Proceedings of the **Maryland Oral Health Summit: Pathways to Common Ground and Action**

Like the Roman god, Janus, the 2011 Maryland Oral Health Summit: Pathways to Common Ground and Action, held in Columbia, MD on October 20-21, 2011, provided a look back as well as a look forward. The look back was to 2007 when the 12-year-old Maryland schoolboy Deamonte Driver died from an untreated dental infection that had spread to his brain. His death shocked the nation and galvanized state action. John M. Colmers, then Maryland's Secretary of Health and Mental Hygiene, convened a Dental Action Committee (DAC), urging the group to make recommendations to ensure that such a tragedy would never happen again. Within months the 24-member committee made seven recommendations, all of which have been acted upon. And more: The Dental Action Committee has evolved into the larger Maryland Dental Action Coalition (MDAC), a public-private partnership numbering over 100 individuals and organizations, and co-sponsor of the Maryland Oral Health Summit in collaboration with the Santa Fe Group, a dental professional think tank that develops actions and policies to improve the nation's oral health and general health. MDAC's mission is to maximize oral health, especially targeting vulnerable groups. Toward that end, the Coalition launched Maryland's first 5-year Oral Health Plan (2011–2015) in May 2011.

During the Summit, some 150 attendees, representing professionals, organizations, and advocates from both the public and the private sectors, had an opportunity to review the Maryland Oral Health Plan and participate in a priority-setting exercise for its implementation. They also heard speakers describe changes and challenges to oral health in Maryland and in other states as well as in the country as a whole. This "bigger picture" outlook reflected the thinking of MDAC and the Santa Fe Group. These two groups partnered to "broaden mutual learning" and "extend this conversation both locally and nationally." The Summit was dedicated to Deamonte Driver and to Dr. John Rossetti, a long-time oral health advocate who served as Chief Dental Officer of the Maternal and Child Health Bureau, Health Resources and Services

Administration (HRSA), U.S. Department of Health and Human Services, who died earlier in 2011.

The "long shadow" of today's economic strain is clearly a challenge to oral health programs, said MDAC chair, Beth Lowe, in her welcoming remarks. But as she outlined the meeting's agenda, she also saw cause for celebration. She was pleased, too, that two Maryland congressmen who have played a pivotal role in enacting oral health legislation, U.S. Representative Elijah Cummings and U.S. Senator Ben Cardin, would be present. She concluded with thanks to the organizations* that had provided support for the meeting.

Speaking as President of the Santa Fe Group, Dr. Dominick dePaola explained that the group had formed in 1996 with a "passion to catalyze change." Under the inspiration of the group's founder, the late Dr. Larry Meskin, members meet to analyze and disseminate data, with a "mission to shape what happens next." He said that the Santa Fe Group's participation in the summit was in part based on its conviction that what Maryland had accomplished since Deamonte Driver's death could make the state a national leader and role model for oral health policy. He stressed that access to oral care is a huge problem, not only in America, but also around the world, and he mentioned that a global grant program for innovations in access to care, administered by the Dental Trade Alliance, had received over 100 applications from Africa. The Santa Fe Group's participation in the summit was also a reflection of the group's firm belief in the value of collaboration. Dr. Dominick noted that 10 Santa Fe Group members (out of a total of 16) were in attendance.

Frances Phillips, Maryland's Deputy Secretary of Health and Mental Hygiene, brought greetings from the Department Secretary, Dr. Johua Sharfstein, and Maryland's governor, Martin O'Malley, who, she said, has instilled a strong sense of accountability in government personnel. She commented that the Pew Center on the States had awarded Maryland an A for children's dental health in its report card for 2011, rating the state the

* DentaQuest Foundation, Dentsply, Henry Schein, Inc., National Maternal and Child Oral Health Resource Center, Office of Oral Health of the Maryland Department of Health and Mental hygiene, University of Maryland School of Dentistry, and University of Maryland School of Public health.

top performer of all 50 states. She was pleased, too, that Maryland, in contrast to other states, has already acted on a provision in the 2010 Patient Protection and Affordable Care Act (ACA) by establishing and staffing a Maryland Health Benefit Exchange program which ultimately will allow uninsured state residents to obtain coverage.

Dr. Marcia Brand, Deputy Administrator, HRSA, praised MDAC for taking action following Deamonte Driver's death—for "giving voice to just those groups who are least likely to have a voice." With dental hygienist training in her background, she could speak to the importance of oral health in relation to general health and the toll in pain, lost days at school or work, and social isolation that can result from untreated oral disease. She noted that even obtaining a job can hinge on the appearance of one's teeth. HRSA plays a key role in reducing disparities in health, she said, coming to the aid of individuals who are isolated, uninsured, and vulnerable. Through its programs, the agency was able to provide services to 35,000 Marylanders last year.

Progress in the Face of Tragedy

The significant improvements in oral health services evident in Maryland today were detailed by Dr. Harry Goodman, Director of the Office of Oral Health (OOH) in the Department of Health and Mental Hygiene (DHMH). He described the Office as having a long and checkered past: sometimes the Office existed, sometimes it was gone, with "nobody at the table." Only half of the state's jurisdictions had safety net dental services early in the decade. But now, as a result of the state's acting on the DAC recommendations, there has been "progress in the face of tragedy." By April 2011 *all* Maryland jurisdictions were able to provide access to oral care. The number of dentists willing to treat Medicaid patients has increased, thanks to an increase in reimbursement rates to 70.7 percent of the American Dental Association's customary charges in the South Atlantic region. An expansion of the workforce as well as of venues for the provision of care has also come about as a result of legislation that established a new category of oral health professionals: public health dental hygienists (PHDH). PHDHs are qualified to work in schools and community health centers without the supervision of a dentist on site. Dr. Goodman went on to describe the state's response to DAC's other recommendations. There are now programs in place to train general dentists in pediatric

care and train medical professionals to conduct oral screening and apply fluoride varnish. Also, a major Oral Health Literacy Campaign for pregnant women and new mothers is underway. Finally, in a move to cut bureaucratic paperwork and expedite bill processing, a statewide single vendor to handle all administrative services in connection with state-reimbursed oral care has been created.

Dr. Goodman also mentioned with pride that Maryland is the top state in the nation in regard to water fluoridation, with 99.8 percent of residents served by public water supplies having access to fluoridated drinking water. But he reminded the audience that adult oral health care is not yet covered and that dental caries remains the number one chronic condition affecting 5- to 17-year-old children and adolescents.

Maryland Political Power

The arrival of keynote speaker Representative Elijah Cummings signaled the next item on the agenda. Rep. Cummings, working together with Maryland Congressman John Sarbanes and Senators Barbara Mikulski and Ben Cardin, was responsible for legislation to advance oral health in the state and nationally. The Maryland congressional members were also critical in ensuring that the ACA included numerous oral health provisions. Cummings complimented MDAC for its achievements and for its growth, which had made it an even more powerful voice for change. He then introduced Deamonte Driver's mother, whom he acknowledged for her strong support. "Not a day goes by that I don't think of Deamonte Driver," he said. "I think of him when I brush my teeth . . . and I will not rest until all children have access to appropriate dental care." Cummings described his own childhood, growing up poor, with parents who were strong and well-meaning, but who simply did not understand the value of oral health. He did not see a dentist until he was 17 years old and believed that toothaches were a part of life. His vision is that oral health for *all* children *and adults* be accessible, affordable, and available. "We have a duty to protect our children," he said, "and make sure they have opportunities and never have to go through what Deamonte Driver went through. We need to address adults too," he said, and alluded to his visit to a dental school where homeless men were being treated and were deeply appreciative.

But these are rough times, he said. He felt he needed combat equipment to fight a war in Congress over health care funding, with opponents ready to undo every provision in the ACA. He called the audience Freedom Fighters, and urged them to keep fighting. "We need to guard progress," he said, "guard our own success." He concluded with a moving recitation of the lyrics of "We Shall be Free," a song he first heard at a White House concert sung by a man who has since become a good friend, Garth Brooks. The song includes such lines as, "*When the last child cries for a crust of bread. When the last man dies for just words that he said. When there's shelter over the poorest head. We shall be free.*"

Oral Health Heroes

Following Rep. Cummings' address, Dr. Winifred Booker, Chair of MDAC's Maryland Oral Health Heroes Awards, presented the 2011 Maryland Oral Health *Legislative* Heroes award to him, one that he shares with Senators Ben Cardin and Barbara Mikulski and Representative John Sarbanes. Staff from Senator Mikulski's and Representative Sarbanes' offices later accepted the awards for the members and Senator Cardin was able to address the group and receive his award at the end of the meeting. Oral Health Heroes were also named in other categories. An *Administrative* Maryland Oral Health Heroes Award was presented to Susan Tucker and her staff in the Medical Assistance Program, DHMH, for their work in facilitating an increased reimbursement rate for dentists treating Medicaid patients; a *Communications* Maryland Oral Health Heroes Award went to Mary Otto, a former *Washington Post* reporter whose feature stories on Deamonte Driver were widely circulated and served as a catalyst for change; and a *Community* Maryland Oral Health Heroes Award went to Jane Casper, an oral health advocate and former DAC co-chair. Honorees were formally acknowledged and presented with their awards by Dr. Booker at the Maryland Oral Health Heroes Awards Luncheon on Day 1 of the summit. At that time Dr. Booker also introduced Ralph Fuccillo, President of the DentaQuest Foundation, which supported the luncheon event. He described the foundation's commitment to optimal oral health for all Americans and how it often works in partnership with other agencies to enhance access, prevention, education, and advocacy.

State Highlights

Dr. Harold Slavkin, University of Southern California Dental School, introduced the first of several panels addressing oral health in America at the local, state, and national levels. The state panel began with Penny Anderson, Executive Director, MDAC, who described the evolution of DAC to MDAC and its mission of improving oral health through prevention, education, advocacy, and access. With development funding from the DentaQuest Foundation, support from OOH, DHMH through a state infrastructure grant from the Centers for Disease Control and Prevention (CDC), and other funding, MDAC has filed articles of incorporation, hired staff, and initiated programs. The Coalition has successfully prevented a 1 percent decrease in the dental Medicaid reimbursement rate and has advised Maryland's Health Care Reform Coordinating Council on the importance of including adult oral health in any health care reform plan. Several Coalition members are also advising the Health Benefits Exchange Program on the inclusion of oral health care benefits in insurance plans. Ms. Anderson also described a $173 thousand grant from Kaiser-Permanente for a pilot project to determine the feasibility and effectiveness of a school-based dental screening program and a $99 thousand grant from the DentaQuest Foundation for the development of an Oral Health Learning Alliance. The Coalition is also collaborating with OOH, DHMH, on an oral health literacy campaign to be launched in March 2012. MDAC is playing a leading role in the development of other statewide and national coalitions. Much of 2012 will be devoted to implementing the new 5-year Maryland Oral Health Plan, she concluded, with objectives that go beyond children to include the oral health needs of all Marylanders, with emphasis on those most vulnerable.

Jane Casper, former DAC co-Chair and a dental hygienist for 37 years, is currently a Clinical Dental Public Health Specialist in the Office of Oral Health. She addressed implementation of the DAC recommendation to create the new Public Health Dental Hygienist category of oral health professionals. She explained that legislation passed in April 2008 enables Maryland dental hygienists who meet certain qualifications to practice in schools, Head Start programs, Federally Qualified Health Centers, and other public health settings without the supervision of a dentist on site. The idea is that after conducting oral screenings and applying dental sealants or other preventive services,

PHDHs should be able to refer individuals to dental homes for further treatment, as necessary. Ms. Casper read letters from a number of County Health Departments praising the new system as a cost-effective measure that saves time, enables children to be seen in school or in response to a school nurse's concern, and allows dentists to spend more time—as much as 49 hours more—in the clinic providing restorative services rather than supervising hygienists elsewhere. The next step will be to conduct a formal evaluation to determine the impact of the system on the underserved.

"When we look at the data on access to care in Maryland comparing 1997 to 2009 we see impressive improvements," observed Dr. Normal Tinanoff, a pediatric dentist who is Chairman of the Department of Health Promotion and Policy at the University of Maryland School of Dentistry. There were eight times as many preventive visits in 2009 compared to 1997 and nine times as many treatment visits. But these figures need to be measured against the increase in Medicaid patients: 89,000 in 1997 compared to 225,000 in 2009. Moreover, he cautioned that we need to look more closely at those preventive services and how we are delivering them. He mentioned the case of a 4-year-old who had had extensive restorative care in the operating room of the dental school clinic last year only to appear this year with another mouthful of cavities. The child confessed to a liking for soda. Certainly dentists and dental hygienists provide information about the importance of brushing and flossing and the value of fluoride, he said, but is that information sufficient to change behavior? Dr. Tinanoff suggested that there is good evidence that the technique of motivational interviewing (MI), a patient-centered approach to enable individuals to make decisions on their own, without being lectured, might be a more effective approach to promoting healthy behaviors—maybe even persuading children to give up soda. But MI is not being taught routinely in dental or dental hygiene schools. He also had concerns that dental insurance plans are too slow to adopt evidence-based practices and generally adhere to a fee-for-service model, which may not reward procedures aimed to resolve any underlying disease process.

The point made by Dr. Mark Macek, Division of Health Services Research, Department of Health Promotion and Policy, University of Maryland School of Dentistry, was that failure to navigate the health care system is often the major stumbling block in obtaining access to services, especially for vulnerable populations. "Case management is

critically important to connecting folks to the system," he said, and described a pilot project administered by the dental school that uses a case manager at each of two rural locations on the Eastern Shore. The goal is to improve access, improve oral health status, and improve health literacy and education. So far over 250 families have been helped, and a survey of private practitioners indicates that 15 percent of those replying said they would increase their services to Medicaid patients if a case manager was on hand to handle appointments, arrange transportation, conduct follow-up, and otherwise facilitate access and delivery of services. The program has been extended to a second year with plans to increase outreach activities to the community and to other care providers including emergency room personnel.

The needs of the poor were highlighted by Dr. Frederick Clark, a private dentist who has a long history of providing care to Medicaid patients, even when reimbursement rates were low. Dr. Clark, President of the Robert Freeman Dental Society of the National Dental Association, described Prince George's (PG's) County at the time of Deamonte Driver's death as a wasteland, with minimal Medicaid reimbursements, maximum red tape, and few dentists in private practice willing to treat Medicaid recipients. He stressed the importance of getting the message out: people have to understand the connection between oral and general health and that poor oral health can kill you. He cited the story of a young man who had sought emergency room treatment for a dental infection. He was given prescriptions for an analgesic and an antibiotic but could afford only one. He chose the analgesic—and died of the infection. In Prince George's County today dentists have formed a foundation, with funding from diverse sources that has arranged for volunteer dentists to conduct oral screenings of thousands of children in Prince George's County public schools and refer them to dental homes. Many more children enrolled in Medicaid are now being served, aided in part by the state's streamlining of the administrative process as well as by higher reimbursement rates that provide an incentive for more private practitioners to enter the system.

Dr. Clark's emphasis on the importance of "getting the message out" was echoed by Dr. Alice Horowitz, University of Maryland School of Public Health, whose research has focused on oral health literacy and its impact on health outcomes. "Efforts to improve the quality of oral health and reduce disparities will fail," she said, "without oral health

literacy," defined as "the degree to which individuals have the capacity to obtain, process, and understand basic oral health information and services needed to make appropriate oral health decisions." Moreover, she stressed that heath literacy applies to politicians who draft laws and design programs as well as to health professionals who need to adopt user-friendly and culturally appropriate means of communicating with their patients. Dr. Horowitz mentioned a number of phone surveys and focus groups used to gauge public and health professionals' perceptions and knowledge. Generally these indicate limited knowledge in such areas as the purposes of fluoride or dental sealants and even less knowledge about the early signs of tooth decay. She reported that individuals with low incomes are also less likely than those with higher incomes to drink tap water (fluoridated in Maryland) compared to bottled water or canned drinks (fluoride status unknown).

The panel on state initiatives concluded with a presentation by John Welby, Director of the Maryland Oral Health Literacy Campaign, OOH, DHMH. Staff have created the infrastructure and marketing components for a launch to begin in March 2012. The campaign will target pregnant women and new mothers who participate in Medicaid, reaching out to them at critical points in their or their infants' lives (during pregnancy, at birth, and around the time the infant's first tooth appears) with messages on prevention and access to care. A variety of social marketing tools and interventions are planned, including ads, a Web site, a hotline, and an oral health kit with adult and child toothbrushes, toothpastes, and educational information. The campaign has a built-in evaluation component and if successful will serve as the foundation for future efforts.

The Maryland Oral Health Plan

The afternoon session of the Summit was devoted to a discussion of the Maryland Oral Health Plan and an audience-participation exercise to establish policy priorities for the implementation of its goals. Dr. Nicholas Mosca, Director, STD/HIV Office, Mississippi Department of Health, and a Meskin Fellow in the Santa Fe Group, moderated the session, introducing Jane Casper and Katrina Holt, Director, National Maternal and Child Oral Health Resource Center at Georgetown University, to provide background. Ms. Holt outlined the Plan's three goals and objectives:

Access to Oral Heath Care

- Ensure continuously accessible, coordinated, affordable, and effective oral health (dental home) for all Marylanders through an integrated state oral health and health care system.
- Build an optimal oral health work force to ensure the availability of oral health services for all Marylanders.
- Strengthen the integration of oral health care and overall health care.

Oral Disease and Injury Prevention

- Regularly assess the oral health status of all Marylanders, including those living in nursing homes, assisted-living facilities, group homes, and shelters; those who are homeless; those with disabilities; and those who are migrants or immigrants.
- Increase the use and adoption of best practices to prevent oral disease and injury in all settings, including public health and private practice.
- Promote the public's awareness of risk factors for oral cancer, its symptoms, and ways to prevent it.
- Ensure that communities have access to oral disease- and injury-prevention programs.

Oral Health Literacy and Education

- Enhance individuals' awareness of the relationship between oral health and general health and wellness and empower them to adopt oral health behaviors supported by evidenced-based practice.
- Enhance individuals' ability to navigate the oral health care system and to establish dental homes.
- Promote primary care health professionals' and specialists' awareness and knowledge of the importance of oral health interventions for medically compromised individuals.
- Enhance oral health professionals' ability to work with diverse populations.

The Plan was developed as a tool, a roadmap, to achieve optimal oral health for all Marylanders and needs everyone's involvement for successful implementation, Ms. Holt said. It reflects the work of many individuals, many of whom were present in the audience and who were introduced

Discussion then turned to the work of the afternoon in setting policy priorities for the Plan's implementation. Attendees were advised to keep in mind two broad criteria that an oral health policy should address: its impact on the general health of the public and its feasibility. The audience was reminded that the Department of Health and Human Services (DHHS) also establishes health goals (including oral health goals) for the nation every decade, currently stated in *Healthy People 2020 (HP 2020).*

Dr. Lynn Mouden, Director, Office of Oral Health, Arkansas Department of Health, described several forms from the Oral Health Policy Toolkit, which had been distributed to the audience. The toolkit was developed by the Washington D.C.-based Children's Dental Health Project (CDHP) with support from CDC. Dr. Mouden and Marcy Frosh, Associate Executive Director, CDHP, facilitated the exercise, with Dr. Mouden explaining the criteria to be used in deciding on proposals (e.g., are there data to support the need for a policy to address the problem? to what extent is the community aware of the need?) and the numerical scoring method for weighing each criterion. Audience members, with six or more seated at tables, were encouraged to introduce themselves, be free-wheeling, and think big, but to come to consensus on one proposal per table.

The Summit exercise was something of an experiment in that it was the first occasion for using the toolkit in a large group (over 100) with diverse backgrounds and limited time. Nevertheless participants liked the approach and came up with three policy proposals that ranged from the very broad: extend dental Medicaid to adults, to more specific policies addressing new mothers and infants: extend dental coverage to mothers 18 months post-partum, provide coverage at a child's first birthday, and conduct oral screening at the time of school entry, elementary through high school.

Lack of time prevented the audience from proceeding to part 2 of the toolkit exercise, pertaining to a more thorough review of the evidence base for the recommendations and their feasibility. There was regret, too, that a lot of good ideas had

been put forward that might be lost. Accordingly, it was decided to collect the output of all the table groups for further study and to continue to use the toolkit on occasions of future decision-making.

The last speaker of the afternoon was Rear Admiral William Bailey, Chief Dental Officer, U.S. Public Health Service, and also Acting Director, Division of Oral Health, CDC. He, too, complimented the Coalition for "working in harmony" to improve the outlook for the future, quoting a favorite saying of his, "to celebrate every deed done in the harmony of the moment." Maryland is one of 20 states with a cooperative agreement with CDC to improve infrastructure and develop a State Oral Health Plan, he observed, with aims to improve access and expand prevention and other activities. Such plans are essential if we are ever to reverse the "silent epidemic" of oral disease that U.S. Surgeon General Dr. David Satcher alluded to in the 2000 report, *Oral Health in America: A Report of the Surgeon General.* Access and cost remain major issues, and Rear Admiral Bailey quoted a Bureau of Labor Statistics 2008 report indicating that Americans' out-of-pocket expenses for dental services were second only to their expenses for pharmaceuticals, 50 percent more than expenses for physician services, and 50 percent more than for hospital services.

But there is more attention being paid today—in part because of Deamonte Driver and the action that Maryland has taken—and more signs of groups like MDAC working together, to make a difference. Rear Admiral Bailey went on to describe the work of the PHS Oral Health Coordinating Committee, as another example. The Committee represents a dozen federal agencies and is currently building the foundation for a public-private partnership and planning a large stakeholder meeting. He also alluded to two recent Institute of Medicine reports, *Advancing Oral Health in America* and *Improving Access to Oral Health Care for Vulnerable and Underserved Populations.* Finally, he hinted that oral health might be named one of the 12 leading health indicators used to measure progress in *Healthy People 2020.* There are 42 topic areas in *HP 2020* and only 12 leading health indicators, so if oral health was named a leading health indicator, it would elevate oral health to a major focus area over the decade. (Note: This indeed has come to pass. At the American Public Health Association's annual meeting in October

2011, oral health was announced as one of the 12 leading health indicators. This is a first for oral health.)

Day 2 of the Summit began with a recap of the preceding day's achievements by Dr. Dushanka Kleinman, Associate Dean, University of Maryland School of Public Health, who emphasized the diversity of the audience, a diversity that was also reflected in the growth and varied representation of DAC to MDAC. She mentioned again that the attendees represented the largest group to have participated in the priority-setting exercise and that further work was in store in moving to policy action. The role of stakeholders in building the evidence to lead to next steps was critical. She then introduced Leigh Cobb, Health Policy Director, Advocates for Children and Youth, who introduced Vincent de Marco, President of the Maryland Citizens' Health Initiative, the keynote speaker for the day. Ms. Cobb cited the work of the Initiative in the passage of the 2007 Tobacco Tax Act, which added $1 to the cost of a pack of cigarettes. Not only were the additional tax revenues used to expand health insurance coverage to 250,000 low-income Maryland residents (70,000 of whom were children), but also the higher cost of cigarettes led to a reduction in cigarette-smoking in Maryland by a third.

Advocacy 101

Vincent DeMarco attributes the success of the tobacco tax campaign to strategies developed over the past two decades to energize communities. He was pleased to note that as a result of that one tobacco tax increase alone, Maryland moved from 44th state in the union to 14th in the extension of health insurance to individuals with low incomes. He had similar success stories to tell about raising alcohol taxes (which helped cut the rapidly increasing rate of adolescent and young adult drinking) and implementing gun control laws. "It's not easy to effect these laws," he said, "because the opposition is so powerful: Big Tobacco and Alcohol and the National Rifle Association have so much clout. And it doesn't happen overnight. What you need to do is build a case and a coalition." He outlined the six steps his group has honed over the years to do just that.

Step 1. *Come up with an evidence-based Plan*. You need to show that the public health issue you want to address has serious health consequences, which you can

document. (In terms of tobacco use in Maryland, the 1990s saw both tobacco and alcohol use among children and adolescents skyrocketing).

Step 2. *Do serious polling of the public*. DeMarco remarked that legislators don't care if a policy change you want to make will save lives; they **will if they begin to hear about it from constituents.** He also said that in these polls it was valuable to ask people how they voted and how they would feel, say, if a Democrat was in favor of the policy, but a Republican opposed it— or vice versa.

Step 3. *Build a powerful coalition.* You do this by creating an easy-to-read document that people can sign on to. Keep it to one page, he emphasized, summarizing the problem and the solution. This is especially important in the case of legislators who do not have a lot of time. He also emphasized diversity in coalition-building. Build a grass roots movement, mobilize the community, get faith leaders behind it: "God vs. Tobacco."

Step 4. *Use the media to the hilt.* That means holding press conferences when you have a good story to tell. Get to know reporters. Use paid media as well, such as radio ads, which are cheaper than TV ads.

Step 5. *Make your issue an election issue.* Develop a resolution that legislators can sign and let voters know who has signed and who hasn't. Non-profit groups have to be careful here to avoid overt lobbying (telling people how to vote), which would affect their non-profit tax status.

Step 6. *Close the deal. Make sure that once legislation is passed the law is fully implemented as it was intended.* He noted that in the case of the enacted alcohol tax, some first-year revenues were used for school construction—not a bad idea, he said, but not the public health issue originally intended for support. So it is important to stay on the case, which they are doing.

Vincent DeMarco concluded by summarizing current campaigns the Maryland Citizen's Health Initiative is conducting. The Initiative will continue to support ACA, which he described as one of the most notable achievements of the Obama administration. It is also proposing another $1 increase in taxes on tobacco products, this one to include both cigarette and non-cigarette tobacco products, whose use by young people has increased. Proceeds from the tax would be used to fund the state tobacco

control program, the state health improvement process, and other community-based health initiatives, including those that address childhood obesity, long-term care for older adults, and improved access to health care services for Maryland families. As a concrete illustration of the six-step process, the audience received handouts from the Initiative that included a one-page resolution documenting the tobacco public health issue, the proposed solution (the tobacco tax increase) and the improvements in public health that could be expected.

Community Actions

Vincent DeMarco's philosophy of engaging and energizing communities was further demonstrated by the panel that followed his keynote address. Dr. Dominick DePaola introduced representatives of four community agencies who described the strategies they used to improve oral health in the populations they served and the challenges they faced. "It is here at the community level," Dr. DePaola commented, "that one comes to grips with the social and behavioral determinants of health."

The first speaker was Dr. Brooks Woodward, Dental Director, Chase Brexton Health Services, Inc., a Federally Qualified Health Center with four locations in Maryland. With limited staff (three full-time dentists and one full-time and one part-time dental hygienist) the strategy that has worked for them lies in partnering and collaboration. The Howard County Health Department has contracted with them to provide oral services that the County no longer supports. The Center was able to secure federal funding and continue the County's in-school dental programs applying dental sealants and fluoride varnish. The receipt of Ryan White funding enabled the Center to provide oral health services to individuals with HIV infection. The Center has also partnered with the Oral Health Impact Project, which uses mobile units to treat children. Chase Brexton complements these services by supplying follow-up, with case managers able to call parents and arrange appointments for children seen in the mobile units who need additional care. The Center also works with Early Head Start and WIC programs in Baltimore. At WIC sites, parents bringing their children in for nutrition services are required to meet with a dental hygienist for one-on-one oral health instruction and counseling. It is through these one-on-one encounters, in schools working with children,

or in conferences with parents, that staff experience their most rewarding but also their most challenging situations.

Liza Frye, Director, Carroll County Head Start and Early Head Start Programs—covering the years from birth to age 5—sees the goals of the programs in terms of self-sufficiency. By contacting families at the time they are most likely to have the greatest concerns about the health of their children and by instructing them and their children in oral hygiene and dental care they aim to establish good oral health habits. The children learn to brush their teeth after breakfast and lunch and now remind their parents to do the same. Children also have access to oral health care by County Health Department dentists. Families can also be seen at home for instruction, for example, in how to wean young children from bottle-feeding and begin to eat healthy foods. The challenges they face are largely in engaging dentists in private practice and finding dentists who will accept individuals with low incomes.

The Frederick County Dental Program may be unique in that its Director, Monica Grant, is not a dentist but a physical therapist. She described herself as an "accidental" dental director who had not understood the importance of oral health care a decade ago, when she assumed management of a program for early intervention for children with developmental disabilities that included a dental plan. It was through a long-time staff dentist and others that she came to understand the importance of oral health and the challenges in finding dentists willing to treat, obtaining the necessary funding, and recruiting private dentists for referral. She credits her staff and their knowledgeable connections to the community for successes they have achieved. She described the case of a 5-year-old boy, a recent immigrant with autism, with no speech in any language, and severe oral disease. Within a week, the program found him medical and dental care, a case manager to coordinate care, and arrangements for special education services. Among other successes she recounted was the ability to recruit additional dentists with the result that waiting times for appointments have been reduced from 4 to 5 months to zero. Also, through grants, the program has been able to reduce dependence on local funding. But challenges remain. Among them are needs to shore up infrastructure, reduce emergency room dental visits, provide adult services, and increase language and cultural competencies to meet the needs of an increasingly diverse population in Frederick

County. Lastly, she cited the need to increase oral health literacy, relating the distressing story of a young family, the 17-year-old mother with dental caries in every tooth whose two young children were similarly afflicted with rampant caries.

The last community panelist to speak was Colleen Pierre, a nutritionist with Maryland's WIC program. She said that WIC staff were trained on the importance of oral health and that in addition to providing nutritional counseling for mothers (such as recommending low- and non-fat milk and diets rich in fruits and vegetables) they can refer children for free oral health care. She counted as a major success the ability to provide a dental chair on site at one location, since that addressed the difficulties in transportation that hamper access to oral health care. Children are seen every 6 months, at which time they can be provided with toothbrushes while their mothers receive educational materials and information, including oral health messages. The problems she cited were the difficulties in finding enough dentists for referrals and keeping the lists of available dentists, which change often, up to date. She was also concerned that some dentists have stopped prescribing fluoride out of concerns that fluoride levels in the water supply are already high.

A lively discussion period followed the panel talks with audience members sharing experiences and offering suggestions to overcome barriers or add to educational messages, for example, by explaining to new mothers that oral health is not just about toothbrushing and dental sealants but also about preventing a transmissible infectious disease.

The National Perspective

The speakers comprising the final panel of the Summit represented a non-profit organization, two private foundations, academia, and two federal agencies, providing a range of perspectives on oral health priorities and policy. They were introduced by Dr. Raul Garcia, Department of Health Policy and Health Services Research, Henry M. Goodman School of Dental Medicine, Boston University.

The Children's Dental Heath Project. Marcy Frosh is Associate Executive Director, Children's Dental Health Project (CDHP), a non-profit organization with a vision of achieving equity in children's oral health. Ms. Frosh said that 40 states have

received federal funding to generate State Oral Health Plans, which CDHP analyzes and monitors. They have developed a State Oral Health Plan Comparison Tool, a database enabling users to cross-walk among plans to determine similarities and differences in policies and coverage. The Project also monitors four key federal laws affecting oral health and dental care: the 2002 Health Care Safety Net Amendments, the 2009 Children's Health Insurance Reauthorization Act, the 2009 American Recovery and Reinvestment Act, and the 2010 Affordable Care Act.

The DentaQuest Foundation. Ralph Fuccillo, President, DentaQuest Foundation, said that the intent of the Foundation was to strengthen the oral health safety net, but that the Foundation was about more than dental care. There were prospects for greater medical and dental collaboration and for advancing education and research. He saw the role of DentaQuest not as an external donor, but as a partner working to build coalitions in communities, very much as Maryland has done and as Vincent DeMarco has emphasized. The Foundation started in Massachusetts but decided to move outside the state, looking for states like Maryland, which clearly had mobilized to expand oral care through its coalition building and was ready to move forward. The DentaQuest Foundation is also a founding member of the U.S. National Oral Health Alliance and is a collaborating partner in an Oral Health 2014 initiative. The Foundation's role here is to provide grants to selected states to develop oral health capacity and leadership or to support other priority areas.

Centers for Medicare & Medicaid Services. Laurie Norris is a Senior Policy Specialist, Oral Health Initiative, Centers for Medicare & Medicaid Services (CMS). "Oral health has become one of the top three agency priorities," she said, "and there is a new emphasis on collecting state-by-state data and publishing it for all to see." In 2008, Maryland was among 16 states that had fallen behind in utilization of Medicaid for oral health care. Two years later, in 2010, Maryland was among 8 states that had achieved the highest utilization rates—representing the greatest rate of change for any state. She went on to say that in April 2010 CMS announced a new 5-year initiative with two goals for oral health. Goal 1 was for states to increase by 10 percent Medicaid utilization for preventive dental care over the 5-year period, with 2011 representing the base year. The second goal was to increase by 10 percent the number of 6- to 9-year-olds receiving at

least one dental sealant on a permanent molar tooth. She did not have base figures on the numbers of sealants in place, but felt that it was very low and that to increase utilization would take some innovative thinking. To implement the CMS goals states would need to develop action plans, and as so many other Summit speakers had said, it would be critical for states to seek partnerships and get stakeholders involved. However, she was sure, given Maryland's recent achievements, that the state would reach these goals.

Office of Minority Health, Department of Health and Human Services. Rochelle Rollins, Director of Policy and Data, Office of Minority Health, DHHS, described the agency as one dedicated to reducing health disparities and increasing equity as they relate to the health of ethnic and racial minority populations in the United States. She alluded to a number of departmental plans and conferences that include oral health and/or that will enlist advocates in their implementation. These include the *National Stakeholder Strategy for Achieving Health Equity*, a product of the National Partnership for Action. The Strategy provides goals and objective as well as ideas and suggestions for implementation that can be adopted by local groups and communities. Oral health is also featured in the document, *Promoting and Enhancing the Oral Health of the Public: HHS Oral Health Initiative 2010*. Ms. Rollins also alluded to *Healthy People 2020* and the potential (now actuality) that oral health will be named one of the 12 leading health indicators. Finally, she mentioned a conference on prevention scheduled for April 2012, the National Health Promotion Summit: Prevention. Promotion. Progress, which will also provide many opportunities to highlight oral health.

Children's Dental Campaign, Pew Center on the States. Shelly Gehshan, Director, Children's Dental Campaign, Pew Center on the States, began by stating how pleased she was to be in the same room with the people who had made Maryland's success story happen. She was alluding to the state's A rating in 2011 as the top performer among all 50 states in children's oral health according to the Pew Center on the States, which is part of the Pew Charitable Trusts, a private foundation. She then went on to say how difficult it was to arrive at the benchmarks chosen to rate and compare state performances and thanked Dr. William Maas, a former Chief Dental Officer in the U.S. PHS, who served as a consultant. "However," she sighed, "there is so much to be done. We are so far behind in prevention," she said, "that one of the benchmarks they

used was a measure of whether a state had achieved a score of at least 25 percent of schools with a dental sealant program." Plans for next year call for limiting their focus to a few areas, given staff and funding limitations. But already high on this agenda is water fluoridation. This is still "our best arrow in the quiver" in terms of cost-effective dental disease prevention, she said, but the anti-fluoridationists are on the rise again and have the potential for reversing water fluoridation programs in local communities. She invited the audience to use the website as a resource for countering anti-fluoridation arguments. (There is a water fluoridation FAQ sheet that can be accessed though the Pew Center on the States website)

There was a lively discussion following the panel, shortened by the appearance of Senator Ben Cardin. After receiving his Maryland Health Heroes Award, he addressed the group. The Senate had been in session until 2 a.m. that morning, he said, where he addressed the importance of health reform. But, as his colleague Rep. Elijah Cummings had earlier remarked, the atmosphere in Congress was nothing like the warm reception he was experiencing here at the Summit. The death of Deamonte Driver had occurred "under their watch," and they would never forget it. As a team in Congress, the Maryland legislators worked to get legislation passed to improve access to care and led the effort to see that oral health provisions were included in the ACA. They would continue as a team to fight the battle over health care now being fought in Congress. "We've done the right thing," he said, "as you have." He praised the audience for what the Coalition had accomplished; for earning that A for Maryland from the Pew Center on the States. "You all "got it" he said, "and in so doing, you changed the landscape in America."

Senator Cardin's comments provided a rousing conclusion to 2 days of listening and learning from a broad range of experts at local, state, and national levels. The meeting brought together colleagues who had worked together to resolve the issues occasioned by Deamonte Driver's death along with Santa Fe Group members and many others drawn to the meeting by common interests and concerns to advance oral health in America. The poster sessions, receptions, and in particular, the priority-setting exercise provided attendees opportunities to get to know one another, brainstorm, and contribute to the future of the Maryland Oral Health Plan. Overall, to paraphrase the words of Rear Admiral Bailey, the Summit was an occasion to "celebrate words and deeds done in the

harmony of the moment" and commit to a future of making further improvements in oral health.