s influence is questionable.
- The summit helped to define the direction the oral health division and its new director have taken. *** Summit feedback aided in advising the state on grant applications.

Q27. The summit influenced: Development of an oral health strategic plan or action plan for the state. (None, Weak, Strong, Don’t Know)

- The state’s Oral health Plan 2002-5 is the result of the summit and follow-up planning meetings. The plan included 6 priority goals with strategies and desired outcomes.
- A Health Agenda, and Dental Action Plan (were developed) and have proven to be important in reaching objectives to improve oral health and access…but the state has yet to develop a strategic oral health plan.
- Summit resulted in significant update of the state’s oral health strategic plan. *** Several areas have been identified and committees formed to address identified issues. *** The plan is regularly reviewed and updated. Outcome measures are being developed and outcomes assessment is being integrated into the plan.
- The development of the state oral health plan is directly attributable to the summit.
- The state continues to use Healthy People 2010 as our state’s action plan. The vast majority of activities are directly related to those objectives. *** The outcomes of the summit roundtables have been used as a guide for action/activities.
- A strategic plan has not yet been developed. *** But, with the summit and the NGA conference, there is an action plan for the state, with written/measurable objectives.
- By the end of the summit, a strategic plan was created by each focus group; this was then typed and sent to each participant. *** Next steps were determined and the plan of action was worked on. *** The final document developed by the summit committee…should be the source document for developing the state plan of action.
- The state already has an oral health strategic plan. *** The Coalition accepted the plan compiled by the NGA Academy attendees.
- A strategic plan for the office of dental health has been developed and integrated into the Health Department’s Strategic Plan. One of the summit sessions was devoted to a state oral health plan. *** The plan presented basically was the national oral health objectives. *** The state dental director has been working on the plan for the state, but is very reluctant to delegate any of the tasks to the stakeholders. *** This has been a high priority at the Summits. It is a work in progress with a lot of time and energy being directed to it.
- Unaware of a complete plan having been developed as yet. *** A number of strategic plans are described in the summit report. The summit report serves as a blueprint for future endeavors. *** The Department of Health has a plan, and is in the process of developing a plan for the state.
- The summit findings provide the opportunity to strategically plan in a number of areas, however Coalition leadership has not moved this forward. *** This is still in progress—the
Coalition intends some follow-up planning activities based on the summit. *** Since we don’t have a central paid person (e.g. a State Dental Director) to lead this process on a day-to-day basis, there has been little progress.

- Many things were discussed in the summit workgroups, but no one left with a plan or was designated to follow thru with anything.
- The planning process begun during the NGA Academy was modified during the summit and finalized during a follow-up session six months later. *** This is underway right now and meetings are going on. *** Currently are working on a plan as a member of the state oral health policy committee—using 2010 objectives. *** No formal state plans can be sustained after the (current) grants (expire).
- While a formal plan has not been completed, our summits have provided direction for several projects. *** A plan will result from the work of the oral health coalition.
- It’s still in the planning stages. *** The priorities set by the summits have evolved to form the framework for the state’s oral health strategic plan. *** We now have a 4-year plan. *** This has not happened, but needs to.

Q28. No comments were requested or received for this question.

Q29. What were the most positive features or outcomes of the Summit?

- The summit was a necessary first step in the right direction. Federal support, guidance and participation made a big impression on the participants and legislative members. *** Bringing together representatives of a broad coalition of groups interested in dental access issues. This has helped to unify the groups. *** It increased public awareness of oral health issues; helped foster new partnerships and interest in oral health; helped create a public health consciousness for dental professionals. *** Establishment of the dental hygiene school, getting reimbursement rates raised and raising public awareness of dental issues. *** All stakeholders were together in the same place at the same time. Good honest discussion of issues. Everyone listened.
- Participants responded positively to having the ability to propose possible solutions to complex questions relative to access to dental care. *** The summit presented an excellent forum for key stakeholders to connect, learn and collaboratively problem solve. *** It was a start and private and public practitioners and advocates had meaningful exchange around common challenges. *** It raised awareness of oral health issues within the state and allowed participants to discuss solutions to state and local issues related to access.
- Bringing different groups or individuals together and seeing new activities as a result of contacts made at the summit. *** The varied audience of policymakers, dentists, educators, etc. The materials were excellent and made available to a wider audience than the summit participants. *** All players together in agreement, new issues added to the strategic plan, awareness of oral health issues. *** For me, working with state dental officer for my own county’s needs. *** Printed participant list with phones has been very useful. The summit’s 3-year binder program included tons of information.
- The opportunity to meet and network with other oral health providers and constituents.
- We developed an achievable oral health plan for the State as the first step in developing a shared vision. *** Positive features include the creation of the state’s Oral Health Plan, better communication with legislators, and between public and private partners, new champions identified, changes being considered by the state Board of Dentistry. *** Physician and oral health care provider collaborations.
- Networking.
- Creating an oral health agenda for the state; increased participation by organized dentistry and the corporate world. *** Positive effects at the state government level. *** Bringing together many different stakeholders at one time and making sure that all of us are talking to each other
about our different approaches to solving our problems. *** I realized how far behind our state was.

- Focus by many on oral health issues and its relationship to other conditions and illnesses. *** The amount of parent participation. *** Brought a lot of stakeholders together who hadn’t necessarily seen the “big picture.” Networking opportunities, increased awareness of successes and possible replication of programs. *** There were excellent speakers sharing fresh information. *** The summit provided concise statistical information, discussions between a variety of knowledgeable individuals and groups, and offered entertaining and informative speakers.

- Provided a forum for exchange of ideas and opinions, discussion of issues and created a venue for better understanding among stakeholders of one another and the significance and wide variety of oral health issues.

- A greater recognition of the problem by all stakeholders. *** The opportunity to present good oral health models and update people on the state’s Strategic Plan. The summit really focused more on legislative influences than prevention or education, etc., but this seemed necessary in light of current activity (Medicaid reimbursement problems, benefits, etc).

- We had broad participation of interested parties willing to follow through on the action items identified at the summits. *** Good ideas came from the summit that will strengthen the Oral Health Coalition. Many new faces present. *** Networking that continues among a broader constituency. Interstate contacts and ongoing dialogue. Amendment of the state Health Services Corps and funding of stipends for dental health professional students. *** The networking that it has created is the biggest positive outcome. *** The coming together of many disparate health agencies that I had not known existed.

- Visibility. A nice report that can be shared with policymakers. *** Diversity of the group in attendance, a true coalition of stakeholders, advocates, educators, practitioners, legislators and more. *** Development of a highly focused children’s oral health strategic action plan. *** Specific recommendations. *** Formation of a state-wide dental coalition.

- The development of the statewide Coalition for oral health. The President, Past President and President-Elect of the state dental association all attended the summit. As a result, the state dental association formed a task force that directly addresses the State Director’s Task Force’s recommendations on oral health access. *** It was the beginning of broadening empowerment to address the issues of access to oral health services. *** Coalition building. *** Networking of agencies.

- It was good to hear a Medicaid provider with a positive attitude. *** Having a Medicaid mom speak of her frustration with finding care. *** For the first and only time all the players were represented and actually talked to each other. *** It raised the dental IQ and exposed great needs. *** The ideas were enlightening, just too bad there is not follow through. *** Attendance, groups writing grants and the appearance of an interest in oral health care.

- Sharing of success stories and information from national and state perspectives. *** The alliances that have been built. *** Networking, the development of a state plan having a large support group, and being with others who have a passion for this issue.

- The formation of the state Oral Health Coalition. *** Support to keep working with a Coalition. It was extremely beneficial to have both providers and social service advocates i.e., Head Start in the same room hearing each others’ concerns and issues.

- Opportunity for broad cross section of the oral health community to network and build partnership, along with learning about local results of national trends. *** The networking, attendance by legislators and ideas generated. *** The most positive outcome was that it was a full day, without distraction, to focus on the subject matter The state oral health coalition is now questioning its relevance, which it should!

- Bringing all the players into one room. *** Creation of the oral health coalition, and the development of a healthier perspective from broader voices coming to the table. *** Facilitated
understanding between groups of each other’s needs; laid groundwork for formation of the Coalition as a powerful tool for lobbying for legislation and directing oral health initiatives. *** The emphasis placed on educating legislators about low reimbursement rates and adult Medicaid. *** Creation of three workgroups and follow-up summits.

Q30. What were the biggest disappointments or “turn-offs” of the summit?

- Turf issues and political positioning were present and too much emphasis from the dental profession regarding Medicaid reimbursement being the “magic bullet.”
- That the follow-up of the summit has not moved forward significantly. *** That the dental association from the beginning showed their concerns that the summit was not going to be truly representative of a well-developed stakeholder process. *** The lack of resources and perceptible change in Medicaid policies. *** Not enough time, lack of closure or clear responsibility for “next steps.” *** No vetting of brainstorming; consequently it appeared that “ideas” were “recommendations.” The emphasis by the planners on “diversity” of speakers over any substance they could add. *** There were fewer legislators than anticipated, and they seemed reluctant to engage in oral health policy discussions. *** The room was not conducive to a positive environment. *** It was supposed to be a gathering of “decision makers,” but in fact was a gathering of the same people who always met on these issues, many of whom have no voice in decision making. *** Actually, the event was well conducted and all topics seemed appropriate.
- Limited participation of private dental/medical providers, those from private business (large employers). A significant number of participants were unable to stay for the entire session (some came one day, but not both, due to need to cover practice, time away from office, etc.). *** Traveling back and forth takes too much time out of my private pediatric practice. *** Inadequate representation by elected officials; lack of information on the latest science regarding dental caries and prevention. *** Little media attention, lack of follow-through. *** Lack of consumer involvement, lack of addressing children with special health care needs, zero follow up (no notices of additional meetings, etc.). *** For many in the audience, it was not defined as to how the presentations linked to a common thread to direct our group to its next steps. *** It was a one agency show—I don’t believe that anyone outside that agency was contacted to be in planning group. *** Leader of the Coalition sometimes dominated the agenda; however, on the positive side, the leader kept things moving forward.
- A few individuals had “private” agenda items that they attempted to force on the participants. *** Certain groups/individuals were using the Summit to further their political agendas (i.e., scope of practice, etc.). *** The lack of concrete outcomes or actions. *** More participation from school administrators/parents needed.
- Disagreements between dentists and hygienists regarding expanded care. *** Some dentists perceived the summit as being driven by dental hygienists and many of their representatives dropped out after the first summit. *** They felt threatened by the hygienist’s efforts to show how their roles could be expanded to improve access to oral health care, based on their education and experience. *** Friction is greater now between dentists and dental hygienists. *** Turf issues cloud progress.
- Too few dentists, policymakers and legislators in attendance. *** Biggest disappointment was that I wasn’t able to attend the entire summit. *** This was a wonderful public relations opportunity to promote oral health issues—I wish there had been more news about it. *** Participation by legislators was minimal. *** Where do we go from here? *** No resources to carry on the effort.
- Little publicity.
- Our HRSA speaker was not able to make it to the summit because of bad weather preventing his plane from departing. *** Lack of upper level state government participation. *** Too much time spent on access issues and government financing (Medicaid); those are important, but
seemed to take up 60-70% of the program. *** Not enough discussion regarding Medicaid coverage of oral health care. *** It would have been nice to have more politicians in attendance. *** The room was very cold. *** Location and parking were turn offs.

• The pervasive negative attitude towards the Medicaid program, even while the state Medicaid agency had taken big steps to improve operations. *** Activity has not been sustained at the level I would have liked. *** Lack of executive and legislative branch participation and interest. *** Not enough time to network. Some key stakeholders not present. *** Private dentists largely ignored the invitation to attend; also, some advocacy groups used the summit as a platform to “attack” the dentists.

• Biggest disappointment is the lack of follow-up by the state oral health program. Many recommendations were made, but were tabled by the state agency. *** The non-participation of the Medicaid program demonstrated the lack of interest of this agency in oral health issues. *** The attitude by some with the new ideas such as unsupervised practice of dental hygienists is disappointing; instead of it being looked at as a possible answer to access to care it is often a turf battle. *** Failure by key stakeholder to even participate in the summit.

• Not enough time! *** Too much information to cover in too little time.

• Lots of “what is,” and not enough of “what needs to be done,” “who needs to do it,” and “let’s get started.” No definitions for future action—this was a complete afterthought. *** Need a marketing plan to the broader community. *** I would have developed a work group of dental educators (dental and allied health) to produce a model for the nation around the issue of workforce development and improving access to treatment. *** Lack of sharing of information useful to everyday operation of dental clinics dealing with access issues. *** We tried to have more legislators, but the legislature was currently in session.

• Too small room size made discussion group more difficult. Hesitancy of dentists and others to work with hygienists. *** Not enough time to delve deeper. Uncomfortable meeting facility. *** No follow thru. *** I had hoped the momentum could have continued. Not enough publicity and not enough legislators present. *** Once you leave nothing changes. The main coordinator was not knowledgeable enough about oral health and had very poor planning skills.

• The same people as always and too many state agency people present. *** Too much control by organized dentistry. *** It has taken so long to implement the recommendations from the NGA Academy, this summit and the summit recently held. *** Lack of progress on the workforce issue.

• Ran out of time to make assignments for the workgroups.

• Lack of concrete action steps/follow-up and a process for letting participants know of outcomes. *** Despite support from key legislators, legislative representation was weak, but this was not unexpected. *** The strategic planning part gets old and could have been more productive. *** We had hoped for better attendance by department or health policymakers. *** Minimal support from the Governor’s office.

Q31. What changes would you have made to improve the summit? ALSO SEE TABLES 4 AND 5 IN THE REPORT’S RESULTS SECTION LISTING GRANT CONTACTS’ ADVICE TO FUTURE SUMMIT PLANNERS.

• Create a vehicle to attract more policymakers, legislators and dentists. *** It’s wise to invite a diverse audience including hospital leadership, as many health issues impact hospitals dramatically. Also include funders and other advocates. *** Include dentists in planning of the summit to increase potential of their attendance and involvement. *** There is a need for more professional marketing expertise in order to promote and further oral health issues. *** Have a defined next step.

• One day is probably about the right length of time. *** Involve more stakeholders. *** I would have made partners of families, family run organizations, consumers and consumer-run
organizations. Also should have developed a legislative advocacy plan, and improved communication among participants
• Advertise more broadly. *** Need to broaden our base to get more “influential” people to see the problems with oral health issues. Until the business community sees the need, it is difficult to get state government and community officials to deal with the problem.*** I would have liked to hear more about specific action items the summit audience wanted to present to policymakers in terms of change, increase in funding, legislative issues, etc.
• Use a trained outside facilitator to lead and direct the summit. Because the summit and coalition sessions were primarily financed by the primary care association, they were the principals and the leaders of the discussion and agenda developer, and, frankly, it became their forum. *** More time for discussion with “local” groups. More diversity of participants.
• Identify more leadership outside of state agencies. *** Make participants accountable for the changes needed.
• My only suggestion would be that they be held on a regional basis, in concurrent or staggered sessions. This would allow more participation.
• The summit needed attendance of more dentists and legislators. *** Dental hygienists showed up in droves to promote their ideas. Everyone supported them except the dentists. *** Recruit more physicians to participate.
• Start earlier and plan more intensively. *** Get more legislators there and more administrative support. *** Need more follow-up of proposed recommendation. *** Involve more policymakers, the public and the media. *** Could have extended the meeting over a longer time.
• Should have more legislative presence. *** Provide more info on research and what’s happening elsewhere around the country. *** Make available the list of those who attended with contact information. Printed information from the various programs could have been made available by having a table for agencies to put literature.
• Need more private practitioners attending. I would have made some changes to make sure an appropriate number of legislators would be present. *** Focus on one or two topics instead of the broad spectrum of challenges. *** Needed more information about budgets and money resources. *** Making changes to the days it is scheduled and having more advanced notice would be helpful to private sector attendance. *** The first day sessions were held concurrently and participants could only attend one of the several sessions. More time should have been allowed to enable participants to attend at least two sessions by extending the session by 1/2 day. *** More time should have been spent in group discussion before and after concurrent sessions. It would have been beneficial to have results of concurrent session work summarized for all participants at the conclusion of the summit. As is, there was no joined consensus, direction, or call to action at the conclusion.
• I would assign “ownership” to specific areas in the action plan. *** Have small workgroups. *** Improve media coverage. *** Increase the length of the summit to at least two days. In addition to discussion and recommendations, develop a plan for implementation of recommendations.
• There was good energy around the summit and disappointment that it was a one-time deal. We have no venue to bring together these groups again. *** I suggest a series of local or multi-county summits. This has a better chance of getting more grass roots participation and support. *** While individuals can meet quarterly, a summit is a good format for bringing folks together.
• Even though this summit was more a “search and discover” session, we needed more solutions and action plans that could be readily implemented. *** Encourage participation of the governor, state legislators and the state dental association. *** Don’t discuss the problems anymore; invite people who are willing to commit to work to find solutions; multiple workgroups representing many agencies could make a huge impact. *** More time in breakout
groups and more knowledgeable facilitators. *** We have so many issues; we need to limit the subject matter and allow a sustained focus to be formed. *** We need more legislators and lobbyists. *** Expand to a two day meeting.

• Better location. *** More time for breakout sessions. *** None—for the first summit it was a big success.

• Have more legislators, CEOs of business, fewer local staff, fewer strident hygienists using the summit as a forum to browbeat government and dentists. *** Get a dental director who could be responsible and accountable for follow-up. *** Pick one or two objectives and create action. *** Reduce presentations and create more time for facilitated dialogue. *** A one day summit means it is difficult to fit everything in. There is a trade-off in getting good participation for one day, versus less participation if the summit is held over two days. Hire a conference coordinator as soon as possible—it would have saved us time and logistical juggling. *** We might think more about how to best achieve our goals and about how many and which people should attend…or perhaps have a planning meeting with all of the key stakeholders (much broader than the planning committee) and then take their input into a broader summit). *** None—the approach was sound.

• Too much time used in processing the issues; use more time to move forward.

• Greater attempt to involve media. *** More rural involvement and participation by policymakers. *** Have a bi-annual newsletter to keep stakeholders informed

Q32. Would a follow-up summit be useful in furthering your state’s oral health agenda?

• Two years after the initial summit, we are still seeing some results in the Legislature from strategies that were developed and prioritized through that process. *** Due to severely limited state revenues it may not be beneficial to reconvene the summit at this time?*** (Another summit)…may be helpful in exploring other avenues to follow to see what the state could do to attract more care providers into the state.

• A second state dental summit was held in 2003. *** The follow-up summit was held on the coldest day of the year, so attendance was poor. *** Not at this time; perhaps in the future. *** Yes, I feel this is a great beginning of systemic change that will impact other areas of health care. *** Yes, just to keep awareness and information before the Governor, legislators and the public. *** Would like to see smaller summits held throughout the state. *** Not unless it were a different kind of summit.

• Plan another summit in a few years. *** It should be held in about a year, after the Task Force has had enough experience to give a good report of their activities. The next summit should be a time to learn from each other, what does and does not work, so pitfalls can be avoided and effective programs replicated. *** I do not think another summit would be helpful until the current economic situation improves because no funds are available to support new oral health initiatives.

• Don’t have it again—it’s a waste of taxpayers’ money. *** Yes, we need to sustain the momentum—reinvigorate original participants and educate/energize new players. *** I think maybe in 2-4 years. Things are rolling now, key people are meeting regularly, I don’t see how we can accomplish more right now. *** I would like to see a follow-up to support the work accomplished and to secure buy-in for future efforts.

• We were fortunate to have had both a summit and a follow-up. However, it would be worthwhile to have periodic follow-ups to maintain the momentum gained at prior summits. *** It is critical to keep the momentum and also to fine tune the direction based on the input of stakeholders. *** I like the idea of an annual summit with all stakeholders present. *** Perhaps on a smaller scale and a new focus with each follow-up, e.g., Head Start, the elderly.

• Planned for Fall 2003. *** In a sense we did this recently through a small ASTDD grant which allowed us to have a one day advocacy workshop with about 100 participants. We presented
were we were before the summit, where we are now (accomplishments, in the works, not done), with consensus groups giving direction as to where we need to go.

- Another summit would allow us to report the progress we have made. *** Could further develop the plans of action. *** Definitely. I left the summit hoping to get a report of the summit and am looking forward to the next one. *** This would be useful as long as the agenda built upon this past summit as opposed to replicating it.
- We have had three additional summits since the 2001 summit. *** Only if we can get legislators and the Governor’s office to really participate, take an active role in the summit and make oral health a legislative priority when developing the state (Medicaid) budget.
- Another summit, the 4\textsuperscript{th}, is being planned for August on dental education. *** Yes, to continue the momentum, evaluate progress and evaluate where more work is needed. *** It would also prevent overlap by stakeholders. *** Only if oral health leaders sense that key players (legislative and Medicaid) have any interest in supporting efforts to formulate solutions. *** Yes, at a two year interval. *** Only if government agencies participate and follow through.
- We have made progress and a follow-up meeting would solidify relationships and refine the agenda. We would also benefit from an opportunity to address adult issues and prevention issues in depth. *** We plan to use CDC funds to keep this alive and expand to all age groups. *** Absolutely! Can’t keep the momentum going or spotlight the issue without follow-up *** Makes absolute sense, especially in light of the significant progress made. These success stories will further invigorate commitment of the summit participants. *** Absolutely, we need to be updated regarding outcomes of the recommendations.
- This happened in 2003; it was a little bigger and better, more state specific and built beautifully on the first summit. *** The 2003 summit emphasized Head Start. *** We need greater participation from the state dental association, legislators and FQHCs. *** Only if the “problem” wasn’t the key topic and the “solutions” were! *** After we evaluate progress in a year or two. *** Concentrate on fewer issues.
- Should be an annual event. *** Would give us more time to work together. *** Should be held not by a state agency, but by the Coalition—that would help to gain more participation from the private sector.
- Holding a meeting to move the agenda is worthwhile, however the amount of work to staff the effort is huge and yearly meetings are not reasonable. With careful planning, a follow-up summit could further define action roles and provide an issues forum. *** Not until the Coalition reorganizes; it has outlived its usefulness at the state level. *** Maybe, but there would need to be an accountable individual to follow-up on the meeting. *** Yes, we need to sustain momentum; reinvigorate original participants and educate/energize new players.
- A follow-up summit was held in 2003. *** We are planning another summit in 2004 so we can summarize progress and discuss future projects.
- We had a follow-up summit already; it was very helpful. *** We had one follow-up summit that wasn’t all that useful—the Coalition retreat was more productive because of its focus on issues and solutions. *** Not yet. We have lots to work on from the first summit, and some good momentum. *** Although the Coalition will continue with a lot of needed work, a summit every 12-18 months is healthy to make sure that all the points of view are heard, recent effort and issues shared, and we have an opportunity to prioritize activities. *** Yearly summits are not helpful.

Q33. **Please share any additional comments about the oral health summit.**

- Everyone who was present should have come away feeling that they learned a great deal about the state’s oral health issues and how they should be addressed. *** I must say the summit gave me another perspective to the importance of oral health care needs in the United States. It’s more important to me now than ever before. I now don’t feel like a lonely man on an island all
by myself. *** As a dental educator, it really helped me put the role of the dental school in a
different perspective and to see us as one piece of the puzzle, rather than in isolation. ***
“Many of the same issues and topics that have been discussed over and over were discussed
again without any corrective action being identified. There was no final “charge” to the group
or concrete conclusions reached to remedy the problem areas identified. We continue to
“preach to the choir” when it comes to oral health.
• Outstanding! *** This summit was really more for the providers, advocates and policy makers.
To involve consumers in a meaningful way, a different type of summit is needed.
• By far, the most ‘bang for the buck’ to bind oral health partners together and focus on the oral
health of our population and its needs. *** The professional facilitators that were hired by the
state to conduct the meetings were very effective, and in my estimation, worth the money.
• It was wonderful to have private and public supporters of oral health, educators, medical and
dental professional and policy makers in one room and see the (oral health) plan developed.
*** Organizers will stretch hard to take credit for improvements in the state’s access problem,
but any and all improvements and progress would have happened anyway, and the
organizations that worked the hardest would have been credited, rather than the summit.
• Great program! In states with limited resources available for activities of this kind, the oral
health summit (funding) is a godsend. *** Great job—thoroughly enjoyable and thought
provoking *** These summits are good ideas. Lots of positive contacts are made and problems
and ideas are brought into the open with many points of view participating in the discussion.
*** It was a constructive exercise—next one should be planned with expectations for
outcomes.
• Great experience—one of our private dental practitioners deserves credit for leading the state in
having a summit and following through up to the present. *** It was a critical first step! And
essential to get people and resources together. *** We should not lose momentum.
• It may also be a good idea to have dental and dental hygiene students attend the summits. Use
the summit as a recruiting tool for students (to underserved areas) and groups seeking their
services (after graduation). *** I am extremely glad to participate in the summit and the oral
health committee...It is comforting to know that some action can be taken based on concrete
date reported.
• Good program and should be continued in some fashion. *** A lot of rhetoric, but little
outcome. *** Getting this information out to the early childhood community is important
because good oral health has such an impact during the early years.
• The oral health summit was timely in terms of state and national interest in oral health. The
support of the oral health Coalition by a number of organizations clearly contributed to the
outcomes of the summit and built a strong advocacy group for future work. *** This was our
second summit; currently, there are critical issues facing the state that need addressing. *** It is
humbling to see how loss of certain talented individuals and driving forces from leadership
positions can curtail advancement and success. Any sort of action plan generated from the
summits need a dynamic individual or group to continue to spur on progress and keep the
vision viable. *** Overall the summit was productive, however, lack of leadership at the state
level and non-participation of state agencies makes it difficult to affect change in the state.
*** The summit is a mechanism to keep moving forward.
• I helped plan an oral health summit in another state that had quite different results and helped
fuel consensus and move successfully on several issues—the focus was tighter. *** I would
like to see less “fantasy ideas” and more concrete ideas (e.g., my group decided we should
include basic dental insurance in the state insurance available to the public at 100% state
funding—right after the legislator’s forum discussing a multi-billion deficit!) *** The
ASTDD/HRSA seed money was a great impetus for the larger effort. *** Thanks again for
ASTDD/HRSA help, it really helped to catalyze interest and support for the summit.
• I was honored to have participated. *** All in all, this has been an excellent, well thought out and organized oral health summit. *** The oral health plan needs to be developed and implemented. The first summit was just the beginning. There is still much to be done.

• Some of these questions about specific content and highs and lows are very difficult to answer more than a year and a half after the fact. My memories are more general in nature: the summit was successful and the state needs such a meeting on an annual or at least bi-annual basis. *** The summit was geared more for information giving and sharing, but not for action. Although it opened the door to non-dental folks, it still was an awful lot of preaching to the choir. *** I don’t remember all the summit detail; it was over 2 years ago. *** In the future, developing measurable goals should be instituted; that way efforts can be tracked more specifically.

• It had a tremendous effect on focusing my attention on oral health as a critical issue for advocacy. *** Proud to have been included so that children with special health care needs could be on the agenda.

• The summit resulted in the creation of the state oral health coalition, which, in turn, was responsible for successive oral health activities that occurred and are still occurring in our state. *** The summit has truly been the impetus for several oral health projects…organizations are now working together on issues like access to care, the dental workforce, etc.

• The first summit was very successful in bringing together individuals concerned about oral health. *** It was a turning point in improving awareness and interest in oral health issues in the state.