Oral Health in Maine
Planning for the Future

Conference Report

November 14, 2005

Augusta Civic Center

Good Group Decisions

98 Main Street, Brunswick, Maine 04011 207-729-5607 http://www.GoodGroupDecisions.com

Table of Contents

Note: For ease of use, this conference report is organized by topic, not by chronological order as planned by the agenda.

Attendance

Wendy Alpaugh	Island Medical Center, Stonington
Tim Archer	Health Access Network, Lincoln
John Baldacci	Office of the Governor
Ron Bansmer	State of Maine WIC Program
John Bastey	Maine Dental Association
Ellen Beaulieu	University of New England
Kristine Blaisdell	Prevention Partners, Inc.
Joanne Burns	Kennebec Valley Community Action Program
Karen Cobbett	Early Head Start
Beryl Cole	Maine Dental Hygienists' Association
Marc Coulombe	Maine CDC, Office of Rural Health and Primary Care
Amy Cronkhite	B Street Dental Program, Lewiston
Nena Cunningham	Kennebec Valley Community Action Program
Jessica Dafni	Good Group Decisions
J. Curtis Dailey	Penobscot Community Health Center, Bangor
James Dowling	Maine Primary Care Association
David Drohan	Maine Coast Community Dental Clinic, Ellsworth
Carmella Dube	Spruce Street Health Center, Sanford
Debra Dunlap	Good Group Decisions
Sandra Evans	Waldo County Dental Project, Belfast
Judith Feinstein	Maine CDC, Oral Health Program, Augusta
Craig Freshley	Good Group Decisions
Robin Gardner	York County Head Start
Mary Ann Gleason	Spruce Street Health Center, Sanford
Sophie Glidden	Maine CDC, Office of Rural Health and Primary Care, Augusta
Valerie Heal	Penquis Head Start
Vicki Helstrom	Aroostook County Action Program, Presque Isle
Lisa Howard	Maine Dental Association
Larry Jacoby	Community Dental - Farmington
Saskia Janes	Medical Care Development
Patricia Jones	Maine Dental Access Coalition
Karey Kershner	Sebasticook Valley Hospital, Pittsfield
Carolyn Kimball	Aroostook County Action Program, Presque Isle
Hope Lanza	City of Portland Health & Human Services Dept.
Norma Larocque	Androscoggin Head Start and Child Care
Martha Lawrence	Martha Lawrence, DDS, Auburn
Barbara Leonard	Maine CDC, Division of Chronic Disease, Augusta
Steve Letourneau	Catholic Charities of Maine
Jean L'Italien	Health Access Network, Lincoln
Debbie Littlefield	City of Portland
Dorothy Maroon	Tooth Fairies, Inc.
Kathleen Martin	Portland Public Health
Judith McCollum	University of New England

Brenda McCormick	Bureau of Medical Services
Kate McNamara	CarePartners
Daniel Meyer	Maine-Dartmouth Family Practice Residency, Augusta
Frances Miliano	Maine Dental Association
Lisa Miller	The Bingham Program
Dora Anne Mills	Maine Center for Disease Control
Colleen Myers	Good Group Decisions
Julie Ouellette	Androscoggin Head Start and Child Care
Kathleen Perkins	Medical Care Development
Andrea Perry	Good Group Decisions
Julie Peters	Kennebec Valley Community Action Program
David Rappoport	Maine Health Access Foundation
Valerie Ricker	Division of Family Health
Jennifer Robicheau	City of Bangor
Elizabeth Rogers	Oral Health America
Bernadette Serafin	Community Dental
Jonathan Shenkin	Penobscot Children's Dentistry Associates, Bangor
Jenny Sobey	Portland Public Health
Loreene Stacy	Riverton School, Portland
Kim Stowell	Peoples' Regional Opportunity Program, Portland
Kathleen Walker	Northeast Delta Dental, Concord, NH
Toni Wall	Maine CDC, Children with Special Health Needs Program
Becky Whittemore	University of New England
Vaneesa Woodward	City of Portland
Shawn Yardley	City of Bangor Health & Welfare
Carol Zechman	CarePartners

Welcome and Conference Overview

Craig Freshley welcomed everyone and introduced himself as facilitator and lead staff for drafting the State Oral Health Plan. Craig introduced breakout session facilitators: Andrea Perry, Colleen Myers, and Debra Dunlap. Craig also introduced Judy Feinstein, Director of the state Oral Health Program. Judy is the engine behind the work to date, and will probably have primary responsibility for assuring completion of the plan.

Craig reviewed the conference goals and objectives:

- Understand the importance of oral health and the value of a statewide plan
- Provide thoughtful advice on:
    - The ideal outline and nature of a statewide oral health plan
    - Specific outcomes that we expect a statewide plan to achieve
    - Specific actions required to achieve the outcomes

Craig reviewed the agenda for the day, as follows:

AGENDA

8:15 am Registration & Refreshments

8:45 Welcome and Overview of the Day
Craig Freshley, Facilitator

Opening Remarks
Governor John E. Baldacci

9:15 Keynote: "The Importance of Oral Health – Across the Lifespan"
- Jonathan Shenkin, DDS, MPH, Penobscot Children's Dentistry, Bangor

9:55 Break

10:15 Overview of the Draft Plan
Instructions to small groups:
- Public Policy and Funding
- System Improvement
- Workforce
- Public Education & Awareness

10:45 Small Group Discussion #1
- Overview of Issue
- Desired Outcomes – what do we want?
- Prioritization?

12:00 pm Lunch

1:00 Small Group Discussion #2
- Desired Actions
- Activities/next steps
- Timeframes, prioritization, and recommendations
- Collaborations & partnerships

2:00 Beverage Break and Reconvene

2:15 Small Group Reports – Next Steps

3:00 Evaluation & Adjourn

Ground Rules

Craig reviewed and explained ground rules for the conference, as follows:

- All views heard – no bad ideas
- Hands to speak
- Minimize distractions
- Assume best intentions
- Seek common ground
- Constituent representation and education
- Explain acronyms and technical terms
- Facilitators serve the group as a whole
- Smiles are good!

Participant Packets

The following handouts were distributed in the conference packets (and may be obtained on request from the Maine Oral Health Program).

Preventing Chronic Diseases: Investing Wisely in Health, Preventing Dental Caries, CDC U.S. Dept of Health and Human Services www.cdc.gov/nccdphp

Federally Designated Dental Health Professional Shortage Areas, Federal Division of Designation [map], Compiled by the Maine Office of Rural Health and Primary Care

Oral Health and the Role of the Geriatrician, Jonathan Shenkin, DDS, MPH, and Bruce J. Baum, DMD, PhD, 2001 American Geriatrics Society

CDHP Policy Brief: Cost Effectiveness of Preventive Dental Services, Shelly-Ann Sinclair MPH, Burton Edelstein DDS MPH, Feb 2005, Children's Dental Health Project, www.cdhp.org

CDC Oral Health Resources Fact Sheet: A National Call to Action to Promote Oral Health, June 2003, www.cdc.gov/OralHealth/factsheets/call_to_action.htm

Special Medicaid Report: Does Flexibility Spell Loss of Dental Benefits, October 2005, Children's Dental Health Project, www.cdhp.org

Periodontal Disease Association with Poor Birth Outcomes: State of the Science and Policy Implications, David Krol MD, Burton Edelstein DDS MPH, Anne De Biasi MHA, June 2003, Children's Dental health Project www.cdhp.org

Keeping Health in Head Start: Lessons Learned from Dental Care, Children's Dental Health Project 2003, www.cdhp.org

State Oral Health Plan Draft Outline, 11/9/2005

Draft Outcomes of the Plan, Developed by Oral Health Advisory Committee Sept. 2005

Using a Coordinated Approach to Address Health Issues in School (CSHP), CSHP, BOH & DOE 4/04 [Logic model]

Judy Feinstein also called attention to handouts on tables: Watch Your Mouth materials, and the report on Maine's Oral Health Summit in April 2003. Judy noted that there has been work that has proceeded around the 2003 recommendations. Judy also announced the next Oral Health Advisory committee meeting will be held on Thursday Dec 8th. She shared that the committee is not a closed group, and welcomed volunteers to join the committee to develop and guide the state plan.

Governor Baldacci's Address

Craig Freshley introduced Dr. Dora Anne Mills and pointed out that she has served as Maine's Public Health Director for almost 10 years. Dr. Mills is a native of Farmington.

Dr. Dora Anne Mills introduced Governor Baldacci. She first noted that a draft State Health Plan was unveiled last week and today's planning can be linked to this plan. The State Health Plan is available on the State of Maine website.

John Baldacci was elected governor of the state of Maine in 2002 and was sworn into office on January 8, 2003. Governor Baldacci was born and raised in Bangor. He was first elected to public office in 1978, when he won a seat on the Bangor City Council at the age of 23. While working at the family restaurant in Bangor, he earned a B.A. in history from the University of Maine. During this time he learned much about the opportunities and challenges facing Maine's small businesses. In 1982 he was elected to the Maine State Senate, where he served until 1994.

In 1994, Baldacci was elected to represent the Second District of Maine in the U.S. House of Representatives. Re-elected to Congress in 1996, 1998, and again in 2000, Baldacci served on the House Agriculture Committee and the Committee on Transportation and Infrastructure. Elected as Governor of Maine in 2002, one of the hallmark initiatives of his administration is the Dirigo Health Plan.

Governor Baldacci thanked Dr. Mills for the introduction, and proceeded as follows:

- Health is like conservation of energy; we can send a message to oil companies and to health care companies.
- Preventive health care impacts cost by 50%.
- The governor set up an Office of Health Care and Finance on his first day in office by executive order; he wanted to start "off the ground" as much as possible.
- DHHS is the largest department of state government and is going to evolve.
- One of the Governor's top priorities has been setting up the State Health Plan.
- People also need to take responsibility for their own health.
- Dirigo Choice is about expanding access.

    - People without insurance are not really getting services for "free". Hospitals charge the highest possible rate for "free" services, and the cost goes back and is charged through insurance premiums.
    - Expanding access to cover uninsured and underinsured saves costs.
- Dirigo Choice is funded with no increase in taxes through a federally funded one-time grant.
    - The goal is to bring health care cost down by improving health habits.
    - Everything is being done with an eye toward long-term, sustainable practices, creating foundations for the 21st century.
- Maine is positioned to take advantage of the new knowledge-based, information-based economy like no other state.
- The governor's goal is to give people resources and protect their services.
- Healthy Maine 2010 objectives include oral health education and programs, including:
    - To increase the number of dental health providers
    - To implement water fluoridation where possible
    - To promote programs in schools
    - To encourage initiatives to reduce children's dental decay
    - To maintain community-based services (e.g., sealants, school-based education and fluoride)
        - 40% of elementary schools and about 40% of children in grades K-6 participate in state-funded school oral health programs
        - About 250 schools are participating this year
        - About 84% of of people who get their water from public water systems have fluoridated drinking water
- State funding for oral health includes allocations from the Fund for Healthy Maine as well as several other sources.
- There has been a 25 to 50% increase in the number of community-based dental services programs in Maine over the past 3 to 5 years.
- The State Oral Health Plan will add to the State Health Plan.
    - The governor expressed an interest in what people will come forward with in the State Oral Health Plan.
    - A focus on prevention and innovation will benefit the greatest number of people.
    - The governor looks forward to reviewing outcomes and appreciates the collaboration of stakeholders.
- The governor thanked Jonathan Shenkin for being the keynote speaker.

Craig thanked the governor for taking time out of his busy day to focus on oral health.

Dr. Shenkin's Keynote Address

Judy Feinstein thanked everyone for coming and introduced keynote speaker Jonathan Shenkin.

Jonathan Shenkin, DDS, MPH, practices pediatric dentistry in Bangor, Maine. Dr. Shenkin holds teaching appointments in the Department of Public Administration at the University of Maine at Orono and in the Departments of Health Policy and Pediatric Dentistry at the Boston University Goldman School of Dental Medicine. He is the recipient of several honors and awards, serves as a member of the Executive Board of the Maine Dental Association, and has worked in Maine with the state Commission to Study Public Health, chairing the subcommittee on children, nutrition, and schools.

Oral Health Throughout the Lifespan

Outline of presentation – topics to be addressed:

- Pregnancy issues
- Children
- Adulthood
- Elderly/systemic issues
- Health care financing
- What can we do?

Case study of a high-risk mom

- Smoker
- Minimal brushing, no flossing
- Dental care for emergency care only
- No coverage

There is an association between pre-term, low birth weight babies and periodontal disease, and some association between decreased risk and therapy.

Pre-term Low Birth Weight (PLBW) baby case study:

- More likely lower socio-economic status
- Enamel defects
- Extremely costly management

Low Term Birth Weight Case

- Low income moms less likely to breastfeed
- Breastfeeding results in reduction of juice (high sugar beverage)
- Little or no access to early dental prevention, according to AAPD guidelines
    - Problem: pediatric dentists are not providing year one dental visits

Ages 0-4 and at risk (per following risk factors)

- Most do not see a dentist
- Hypomineralized enamel
- Infrequent brushing
- No dental home
- Use of "Sippy cup" with juice but at three times the recommended levels

- Inherited mother's S. Mutans (the bacteria that causes tooth decay)
- Other caregivers supply child with non-nutritious foods
- 72 % of adults report first dental experience was traumatic
- Caregivers:
    - Family that has accepted negative oral health destiny
    - Child pre-ordained to have poor teeth

Status of Oral Health for US Children (data from CDC)
Improvement in oral health for adults but no improvement for children, and overall an increase in children with tooth decay (data 1988-1994, 1999-2000)

- Problem: future risk is based on past history
- Dental community not prepared to deal with emerging problem of increases

Receipt of Preventive Services by Low Income Children
1996: 20%
2000: 31%

WHY do we have low participation by dentists in Medicaid programs?

- Medicaid families give dental services low priority
- Young children most difficult to serve
    - What kind of services do young children need?
        - Preventive that are easy to provide

Impact of dental pain

- 1.6 million lost school days
- 2.4 millionlost workdays
- 4.6 million bed days (Surgeon General's report 2000)

- Increasing Medicaid enrollment does not increase dental access
- Increasing reimbursement does not increase the number of dentists willing to participate in Medicaid

Some solutions:

- ABCD program in Washington State increased access and reduced disease burden
    - Double decay in control group
    - Marginally more expensive

- Early preventive dental visits in North Carolina reduced costs and increased utilization of preventive services
    - Dramatically reduced emergency care and restorative costs
    - One preventive visit between ages of 1-2 can cut needs in half by the age of 4

Research on adolescents 12-18 years who ever had caries in permanent teeth, 1988-94 and 1999-2000, shows that adolescent oral health has improved.

Other research also indicates an increase in dental sealants.

Consumption of added sugars nearly doubled from 1909 to 1998.

What perpetuates high risk?
- Family acceptance of dental disease
- Poor nutrition and modeling
- Exposure to tobacco use
- History of decay greatest predictor of future disease
- Limited access to dental services
- Transportation issues
- Parental leave

Individuals with disabilities
- Profound management issues
- Challenges properly diagnosing disease
- Cost-ineffective care
- Difficulty with home care and nutrition
- Few properly trained and willing providers
- Expanding number of children with Autism

Adulthood
- Cigarettes are biggest enemy in rural Maine

Tobacco and Oral Health
- Increased risk of periodontal disease
- Increased risk of oropharyngeal cancer
- Increased risk of dental caries
- Environmental tobacco smoke exposure and primary caries
- Increased consumption of sugars
- A habit of the poor and a major confounder (difficult to show a true association between diseases)

Poverty and Oral health
- Low SES from childhood to adulthood:
    - Threefold increase in adult periodontal disease
    - Similar increase in caries

Adulthood and At Risk Case Study
- Smokes regularly
- Limited access to dental services
- Poor oral health
- Poor dental IQ/ Low health literacy

What should he do?
- Feed his family?

- Buy heating oil?
- Buy gasoline for his car?
- Miss multiple workdays and risk job loss?
- Full mouth extractions?
- Emergent care only?

Sample treatment plan

- General Dentist
  - 6 root canals
  - 8 crowns
  - 16 restorations
  - Periodontal therapy
  - Price tag--$14,000
    - Dental Visits 15-20
- Sliding Scale (20%)
  - 6 root canals
  - 8 crowns
  - 16 restorations
  - Periodontal therapy
  - Price tag-$2,800

Research 1988-94 and 1999-2000 shows increase in number of adults who have not lost any teeth.

Conundrum

- Decreasing tooth loss means increasing tooth maintenance
- Significant increases in dental visits throughout all age groups
- Modest increases in the number of dentists, compared to larger increases in population growth
- Dental delivery system is being overwhelmed
- Likely increases in dental fees to match demand

Elderly

- More people living longer
- More people have natural teeth
- Few elderly (~15%) have dental insurance
- 77% of dental care is paid for out of pocket
- System is being flooded but people cannot access because of resources
- Increasing utilization because there is an increased number of tooth surfaces to maintain
- Annual visits for those over 65:
  - From 34.6% in 1981 to 54% in 2002

Elderly case study

- In a nursing home
- Suffered a stroke
- No dental services

- No dental coverage

Association between periodontal disease and respiratory disease
- Aspiration occurs normally
- Dysphagia results from altered level of consciousness
- Pneumonia is caused by aspiration of oropharyngeal contents
- Edentulous→ LOW RISK of aspiration pneumonia
- Biofilms, not periodontal disease

Respiratory Interventions
- Multiple studies explored reductions using chlorhexidine
- Other antimicrobials have been used successfully.
- Modest level of evidence that supports interventions

Cardiovascular Disease
- Immune alteration
- Chlamydia infection
- Chronic inflammation increases
- Increased plaque formation

Stroke
- Thrombus to the brain
- Related to plaque formation

Cardiovascular / Periodontal Interventions
- No proven periodontal interventions that reduce the risk for Cardiovascular disease and stroke.
- Dental profession needs to be very cautious about how they inform patients about this POSSIBLE risk for disease.
- All too often, we inform patients that there is an absolute risk of systemic disease, which has not been proven yet.
- Still not adequately informed or scientifically proven yet through research that there is truly a link.

Oral Health Financing
- Spending on oral health care has increased nearly five-fold between 1980 and 2002 ($14 billion to $70 billion).
- Spending on dental services as a percentage of total spending on health care has been declining between 1980 and 2002 (from over 6% to just over 4%).

What can we do?
- Extend dental MaineCare services to pregnant mothers (preventive at least)
- Increase direct preventive dental services to children under age 4 via WIC Oral Health Expansion
- Increase use of dental sealants

- Increase fluoride vehicles (i.e., topical applications, supplements, drinking water – as appropriate)
- Consider new types of dental providers to work in non-traditional settings (note potential cost savings to be realized)
- Have non-dental personnel apply anti-cariogenic and anti-bacterials (school nurses, CNAs, RNs).
    - Cost-effective projects
- Promote breastfeeding among low income/high risk populations
- Marketing/advertising to children
- Carefully include treatment into the public health model

Dr. Shenkin thanked everyone for working to help people in the state of Maine.

Craig Freshley asked if there were any questions.

Questions & Answers

Q: A legislator was intrigued about extending MaineCare to pregnant women: could we get them in, are there enough dentists?
A: Preventive services don't need to be provided by a dentist. Just this week, California extended a program to build the service structure that includes services provided by other professionals.

Q: Is the dental profession ready for that?
A: There are a number of issues. The dental community is afraid to touch pregnant women. Education is needed on the necessity of treating pregnant women. Obstetricians want pregnant women treated and managed; the philosophy within the dental profession needs to be changed.

Q: Please elaborate on the issue of treating pregnant women.
A: There are concerns about harming the fetus (anesthesia, xrays). Obstetricians report daily calls from dentists asking same questions about treating pregnant women.

Q: We are putting too much money into treatment and not enough into prevention: does that extend to prevention work with kids too?
A: Yes, prevention is a way to spend money more wisely.

Q: What are dental schools doing to help with the shortage of dentists?
A: The shortage is not just in Maine; it's nationwide. We're not going to see a huge increase in Maine because there is no increase nationally. It takes over a decade to open a dental school. In the next 10-15 years there will probably be no net increase in the number of providers.

Q: Public health nurses talk about oral health. Are pediatricians getting enough education on the importance of oral health? Should there be a hygienist in the pediatrician's office?
A: The Maine Academy of Pediatrics Fall Conference was a full day of oral health for pediatricians. However, only about 10% of pediatricians in Maine came. Pediatricians see older children, only about 1/3 of whom are covered by MaineCare. This is not enough work in many

practices to support a hygienist. Pediatricians are interested but their practice models aren't set up to be the ideal location.

Craig Freshley thanked Dr. Shenkin for his thoughtful remarks.

Pre-Conference Plan Development

Background

Recent Oral Health Planning Work

- Surgeon General's call to action, May 2002
    - All Americans can benefit from the development of a National Oral Health Plan. This initiative can begin at the state level by the implementation of State Oral Health Plans as a component of the states' general health plans.
- 2003 Oral Health Summit
- Since 2003, 17 states have developed oral health plans (from CDC website)
- 2004 Grant provided by Maternal and Child Health Bureau of the Health Resources and Services Administration to the Oral Health Program
    - Goals: develop plan and companion oral health data and surveillance plan
    - Steering committee and advisory committee established

Project Website

The website for Maine's Oral Health project is www.GoodGroupDecisions.com/OralHealth. This site includes the following:

- Report: Improving Maine's Oral Health
- Conference information
- Notes from past meetings of steering committees
- List of steering committee members
- Useful links
- Contact information
- If you have suggestions for additions to the website, let Craig know

Draft Plan to Date

The following outcomes, character and outline of the plan have been developed to date by the Advisory Committee:

Outcomes of the envisioned plan:

- Overall improved oral health
- Increased funding
- Policy changes
- Private sector action
- Better system analysis
- Shifting roles
- Public education and awareness
- Encourages holistic approach

Character of the envisioned plan:

- Practical
- Inclusive
- Broad scope
- Creative
- Evaluation built in
- Adaptable and enduring

Outline of the envisioned plan:

1. **Executive Summary**

2. **Introduction**
    a. About the project
        i. Who has been involved
        ii. How the plan was developed
        iii. Characteristics
    b. National context and other state efforts
    c. What is oral health/Why oral health is important

3. **Oral Health of Maine People: Many Challenges**
    a. Brief overview – more details in a separate report
    b. Focus on current conditions

4. **How to Improve Oral Health of Maine People**
    a. Overall goal / ideal outcomes
    b. Areas of work
        i. Public policy and funding
            1. Outcomes
            2. Actions
        ii. System Improvement
            1. Outcomes
            2. Actions
        iii. Workforce roles
            1. Outcomes

2. Actions

iv. Public Education and Awareness
    1. Outcomes
    2. Actions

5. **Immediate next steps**
    a. Institutionalize Oral Health Planning Group
    b. Mesh with the State health Plan
    c. Letters of commitment from organizations

Comments on the Draft Outline

- Take Dr. Shenkin's recommendations and Watch your Mouth recommendations
- State Health Plan should address oral health…one coordinated health plan
- Incorporate some evaluation of success
- Get buy-in from a broad section of Maine health care providers
- Education of legislators
- Add oral health screenings in public schools
- Both long term and short term initiatives
- Include some metrics to measure goal accomplishment…where we are, measure progress toward goal

Small Group Discussions

Public Policy and Funding

Participants

Andrea Perry, facilitator
Brenda McCormick
Barbara Leonard
Patricia Jones
Mary Ann Gleason
Steve Letourneau
Kate Perkins
Dan Meyer
Liz Rogers
Jean L'Italien
Lisa Howard

Lisa Miller
Shawn Yardley

Overview of situation

Barbara Leonard from Maine CDC presented an overview of public policy and funding issues. The following notes provided the basis for her presentation. Each of these things may not have been said at this time in exactly this way.

Maine doesn't have an "Oral Health Policy" per se. What state government does around oral health, e.g., through BOH programs, is directly related to the agency's mission and vision. There are two areas of interest:

1. Policy actions that result in or are connected to direct funding

2. Policy actions that support improved access to oral health, workforce issues, broader funding, etc.

State Policy Actions Resulting in Funding

DHHS/MCDC/OHP

School Oral Health Program

- Grew out of legislation passed in the mid-1970's, supported by the MCDC's general fund allocation
- Grants are made to schools, school districts and several community agencies to support classroom based education and the administration of a fluoride mouth rinse program in schools.
- Grants are based on a funding formula:
    - Schools must meet certain eligibility criteria
        - % of children with Free & Reduced Lunch and with MaineCare
        - poverty level of the community or census tract
        - public water fluoridation status
- This year Maine has about 250 schools participating through about 75 granted programs
    - about 40% of the K-6 population
- Dental sealant component
    - Added in 1998
    - Presently offers sealants to 2nd-graders in about half of the participating schools, using the state dollars that match the federal MCH Block Grant
- Total funding directed to the School Oral Health Program (all components) about $250,000.
    - Total number of children = approx. 40,000
    - Cost per child for "core" SOHP = approx. $3-5 per year

- Sealant program funding based on $30 per child purchased an average of 3.1 sealants per child for nearly 1500 children

Federal Block Grants

- Allocations are made within MCDC from the **Federal MCH Block Grant** to support oral health activities (two positions, state match for the SOHP)
- Allocation is also made from the **PHHS Block Grant** to support other staff and activities of the state oral health program.
- Support allocated by the state

Tobacco Settlement: Fund for a Healthy Maine

- Funding for the **Dental Services Development and Subsidy Programs** authorized by the Legislature in 1999
- Encourages the development or expansion of community-operated, nonprofit oral health care programs serving
  - Patients uninsured/underinsured for oral health care
  - Patients covered by MaineCare
  - Low income residents
  - Underserved areas or populations
- Approximately $950,000 administered via the OHP in this funding program.
  - $650,000 directed to a program that provides funds to subsidize dental services for patients without insurance who are paying for care using sliding fee scales.
    - Eligible community-based agencies participate by contract (not via a competitive grant mechanism).
  - Close to $300,000 administered in a competitive grants program.
    - Supports development and expansion of dental services for uninsured, and implementation of oral health case management
- Funding has resulted in an increase of the number of "safety net" dental resources in Maine in the last 3 – 5 years, roughly doubling the number before 2001
- Current grants will end a 30-month grant period in June 2006. An RFP should be issued in the winter for funding to start July 1, 2006

FAME

- FAME administers the **Maine Dental Education Loan and Loan Repayment Program**
- Annual allocation from the Fund for a Healthy Maine of $240,000
- Program provides loans to current dental students
- Loan recipients have service obligation on a year-for-year basis
- Offers repayment to dentists who
  - practice in settings in state-designated underserved areas
  - meet the program's requirements for seeing all patients regardless of their ability to pay, including MaineCare and sliding fee scale
- Loans and repayments limited to $20,000 each
- Maximum of 12 individuals in the program at any one time
- Currently 9 students, and three dentists in repayment program
- Note – there are other FAME loan programs to support students in health professions

Other

- Over past several years a number of private foundations (e.g., MeHAF and Bingham) have recognized oral health in their funding priorities.
- Foundations support model programs and innovative approaches that demonstrate changes in health outcomes and good chances of sustainability

Federal Policy Actions Resulting in Funding

Maternal & Child Health Bureau

Includes Oral Health in the MCH Block Grant with several performance measures, e.g., increasing the prevalence of sealants, and reducing proportion of children who have untreated decay

- Provided specific oral health funding to states for the past 6 years under different systems development grant programs
- Maine has benefited from MCH grants
    - Four year coordinated systems integration grant supported the Maine Dental Access Coalition and the state oral health summit in 2003
    - Three year grant helped expand our school-based sealant grant
    - Current collaborative systems grant to develop an oral health surveillance system and to develop the state oral health improvement plan

Administration for Children and Families

- Home of the Head Start Program, which increasingly has emphasized the importance of oral health
- ACF is now providing support to Head Start Programs through small grants and technical assistance
- Developing HSP capacity to provide oral health assessments to children and education to children and their families

Bureau of Primary Health Care

- Source of much of the funding for federally qualified health centers, which are required to offer access to oral health services, either on-site or through other arrangements
- Recent funding programs have specifically supported development of dental care services and several of Maine's health centers have successfully applied for these grants

Bureau of Health Professions

- Funds the National Health Service Corps, which administers a loan program as well as loan repayment programs, one in partnership with states (administered by Maine's state Office of Rural Health & Primary Care)
- Maine has had dentists and hygienists who are here through the NHSC

Policy Actions that Support Improved Access

State MCH priority

- 2005 to 2010: to foster conditions to improve oral health services and supports for the MCH population

MaineCare

- MaineCare's provides a comprehensive dental benefit for children and young adults up to age 21
- Services for adults are limited
- Problems with the number of dentists who will participate
- Limits on number of patients that participating dentists will see
- Issues in the claims management system
- MaineCare has worked to simplify its dental policy
    - Removed requirements for prior authorizations
    - Reduced the administrative issues for participating dentists
    - Updated claims forms to keep current with ADA
    - Changes have had limited impact, but are considered steps in the right direction.

Dental Practice Act Changes

- Changes in Maine's Dental Practice Act support improved access and improvements in oral health
- Maine has Public Health Supervision status for dental hygienists
    - Facilitates providing preventive dental services outside of/apart from traditional dental office setting
    - Maine considered national leader in this area
    - Supports the sealant component in the state-funded school oral health program
    - MaineCare reimburses for dental hygiene services provided through PH supervision, but private insurers do not. This would take legislative action.

Involvement of other health professionals in dental disease prevention

- Practice Act concerns
- Most state medical and dental practice acts contain few restrictions prohibiting physicians from providing preventive oral health services.
- Policy issues usually around reimbursement
- 12 state Medicaid programs reimburse physicians to provide preventive dental services
- Maine physicians can bill preventive dental codes but need to check with MaineCare for the details

Water Fluoridation

- Still considered one of the safest and most cost-effective ways to help prevent dental decay.

- Community water fluoridation in Maine authorized only by local referendum.
  - Decisions directed to localities by the Legislature in 1950's and 1960's
  - Legislature unlikely to move decision to municipalities or state health agency.
- Only roughly half of Maine's population gets water from community systems.
  - Of people served by these systems, 84% have fluoridated water in their homes.
  - Because of the proportion of our population using wells, this translates to about 35 to 38% of the total population.
  - Only a few larger communities (e.g., Kittery and much of York), and several smaller towns (Farmington, Lincoln, Greenville) remain without fluoridated public water

Other

- Kindergarten (or other school) screenings
  - Some states include dental screenings with other school entrance screenings (vision, hearing, scoliosis)
  - Some Maine schools include oral health but this is their choice.
  - Mandatory screenings would require a policy change, probably legislative.
    - Two titles for bills requiring kindergarten oral health screenings were submitted for this coming legislative session.
    - Latest information is that both were rejected by the Legislative Council as not meeting the requirements for a second session.
    - Note: One of these titles was accepted after the appeal process.

Outcomes

Top Priority Outcomes

After all desired outcomes were identified, the group did a multi-vote which resulted in the following prioritized list of outcomes:

- Maintain State Oral Health Program
- Fluoride rinses and sealants in all schools
- Every 0-4 child receives at least one preventive care visit
- MaineCare Coverage for pregnant women
- Preventive care and education done in nontraditional settings (schools, WIC clinics, etc.)

All Desired Outcomes

The following represents the full range of all desired outcomes identified by the group.

Better data and surveillance of oral health status and need

- Establish a committee to study OH needs of baby boomers and how ME will respond
- Encourage Maine Dental Access Coalition and Oral Health Plan collaborative process

Public and private oral health funding partnerships (state and foundation $)

- Save FHM$ for oral health
- School-based clinics and programs eligible to compete for subsidy program and other state sources (some disagreement about this)
- Save Preventive Health and MCH block grants

Dirigo Insurance and MaineCare expand coverage for oral health

- Enhance knowledge of legislators of OH issues
- MaineCare in nontraditional settings
- MaineCare promotes care for 0-3 year olds
- MaineCare coverage for pregnant women
- Require/mandate health insurance pay for oral health for pregnant women who don't have dental insurance or MaineCare
- Expanded practice OH providers to be reimbursed by insurers (incl. public health settings)
- More dentists treating MaineCare patients

Get general public to recognize that oral health is part of overall health and why

- Maintain state oral health program
- Every new mom is taught about oral health at the hospital
- Establish office for oral health program
- Every 0-4 year old receives at least one preventive care visit
- Make sure oral health stays in Maine Learning Results
- 100% fluoridation of public water

Nontraditional settings for dental care, preventive care, and education (schools, WIC clinics, etc)

- Fluoride rinses and sealants in all schools
- Mandatory school screenings
- Oral Health included in all school-based health centers
- Every pediatric and family physician doing screening and risk assessment
- Medical assistants doing preventive care

More dentists and other providers

- Make FAME loans include requirement that recipients practice in Maine
- Dental residency program in Maine
- Increase outreach and recruitment of Maine kids into dental and dental hygiene training

- Explore opportunities for telemedicine and OH

Other Issues

- Have businesses somehow involved
- Collaborative funding arrangements
- Vending machines out of schools
- Support Healthy Maine partnerships
- Add good practices/models in the state to the Plan
- Are Healthy Maine folks on the advisory committee?

Actions

Maintain State Oral Health Program

Actions

1. Create an office of oral health (January '07)
    a. Program will end if we lose the block grant
2. Educate legislators ('05 and '06)
3. Educate/lobby DHS staff to not cut funding

Key Players

1. All health constituencies
2. Legislators

Fluoride rinses and sealants in all schools

Actions

1. Attach to current money going to schools
2. Policies passed at state and local level
3. Create incentives for schools through current funding streams

Key Players

1. Legislators
2. School board members
3. OH providers

Every 0-4 child receives at least one preventive care visit

Actions

1. Provide money for a campaign to educate providers, parents, teachers

2. Add OH to the well child visit list that children's primary care givers use
3. Rulemaking to require medical professionals provide - will need to get training to be reimbursed
4. Day care providers receive OH training as part of certification process

Key Players

1. CDC's immunization educators who are doing outreach from Bangor and Portland; could also do OH.
   a. Contract is in the works now.
2. Work with prenatal care providers so that they are educating their patients
3. DHHS – day care providers and those that train them
4. Home visitation programs

MaineCare Coverage for pregnant women

Actions

1. Research what other states have done
2. Add to MaineCare priorities (would have to be legislated)
   a. Get good data
   b. Pilot program in WIC clinics
   c. Get buy in from legislators

Key Players

1. Legislators
2. BMS
3. MaineCare folks
4. Governor
5. Women and children advocacy groups
6. WIC providers
7. Obstetricians and nurse midwives

Preventive care and education done in nontraditional settings (schools, WIC clinics, etc.)

Actions

1. Every school add oral health education and screening to essential programs and services
2. Require elder care facilities to provide oral exams every year
3. Collaborate with State's workplace wellness programs
4. Every Healthy Maine partnership include oral health in their priorities
   a. add in the next 5 yrs or try to add through supplemental funding

Key Players

1. Bureau of Health
2. Private sector funders
3. Private foundations
4. Health ME partnerships
5. School boards
6. Department of education
7. BMS
8. Nursing home associations

System Improvement

Participants

Craig Freshley, facilitator
Ron Bansmer
Toni Wall
John Bastey
Bernadette Serafin
Carol Zechman
Kristine Blaisdell
Vaneesa Woodward
Marc Coulombe
Vicki Helstrom
Valerie Heal
Debbie Littlefield
Judy Feinstein

Overview of Situation

Judy Feinstein provided an overview of system improvement. The following notes provided the basis for her presentation. Each of these things may not have been said at this time in exactly this way.

For our purposes here, this encompasses systems analysis and incorporation of evidence-based approaches.

Advisory Committee has that identified desired outcomes would center around:

a. Clarity of who is providing what
    - Issues: Understanding of medical and dental practice acts, scope of service issues, anticipatory guidance for young children, integration of oral health with

primary care – all are underway and all require systems analysis for effective change

b. Better System Analysis
    - Comprehensive and ongoing analysis of access issues
    - Communication about & coordination of available services
c. Development of surveillance and data collection capacity
    - Agreement on which parameters are meaningful, collation of variety of sources, comparisons to other states, comparisons of regions within this state
d. Best use of evidence-based priorities and practices – as the larger scientific community builds the science base, we also want to ensure that care provides value
e. Evaluation of program effectiveness
    - Importance of communications among all parties to share models
f. Dissemination of information on best practices, lessons learned and failed strategies

Evidence based approaches

- State dental and medical practice acts contain few restrictions prohibiting physicians from providing preventive oral health services.
    - Dental screening & referral, risk assessment, counseling, fluoride therapy
    - Caries-Risk Assessment Tool (Developed by the AAPD for general health care providers):
        - Based on a set of factors from caregiver interview and clinical screening
        - Classifies child as: low, moderate, high
        - Should be used as a record of progress in elimination of risk factors
        - Should be tied directly to anticipatory guidance and health education
        - Building programs with the science
    - Fluoride varnish – has been found to be safe and easy to use, apparently effective in primary teeth (6 studies), and ostensibly supported by larger body of evidence – seems effective in permanent teeth and certainly, other topical fluoride applications are effective. BUT according to a report in 2002 by the Cochrane Collaboration (an international not-for-profit organization known for preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care):
      In spite of the apparent "substantial caries-inhibiting effect of fluoride varnish in both the permanent and the deciduous dentition…given poor quality of studies and wide confidence intervals around estimate of effect, there remains a need for further trials."
        - Two studies pending
    - Associations between periodontal disease and adverse pregnancy outcomes, cardiovascular disease and diabetes – there are studies in all areas that prove there are associations and that there are no greater risks, prompting more studies particularly independent clinical trials. Earlier studies of adverse pregnancy outcomes, for example, were observational, and show an association, but not necessarily a causal relationship.
    - Evidence that early visits – early intervention will make a difference – programs such as Head Start's incorporation of oral health screenings and concepts, WIC, Bright Futures.

Outcomes

Top Priority Outcomes

- Better Infrastructure and Service Delivery
  - Public Health Clinics include Dental Health
  - Cooperative arrangements
  - Includes private sector

- Improved Professional Education
  - Dentists, Hygienists, Doctors, Pediatricians, Obstetricians, Parents
  - Focus on Pre-natal and 0-5 age group
  - Adults – connection with job opportunities
  - In the professional schools
  - Coverage – MaineCare, etc and Private Insurance Cards (Public)
  - Prevention focus

- Build on what's in place
  - Cross-training
    - Experts serve as consultants to others
  - Screening and sealants in schools
  - Reduce duplication
  - Expand programs
  - Oral Health Providers volunteering
  - Analysis of who's providing what

- Evaluation of Effectiveness
  - Needs to be useful
  - Maine uniform data collection
  - System analysis
  - Apply evidence-based approaches
  - Applies to all
    - Access, status, goals

All Desired Outcomes

- Clarity of who's providing what
- System Analysis
  - What's going on in terms of access
  - Coordination of services
- Development of data surveillance
- Best use of evidence-based approaches
  - Physicians providing prevention

    - Building programs with science
- Evaluation of Program effectiveness
- Disseminate information on best practices
- Improve instructions for MaineCare cards
- Build on what's already in place
    - Fluoride varnish (kids 1-12)
    - Preventative visits to pregnant moms
    - Head Start
- Reduce duplication
- Expand programs
- Oral Health Providers become part of a volunteer network to help low income people
    - Needs to be done before emergency hits
    - There is some volunteerism
    - Potential reasons not being doing
        - Shortage of professionals
        - No time available
- Physicians prescribe fluoride
    - Make this a customary practice among Health Care Providers (considered as a medication)
- Improved education among dentists, pediatricians, parents and obstetricians
- Dirigo should cover Dental
- Participate in National data collection
    - Utilization data
- Non-Profit clinics
    - MHDO include the non-insured
- Uniform data system for Maine
- Better and increased Public Health Infrastructure
    - Community Health Centers
    - Dental Health Clinics
    - There are some emerging good examples
- Screenings and sealants in schools
    - (Eg. Aroostook County)
    - Good training is important
- Focus on Pre-natal and 0-5 year age group
    - Long-term investment
    - Upstream approach
- Paradigm shift
    - Preventative
- More resources
    - Poor Oral Health prevents career growth
- Survey of who can do what
- Cross-training
    - Experts serve as "consultants" to other providers (CNA's, Family Support Workers, Nurses)
- Improve and expand curriculum

- Integrated Health Services training

Actions

Improve Infrastructure and Services

- Who's doing it the best in Maine and other places?
  - Urban and rural
- Where's the most need?
  - Distribution of dentists
  - Percent of uninsured people
- What's the current infrastructure?
  - Regional survey system of private providers
  - State Agency
  - Medical Board of Dental Examiners, reports from Hygienists
  - Advisory Committee
- Cultivate Public and Political Will
  - Educate legislators
    - Photos
    - Statistics
  - Watch your mouth
    - A system to influence the system
  - Profitable with community return
    - Better jobs
    - Cancer prevention
  - What are the current systems?
    - Spheres of influence
  - It's the #1 chronic disease in kids
- Current cost estimates for oral treatment
  - Insurance companies

Improve Professional Education

- Maine Smiles Matter go into other programs
  - What to look for
- Physicians know what to monitor
  - Similar dental collaborative
- Book of resources/referrals
  - Who serves low-income people
- Improve awareness: It's a disease
- Governing Boards of schools come to a meeting to discuss a curriculum

        - Regulation and Certification Boards
        - High level of the Bureau of Health convene
    - Use CEU system for non-dental professionals
        - Required by licensure to take CEU's in Oral Health
        - Or, Oral Health offering
        - Or, multi-disciplinary requirement
    - Educate pediatricians
        - Year One visits to dentist/hygienist
        - Posters and literature in pediatricians' offices
    - The professional groups need to buy in
        - To include:
            - OB/GYN's
            - Doctors of Osteopathic Medicine
            - AAP
            - Physician's Assistants
            - Nurse Practitioners
            - Visiting Nurses

Evaluate Impacts and Apply Best Practices

We did not have adequate time to discuss this, but basically, here's what's needed:

- Better data collection and analysis re: status and access
- Awareness and application of best practices

Actions to be addressed in other sections

- Prevention Emphasis
    - Public Education and Awareness
- Physicians prescribe Fluoride
    - Workforce
    - Preventions

Workforce

Participants

Colleen Myers, facilitator
Kate McNamara
Becky Whittemore
Beryl Cole
Judy McCollum
Dave Drohan
Jim Dowling
David Rappoport
Sophie Glidden
Frances Miliano
J. Curtis Dailey
Loreene Stacy
Larry Jacoby
Martha Lawrence

Overview of the Situation

Sophie Glidden provided background information. The following notes provided the basis for her presentation. Each of these things may not have been said at this time in exactly this way.

Numbers, age and distribution of dentists (2002)

- 589 dentists, net gain of 8 since 1998 (actively practicing vs. 630 licensees)
- 465 (~80%) were general practice dentists.
- Dentist to population ratio was one per 2,165, compared to national ratio of one per 1,656. Maine was 28th in the 50 states.
- Only 30% of Maine dentists were 45 or younger; average age was 50.5.

Numbers, age and distribution of dental hygienists (2004)

- 739 hygienists, compared to 715 in 1999 (actively practicing); 90% employed in private practices [many more license holders: ~1100].
- Hygienist to population ratio is one RDH per 1,752 residents, statewide. Cumberland County's ratio was significantly lower (better) than the state's ratio; Washington & Somerset were significantly worse.
- About 64% of Maine's hygienists are 45 or younger (compared to 75% in 1999).

Outcomes/Actions

Emphasize Cost-Effective Prevention by Shifting Roles

(Shift within Dentistry and between Dentistry & Medicine)

- Maximize Productivity of Existing Dental Workforce by Shifting Roles within the Profession
  - EFDA (Expanded Function Dental Assistants) -- There was enthusiastic support for upgrading the role of dental hygienists through this Maine Community College degree program which is in the planning stages.
    - Support this program as it moves through Public Hearings in 2006; fast-track if possible.
    - Look for evidence of productivity gains in Pennsylvania, Vermont, US Military programs.
  - ADHPs (Advanced Dental Hygiene Practioners) were noted as a national model.

- Maximize Productivity by Integrating Oral Care with Well Baby, Well Child and even "Well Adult" physician visits.
  - Find out what oral health care issues are explored in Well Baby visits currently-Larry Jacoby
  - Explore sustainability of Maine Dartmouth Family Practice Program - Dan Meyer.
  - Encourage preventive dentistry education by physicians and their staffs, including "out of the box" practices such as:
    - varnishes applied to children's teeth by dental hygienists working in pediatric offices
    - Xylitol gum provided to pregnant patients by obstetricians during prenatal visits
  - See what can be done to equalize benefits as between Mainecare and patients covered by other insurers

- Maximize Productivity by Encouraging the Study and Practice of Pediatric Dentistry

More Dental Professionals

- Reach students as they're beginning to think about careers, while they can still lay an academic foundation for oral health care careers.
  - Ask professional schools how their students chose their dental careers. See if #2 steps is supported by facts.
  - Reach Middle School students through existing or new programs such as

- AHECs (Area Health Education Centers) website and outreach program - Sophie Glidden
- UNE AHEC's travelling science careers program -- FAME could fund?
- Programs of local dental associations
- Scouting Merit Badge programs
- In the chair" recruitment by dental professionals explaining to young patients how and why they work.
- Non-clinical summer programs for high school and college students.
- Jobs for Maine Youth

▪ Be sure to include Safety-Net sites in the outreach to potential students of oral health care.

o Gear training for dental professionals toward
- Prevention
- Clinical work
- Pediatrics

▪ Maine externships for out-of-state students
- Study research done on retention of physicians who serve externships in new locations.
- Understand Penobscot experience.

▪ Loan forgiveness for those serving at-risk and/or under-served populations

o Encourage more new professional practitioners in Maine with
- Out-of-state and out-of-box recruiting for residencies.
- Mentoring for all completing residencies, but especially out-of-staters
- Expanding recruitment of dentists from CODA-accredited schools in, e.g., Mexico, India

▪ Support existing clinical programs with private funds until government funding can be obtained.

o Recognize that average age of Maine dentists is 50+ and ensure that existing practices continue as dentists retire.

Increase Capacity of Private Practices

o Special urgency for pediatric dental practitioners noted, but need to increase numbers of all professionals as above.

o Make Mainecare more user-friendly

        - See recommendations of earlier Muskie Center report on the topic of Mainecare.-Marty Lawrence

    - Financial incentives, e.g. to hygienists to upgrade to EFDAs, professionals to serve at-risk populations, under-served areas

    - Role-shifting, as above.

Expand Safety-Net

    - Identify Capacity of Existing Safety-Net, including all public health sites, community clinics, free clinics, and CDCs as well as Federally-Qualified Health Care Sites.

    - Make Mainecare more user-friendly (see above).

    - Emphasize retention of professionals who are already providing the safety net.

Public Education and Awareness

Participants

Debra Dunlap, facilitator
Marc Coulombe
Wendy Alpaugh
Tim Archer
Jenny Sobey
Kathy Martin
Sandy Evans
Kim Stowell
Amy Cronkhite
Dorothy Maroon
Hope Lanza
Jenny Robicheau
Karey Kershner
Carolyn Kimball
Carmella Dube
Joanne Burns
Julie Peters
Nena Cunningham
Julie Ouellette
Norma Larocque
Valerie Ricker

Robin Gardner
Karen Cobbett
Jenny Sobey

Overview of the Situation

Valerie Ricker from Maine CDC provided an overview of current efforts in prevention and education. The following notes provided the basis for her presentation. Each of these things may not have been said at this time in exactly this way.

State government programs

- State Oral Health Program
    - grants to schools for classroom-based education and administration of fluoride rinse (funding formula, eligibility criteria)
    - 250 schools this year
    - dental sealant component 2nd graders in about half of school programs
    - Total funding: approx. $250 mill
    - Serves: 40,000 children. Cost per child for core: 3-5$ per year
    - Sealant program estimate $30 per child purchased for 1500 children
- WIC program
    - provides oral health care
    - looking to expand
    - Aroostook county hygienist in WIC clinics (started with grant, now self-sustaining through MaineCare billing)
- Head Start
    - last year draft action plan will cross-walk with state plan

- Coordinated School Health Program
    - Dept of Ed, Maine CDC collaboration
    - Includes Oral Health in health approach
    - Worksheet specific to oral health PASSED AROUND CSHP

Beyond state government

- Multiple opportunities for non-dental health professionals
    - Early education and intervention strategies into other health related settings
        - Pediatric practice in Waterville employs hygienist
        - Curriculum Maine Smiles Matter Early Childhood Ed. for non-dental health providers to assist in work with young children (on display table with Watch Your Mouth)

        - Objectives educate, build awareness, enable non-dental providers recognize/identify, provide guidance, improved oral health/access, make positive impact on overall health/wellbeing of at-risk populations
        - Relatively easy to adapt to work with other population groups
    - Variety of organizations and individuals working on dental health
        - Organizations work with schools/community group
        - Maine regulations allowing hygienists to work under public health umbrella
        - Growing awareness of oral health as part of total health
        - Growing body of evidence linking oral health to other health issues
        - Expanding on models developed by Waterville pediatric practice to incorporate dental into health settings
        - Watch Your Mouth campaign
            - Joint NH, MA, ME goal to raise awareness of importance children's oral health, create policy/public climate in support of oral health

- Water fluoridation
    - 84% public fluoridated
    - Less than 50% get water from community systems
    - Only 38% total Maine population has exposure to fluoride in water systems
    - Local issue…decided at local level, not county or state
    - Most bottled water does not have fluoride in it
    - Testing wells for fluoride before prescribing supplements

Outcomes

Top Priority Outcomes

After all desired outcomes were identified, the group did a multi-vote which resulted in the following prioritized list of outcomes (votes shown):

Media campaign	14
Educate legislators	14
Collaboration w/ non-dental providers	13
Education for dental providers: Re: special populations: under 3, disabilities, MDA/ACOG care during pregnancy, under 1 care	9
Connect oral health education to Maine's learning results	3
School wellness plan should include oral health	2
Educate obstetricians importance of oral health	1
Oral Health programs for adults/elders	1

Support past trauma/address fear of dentist	0
Water testing for wells	0

All Desired Outcomes

The group brainstormed desired outcomes, as follows:

- Education not limited to schools
- Traumatic experience
- Public health nursing link
- Who else can do it?
- Home visitors, healthy families, etc.
- Head start, family advocates education, YMCA
- Personal responsibility
- Difference between systemic and topical fluoridation
    - Well water testing free Mainecare
- Media campaign
    - Water testing
    - Past trauma
- Partnering w/ non-dental providers using
    - Maine smiles matter
    - Watch your mouth
    - Others
    - Past trauma
- Education for dental providers
    - Mgmt under 3, disabilities
    - Obstetric
- Collaborative educational events
    - MDA/ACOG
- Education on state plan for providers
- Dirigo health should include dental
- More TV ads
- Promoting personal and community responsibility
    - Starting prenatal
- Free water testing for wells for everyone
    - Education for why
    - Educating MaineCare recipients
    - TV, radio, brochures
    - Re-educate care providers dentists, pediatricians
- Existing head start program
- School wellness plan should include oral health
- Other schools
    - Private, not low income
    - Mailings

    - Educate administrators
- Public TV programs should model positive behavior
    - Maine PBS
    - Community TV: local cable, collaboration w/ HS
- Maine smiles matter promote
    - Pediatricians
    - First well baby visit
    - Hospitals/nurses/prenatal
- Collaborating w/ community organizations
- Educate dental providers re: obstetrics
- Support for past trauma
    - 1:1 support
    - Program
- Addressing the fear of the dentist
- Dentist in a familiar setting (i.e. head start)
- Maine Dental Association offer a CEU course on dental/obstetrics
    - American College of Gynecologists/obstetricians ACOG
    - Collaborate MDA and ACOG re: prenatal, oral health education
- Education for dentists/hygienists re: under 3, disabilities management
- Promoting under 1 care
- Collaborate w/ cooperative extension and other community agencies/groups
- Educate policy makers re: all-school screening
    - Implications for overall savings
- Addressing the uninsured
    - Dirigo health should include dental care
    - Funding for oral health programs adult/elders (and education_
- Educate legislators re: lack of dentists
- Connect oral health education to MLR
- Policy makers aware that oral health is part of overall health
- Traumatic experiences addressed

Actions

Media campaign

What should be addressed

- Oral hygiene
- Prenatal care
- Overall health
- Overcoming barriers (trauma, fears)
- Fluoride in well water
    - Need for systemic fluoride and prevention

    - Difference between systemic /topical fluoride
- Oral disease bacterially transmitted
- ECC education
- Teeth are for life

How

- Watch your mouth
    - Radio, newspapers
- Public access TV/local cable
- Newspaper columns
- Collaborate w/ Partnership for Healthy Maine
- Feb. National children's dental health month
- 207 TV program
- Grant writing
- PSA's radio

Who needs to be involved

- Non dental professionals
- Watch your mouth group
- Maine Dental Access Coalition education committee
- Dental professionals/auxiliaries
- Parent groups: PTA, parent organizations
- School leaders
- People w/ media skills, experience
- Voc departments HS, colleges
- Community leaders

Educate legislators

What should be addressed

- OH plan/importance
- Lack of dentists
- Dirigo health should include dental care
- All school screening and school oral health program
- Cost/overall savings

How

- Hall of flags table MDAC-frequent
- Calling tree to call legislators

- Testify at hearings
- Invite legislators to oral health conferences/events

Who should be involved

- Reps from MDA/MDHA
- Recipients of care/non-recipients
- Board of dental examiners

Educate dental providers

What should be addressed

- Under 3
- Under 1
- Disabilities
- Dental care during pregnancy (both ways ACOG)

How

- Maine Dental Association offer a CEU course on dental/obstetrics
    - MDA collaborate with American College of Gynecologists/obstetricians ACOG
        - Two-way education re: prenatal care, dental care during pregnancy

Who should be involved

- MDA
- ACOG
- MDHA
- Family Practice/GPs
- Medical residency program
- Collaboration non-dental providers
    - Maine smiles matter
    - Medical organizations/conferences
    - Universities training nurses, osteopaths,etc.
    - WIC, Head Start, Early Childhood providers
    - YMCA
    - Nursing homes
    - Homeschool community
    - State Dept of Education

Collaborate with State Dept of Education

- Connect Oral Health Education to Maine Learning Results
- School wellness plans should include oral health

Closing Comments

- Look at Dr. Shenkin's recommendations
- Health plan should address health soup to nuts and fully incorporates oral health
- Incorporate evaluation
- Get buy-in from a broad section of Maine health care providers
- Education of legislators
- Oral health screenings in public schools
- Long term and short term initiatives
- Have some metrics – to see where we are re: accomplishing our goals
- Invitation from Maine Dental Access Coalition; welcome to join as member. Next meeting 12/2 in Augusta, contact Pat Jones if interested.

Judy Feinstein noted the following:

- Governor Baldacci's speech was covered by Maine Public Radio.
- It's important to have different parties at the table.
- A diverse group can work toward providing better access to services when people need them, rather than the "downstream approach" when there's a problem.
- The work done today will help to improve the health status for people of Maine.