

Report to the General Assembly Dental Care Access Under HealthChoice October 2004

Background

The Maryland Department of Health and Mental Hygiene's (DHMH) Medical Assistance (Medicaid) program delivered oral health services to over 100,000 children and adult enrollees in CY 2003. While utilization of oral health services has steadily improved under the HealthChoice Medicaid managed care program, Maryland, like many other states, continues to face numerous barriers in providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation, missed appointments, and a lack of awareness among enrollees about the benefits of primary oral health care.

Senate Bill 590

Senate Bill 590 was passed during the 1998 legislative session and became effective on October 1, 1998. It established the Office of Oral Health within Public Health's Family Health Administration and required the Medical Assistance program to offer oral health services to pregnant women enrolled in Medicaid managed care organizations (MCOs). It required DHMH to establish a five-year oral health care plan that sets targets for enrollee access to oral health services for MCOs. The base for these targets is the rate of service use by children in 1997. In 1997, 19.9%¹ of Medical Assistance enrollees under 21 years of age used any oral health service. The target for the first year of the five-year plan, calendar year (CY) 2000, was 30%, with annual increases of 10%, culminating with a target of 70% in CY 2004.

Senate Bill 590 also requires DHMH to submit an annual report addressing the following:

1. The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance program;
2. The outcomes achieved by MCOs and dental managed care organizations in reaching the utilization targets;
3. The allocation and use of dental funding.

These topics are addressed in this report. This report also includes information on public health initiatives administered by the Office of Oral Health to increase access to oral health care, as well as the Department's new five-year oral health plan.

¹ The rate of 19.9% is based on enrollment in the same MCO for at least 320 days. According to the HCFA-416 report, the utilization rate for 1997 was 14%. This rate was calculated based on services provided to children with any period of Medicaid eligibility and does not take into account a minimum enrollment period.

Action Plan for Increasing Utilization of Dental Services

As mentioned above, Senate Bill 590 required DHMH to establish a five-year oral health plan in 1998. During CY 2003, the Department, in collaboration with the Oral Health Advisory Committee, developed a new five-year oral health plan for CY 2004 - 2008 (Attachment 4).

The new oral health plan outlines the current oral health issues facing Maryland and proposes strategies and potential partners to include in addressing these issues. The four pillars included in the plan are: (1) Improving Access to Oral Health Services and Improving Dental Public Health Capacity; (2) Oral Health Policy Analysis and Development - Local and State Level; (3) Oral Health Education for Patients, Dentists and Others; and (4) Establishing Linkages and Ensuring Coordination on Oral Health. The overarching goal of this plan is to ensure good oral health for all Marylanders.

Availability and Accessibility of Dentists

HealthChoice

HealthChoice is the service delivery system for most children and non-elderly adults enrolled in Medicaid and the Maryland Children's Health Program (MCHP). HealthChoice MCOs are required to offer comprehensive oral health services including preventive care to children up to 21 years of age and to pregnant women. Adult services are optional, and as of September 2004, five HealthChoice MCOs offer some oral health services to adults.

MCOs are required to develop and maintain an adequate network of dentists who can deliver the full scope of oral health services. HealthChoice regulations (COMAR 10.09.66.05 and 10.09.66.06) specify the capacity and geographic standards for dentists. They require that the dentist to enrollee ratio be no higher than 1:2000 for each MCO. In addition, each MCO must ensure that enrollees have access to a dentist within a 30-minute or 10-mile radius for urban areas and a 30-minute or 30-mile radius for rural areas. DHMH primarily monitors for access issues via enrollee complaints.

As of July 2004, there were approximately 330 dentists enrolled as providers in the HealthChoice program (listed in HealthChoice provider directories). This represents an approximately 19% increase in the number of participating dentists compared to last year (Table 1). The overall statewide ratio of dentists (listed in HealthChoice provider directories) to HealthChoice enrollees under age 21 was 1:1158 in June 2004, compared to 1:1368 in June 2003, which is within the COMAR-defined ratio of 1:2000. The Department recognizes, however, that dental provider shortages continue to exist in certain areas and some dentists provide limited services.

Table 1: Dentists Participating in HealthChoice

Region ¹	Dentists Listed in HealthChoice Provider Directories ²		Percent Change (03-04)
	July 2003	July 2004	
Baltimore Metro	149	155	+ 1%
Montgomery/ PG Counties	157	151	- 4%
S. Maryland	20	21	+ 5%
W. Maryland	11	15	+ 27%
E. Shore	8	15	+ 87%
Unduplicated Total ³	277	330	+19%

¹ Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

² Some dentists may not be accepting new referrals and many limit the number of new referrals that they accept. These numbers only reflect the availability of general practitioners.

³The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

Dentists also provide services to Medicaid enrollees through community clinics (Federally Qualified Health Centers (FQHC) and local health departments) in certain areas. Table 2 provides a count of available community clinic dental providers as of July 2003 and July 2004. It is important to note that not all of these community clinic providers have contracts with MCOs, and they offer varying levels of oral health services. The counts of FQHC sites represent sites approved for the provision of dental services by the Health Resources and Services Administration (HRSA), however not all HRSA-approved FQHC sites currently provide full services.

Table 2: Community Clinic Dental Providers

Region ²	FQHC Provider Sites (HRSA-Approved)		Local Health Department Provider Sites	
	July 03 ³	July 04	July 03	July 04
Baltimore Metro	8	5	5	5
Montgomery/ PG Counties	1	2	2	2
S. Maryland	0	0	0	0
W. Maryland	0	1	4	4
E. Shore	3	5	1	1
Total	12	13	12	12

¹ Community clinic providers may also be counted in HealthChoice provider directories (in Table 1 above) if they contract with MCOs.

² Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

³ July 2004 counts differ slightly from counts provided in the October 2003 report because this report counts provider sites instead of individual dentists.

Public Health Dental Initiatives

A number of public health dental initiatives that involve local health departments and other community resources have shown promise in increasing access to oral health care for HealthChoice recipients in past years. The HealthChoice program partners with the Office of Oral Health, who oversees these initiatives. Initiatives include:

Pediatric Dental Fellows: This program places trained dentists into the community (local health departments and Federally Qualified Health Centers/Community Health Centers) to provide comprehensive oral health services to Medicaid recipients. These dentists are specially trained to provide care to children under 5 years of age. In FY 2004 there were six dental fellows practicing in seven sites across the state. These dentists treated 4,110 pediatric patients.

Eastern Shore Oral Health Outreach Program: This program is an outgrowth of the success of the *Oral Health Demonstration Project: Maryland State Children's Health Insurance Program* conducted by the University of Maryland Baltimore College of Dental Surgery from January 1999 through June 2001 in two regions in Maryland. The Eastern Shore Oral Health Outreach Program (ESOHOP) expands the success of the earlier demonstration project to all of the counties on the Maryland Eastern Shore. The goal of ESOHOP is to work with local health departments to identify opportunities within their existing infrastructure to incorporate a case management program that increases access to dental care services for children enrolled in Medicaid/HealthChoice.

Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP): The purpose of the MDC-LARP is to increase access to oral health care services for Medicaid recipients by increasing the number of dentists who treat this population. In Calendar Year 2003, a total of 15 dentists participated in the program; five of these dentists completed their obligation in December 2003. In January 2004 one new MDC-LARP dentist started the program and will continue through December 2006. During 2003, MDC-LARP dentists provided 16,423 appointments for Medicaid recipients.

Local Health Department Program: Funding from the Office of Oral Health helps support sixteen local health department oral health programs. These programs provide a variety of oral health services including clinical services, sealants, fluoride, case management, and oral health education. In FY 2004, approximately 2,885 children and 547 adults received clinical dental care in a local health department dental clinic. In addition, approximately 3,250 children received dental sealants through school based sealant programs; 7,627 children participated in a school based fluoride rinse, tablet or varnish program; 1,750 Medicaid children received case management for oral health services; and over 17,000 children were educated on good oral health habits.

HealthChoice Dental Utilization Rates

Children

Dental care is a mandated health benefit for children through age 20 under EPSDT requirements. However, access to dental services for Maryland Medicaid children has been low for a number of years. In FY 1997, before the implementation of HealthChoice, 14% of all children enrolled in Medicaid for any period of time received at least one dental service. This was well below the national average². The General Assembly passed Senate Bill 590 that established targets for utilization of dental services by children enrolled in HealthChoice to reach 70% within five years, beginning with 30% in Year 1. By regulation, CY 2000 was established as Year 1 of the five-year oral health plan developed by the Department. The Department has worked with the Oral Health Advisory Committee and the MCOs to assess the HealthChoice program's progress in expanding access to dental services for children.

MCO Plan Performance

In an effort to assess the performance of individual HealthChoice MCOs, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. The HEDIS methodology uses an age range from 4 through 21. The Department modified its age range to 4-20 years because the Maryland Medicaid program only requires dental coverage through age 20. HEDIS requires a minimum enrollment of 365 days with a gap of no more than 45 days during the year in one MCO, a 320-day measure. Between FY 1997 and CY 2003, the rate of access increased from 19.9% to 43.2% (Table 3 below). As a comparison, the HEDIS national average for Medicaid was 39% in CY 2002³. Attachment 1 shows the age and regional breakdowns for these utilization data.

**Table 3: Number of Children Receiving Dental Services
Children ages 4-20, Enrolled for at least 320 days**

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	88,638	17,637	19.9%
CY 1999	122,756	31,742	25.9%
CY 2000	132,399	38,056	28.7%
CY 2001*	142,988	48,066	33.6%
CY 2002	194,351	67,029	34.5%
CY 2003	203,826	88,110	43.2%

*Starting with data for CY 2001, DHMH revised its methodology to include children enrolled in the same MCO for at least 320 days, consistent with HEDIS methodology. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.

² Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

³ National Committee for Quality Assurance.

Type of Dental Services

Beginning in February 2002, the Department, in collaboration with the University of Maryland Dental School, began to look at the types of dental services that children in HealthChoice receive. The analysis examined children's access to different types of services – diagnostic, preventive and restorative. Diagnostic services include evaluation services and oral exams; preventive care includes cleanings, sealants, x-rays, and fluoride treatments; and restorative care includes fillings and crowns. The analysis was performed in response to the concern that while access to dental care may have increased, the level of restorative services or treatment may not be adequate.

The findings of the analysis indicate that access to any dental service, as well as access to restorative services, has improved since 1997. Access to any dental service increased from 19.9% in FY 1997 to 43.2% in CY 2003 (Table 3) and access to restorative services increased from 6.6% of all children receiving a restorative service in FY 1997 to 13.6% in CY 2003. The percentage of children receiving a restorative service remains below the anticipated need for low-income children⁴, but is similar to the percentage of low-income children nationally that actually receive a restorative service.⁵

**Table 4: Percentage of Children Receiving Dental Services by Type of Service
Children ages 4-20, enrolled for at least 320 days**

Year	Diagnostic	Preventive	Restorative
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%
CY 2002	31.7%	29.1%	10.3%
CY 2003	40.8%	37.9%	13.6%

In recent years, the issue of access to restorative services has received increasing attention. During the 2003 Session, the General Assembly included budget language with the intent to restrict \$7.5 million of the MCOs' CY 2004 capitation rates for dental restorative services.⁶ Effective March 1, 2004, fees on twelve restorative dental procedure codes were raised in the fee-for-service and HealthChoice programs to the American Dental Association 50th percentile levels for 2003 (Attachment 3).

In addition, in 2004 the General Assembly passed House Bill 1134, which requires dentists participating in HealthChoice to notify MCOs when enrolled children are in need of dental therapeutic/restorative treatment that the dentist is unable to provide. MCOs are required to provide families with a list of participating dentists who provide the needed

⁴ Vargas, et al. "Oral Status of Preschool Children Attending HeadStart in Maryland, 2000" in Pediatric Dentistry, June 2002.

⁵ Macek, et al. "An Analysis of Dental Visits in US Children, by Category of Service and Sociodemographic Factors, 1996," in Pediatric Dentistry, May 2001.

⁶ The General Assembly's intent to restrict \$7.5 million was based on a University of Maryland Dental School analysis in which certain restorative procedure fees would be increased to the American Dental Association 50th percentile levels. The \$7.5 million also accounts for the assumed increase in utilization that would result from the fee increase.

therapeutic/restorative treatment, and assist the family, if necessary, to arrange an appointment for the needed care. MCOs have submitted addenda to their enhanced dental services plans describing how they will meet the bill's requirements. MCOs' compliance with the requirements will be monitored on an ongoing basis as part of the Department's review of MCOs' annual enhanced dental services plans.

Pregnant Women

Prior to the implementation of HealthChoice in 1997, adult dental care was not covered under Medicaid. Senate Bill 590 required that dental services covered by Medicaid be extended to include all pregnant women. The proportion of pregnant women 21 and over enrolled for at least 90 days receiving dental services was 19% in CY 2003 compared to 14.5% in CY 2002. There is no comparable HEDIS measure for dental services for pregnant women.

Table 5: Percentage of Pregnant Women 21+ Receiving Dental Services Enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	17,914	2,474	13.8%
CY 2000	18,514	2,843	15.4%
CY 2001	19,644	3,109	15.8%
CY 2002	21,112	3,063	14.5%
CY 2003	21,819	4,140	19.0%

Adults

Neither Senate Bill 590 nor the HealthChoice program requires that adults other than pregnant women receive dental services. However, in 2003, all MCOs offered some adult dental benefits even though these services were not funded under the MCO capitation rates. A recent analysis demonstrates that 18% of adults enrolled for at least 90 days received at least one dental service in CY 2003 compared to 14% in CY 2002.

Table 6: Percentage of Adults 21+Receiving Dental Services Enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%
CY 2002	117,885	16,800	14.3%
CY 2003	116,880	21,288	18.2%

Given recent reductions in the capitation rates paid to MCOs, the Department decided that the MCOs should not be penalized for not offering services for which there is no reimbursement under the HealthChoice capitation rates. Therefore, the Department submitted regulations that discontinued the requirement that MCOs provide adult dental benefits in order to receive auto-assignments. These regulations became effective on February 2, 2004. Since the regulations took effect, two MCOs have eliminated their adult dental benefits.

Corrective Actions

DHMH monitors the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data. DHMH holds MCOs accountable for not meeting their dental utilization targets through the use of sanctions.

MCOs' enhanced dental services plans present the MCOs' strategies for meeting the yearly utilization targets and for assuring adequate accessibility to dentists. The Department carefully reviews each MCO's enhanced dental services plan and discusses strategies for improving access to dental services with each MCO. Based on the MCO's progress and their enhanced dental services plan, Departmental staff may suggest additional outreach strategies or practices that have been known to be successful for other MCOs. Examples of successful strategies include:

Enrollee Strategies

- Mailings to members about dental care, i.e.; postcards, letters, or newsletters.
- Developing incentive programs designed to induce members to seek oral health care.
- Providing dental education awareness programs in schools in collaboration with sealant and/or follow-up initiatives.
- Developing programs that combine intense case management and outreach, for example, encouraging local health departments to work with dentists to ensure access.

Provider Strategies

- Face-to-face meetings between MCOs' dental vendors and dentists to address and respond to their concerns.
- Changing dental vendors for better performance and achievement of goals.
- Developing flexible contracts for prospective dentists.

Funding

HealthChoice dental funding has increased significantly in recent years, from approximately \$12 million in CY 2000 to \$33 million for CY 2005. This increase reflects increases in the Medical Assistance fee schedule for dental services and increased utilization targets under HealthChoice. Prior to CY 2003, additional funding was added to the MCO rates to ensure that the legislative targets established in SB 590 were funded. Beginning with CY

2003 rates, the Department changed the funding formula for dental expenditures included in the MCO capitation rates.

- For CY 2003, the Department paid capitation rates which included sufficient funds to provide services to 40% of children. A supplemental pool was established to fund the MCOs if they exceeded the 40% utilization.
- For CY 2004, the Department allowed sufficient funding for 40% utilization. The rates were based on actual MCO expenditures for dental services in 2001, with an allowance for assumed utilization growth and inflation. This is consistent with the methodology used for setting rates for other MCO services.
- For CY 2005, the Department used a similar methodology as for CY 2004. The rates were based on actual 2002 expenditures trended forward. In addition, the rates were increased to account for the new fees for the twelve restorative procedure codes.

MCO Funding and Expenditures for Dental Services, FY 1997 – CY 2004
Utilization of Dental Services in HealthChoice, FY 1997-CY 2004

	FY 1997	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005
Amount Paid in MCO Capitation Rates for Dental	N/A	\$12.3 M (estimate)	\$27.1 M	\$40.3 M	\$33 M	\$28 M	\$33 M
Amounts Spent by MCOs for Dental (Source: HFMR) (Includes adult dental)	\$2.7 M*	\$17 M (estimate)	\$23.6 M	\$28.9 M	\$32.5 M**	N/A	N/A
Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)	19.9%	28.7%	33.6%	34.5%	43.2%	N/A	N/A
Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)	6.6%	9.3%	10.8%	10.3%	13.6%	N/A	N/A

* In FY 1997, the Department spent \$2.7 M on dental services under its fee-for-service program.

** CY 2003 MCO expenditures are not final and only represent data run out through 3/31/04.

Conclusion

Dental services utilization has steadily increased over the past few years. Despite these increases, the Medical Assistance program, in partnership with the DHMH Office of Oral Health, continues to focus on improving access to dental care and increasing the number of dentists willing to serve Medicaid enrollees. As this report describes, a number of provider and enrollee strategies have been implemented in recent years to ensure access. The Department continues to look at new and innovative ways to increase dental utilization and improve oral health in Maryland.

ATTACHMENT 1

**Dental Utilization Rates, CY 2000, CY 2001, CY 2002, and CY 2003
Enrollment \geq 320 days in an MCO, age 4-20**

Criteria	CY 2000	CY 2001	CY 2002	CY 2003
Age				
4-5	29.3%	33.3%	33.7%	42.8%
6-9	31.6%	37.2%	38.2%	48.0%
10-14	29.2%	34.1%	35.5%	44.0%
15-18	24.7%	29.4%	29.9%	38.0%
19-20	17.8%	19.7%	20.8%	26.8%
All 4-20	28.7%	33.6%	34.5%	43.2%
Region				
Baltimore City	25.1%	27.4%	27.8%	35.6%
Baltimore Suburbs	32.5%	35.4%	37.7%	46.1%
Washington Suburbs	30.4%	35.9%	39.6%	47.8%
Western Maryland	38.2%	46.0%	42.85	51.0%
Southern Maryland	26.5%	29.3%	31.8%	39.6%
Eastern Shore	26.4%	32.6%	31.3%	44.4%

ATTACHMENT 2

Dental Utilization Rates, CY 2000, CY 2001, CY 2002, and CY 2003
Enrollment \geq 90 days in an MCO, age 3-20

Criteria	CY 2000	CY 2001	CY 2002	CY 2003
Age				
3	16.4%	18.8%	17.1%	24.9%
4-5	24.8%	27.7%	28.6%	35.6%
6-9	27.8%	30.8%	32.1%	40.5%
10-14	26.1%	28.4%	30.2%	37.5%
15-18	21.6%	23.5%	24.6%	31.1%
19-20	14.6%	15.9%	16.5%	20.3%
All 3-20	24.3%	26.7%	27.7%	34.9%
Region				
Baltimore City	21.8%	24.0%	23.8%	30.3%
Baltimore Suburbs	26.2%	27.7%	29.4%	36.1%
Washington Suburbs	24.1%	27.7%	31.0%	37.8%
Western Maryland	32.7%	37.6%	33.5%	40.7%
Southern Maryland	22.0%	23.6%	24.5%	31.2%
Eastern Shore	26.6%	25.4%	24.2%	35.1%

ATTACHMENT 3
Dental Restorative Fee Increase
Effective March 1, 2004

CDT-4 Procedure Code	Description	Previous Fees – Based on Fee-for- Service, 2001	New Fees - 50th Percentile of ADA Rate for South Atlantic Region for 2003
D2140	Amalgam-1surf	\$37	\$70
D2150	Amalgam-2surf	\$45	\$88
D2160	Amalgam-3surf	\$52	\$104
D2330	Resin-1surf, ant	\$39	\$84
D2331	Resin-2surf, ant	\$48	\$102
D2332	Resin-3surf, ant	\$56	\$125
D2335	Resin-4surf, incisal angle	\$66	\$151
D2391	Resin-1 surf, post	\$39	\$93
D2392	Resin-2 surf, post	\$48	\$120
D2393	Resin-3 surf, post	\$56	\$150
D2930	Prefab SSC-primary	\$75	\$154
D2931	Prefab SSC-permanent	\$75	\$180

ATTACHMENT 4

The 5-Year (2004-2008) Oral Health Plan for the Maryland Department of Health & Mental Hygiene Facilitated by the Office of Oral Health

Mission

The mission of the Office of Oral Health, within the Department of Health and Mental Hygiene, is to improve the oral health status of Maryland residents through a variety of public oral health initiatives and interventions, characterized by a focus on health promotion and disease prevention. The Office of Oral Health develops and supports statewide cost-effective preventive and educational programs and policies that demonstrate and define the role of oral health as part of overall health. The Office of Oral Health partners with other State agencies, local health departments, schools, community agencies, and private providers in developing policies, programs and activities.

Dental Public Health Goals

Dental public health addresses disparities in oral health and dental care by:

- Assessing, analyzing, and evaluating the prevalence, distribution, and severity of conditions;
- Implementing or replicating successful community-based preventive programs (e.g., fluoridation and school sealant programs);
- Promoting oral health public education;
- Building coalitions that can encourage reforms and improve oral health; and
- Addressing the need for the development of community-based ‘safety net’ care delivery systems.

Problem – Kids

The 2000-2001 *Survey of the Oral Health Status of Maryland School Children* found:

- 42% of all children (K, 3rd, 9th, 10th grade) had untreated decay.
- 53% of children in kindergarten and 3rd grade had untreated decay in their primary teeth.
- The Eastern Shore had the highest percentage of untreated dental decay (54%) followed by the Central Baltimore region (48%). The Southern Region had the lowest percentage of untreated dental decay (14%)

The 2000 *Survey of Oral Health Status of Maryland’s Head Start Children* found:

- Approximately 55% of the Head Start children surveyed had decayed or filled tooth surfaces.
- The majority of caries experience among these Head Start Children was represented by untreated decay (96%).
- Of those children with decay, almost 17% had complained of pain to a parent or guardian.

Problem – Oral Cancer in Maryland

- The oral cancer mortality rate in Maryland is among the highest (8th) in the United States and ranks sixth for African-American males.
- Maryland’s oral cancer death rate is 15 percent higher than the national rate and the number of new cancer cases in Maryland also is higher than the national average.
- Conservative cost estimates regarding the average inpatient and outpatient treatment for a survivor of oral cancer at the University of Maryland Medical System is roughly \$100,000 per case.
- *2002 Survey of Maryland Adults’ Knowledge of Oral Cancer* found:
 - 42% of Marylanders report having an oral cancer exam.
 - 73% of Marylanders have never heard of an exam for oral cancer.
 - 77% of those who had an oral cancer exam had it conducted by a dentist.

Problem – Capacity

- Lack of dental providers in rural areas.
- Lack of public health clinics to serve the uninsured and underinsured.
- Lack of dental providers accepting Medical Assistance.

Priority Areas

Over the next five years the Office of Oral Health will focus its resources in the following areas:

- I. Improving Access to Oral Health Services and Improving Dental Public Health Capacity
- II. Oral Health Policy Analysis and Development - Local and State Level
- III. Oral Health Education for Patients, Providers and Others
- IV. Establishing Linkages and Ensuring Coordination on Oral Health

Priority One

Improving Access to Oral Health Services and Improving Dental Public Health Capacity

Why: Oral diseases are not self-limiting and increase in severity with time. As a result, medical, nutritional, psychological, educational, social, esthetic, and speech difficulties can originate from preventable oral disease and injury. Adverse oral health conditions have been shown to affect aspects of daily living such as quality of life, economic productivity, and work or school performance and attendance including readiness to learn. Future contributions to society and the workplace also may be affected by the poor self-esteem, physical well being, and quality of life generated by oral health problems.

How:

- Address the three (3) components of dental public health: assessment, policy, and assurance.
- Assess the clinical dental public health programs that currently exist to determine why a certain population is targeted, what services are provided, what gaps exist, if there are overlaps to other programs, what programs work well and what is efficient.
- Identify and evaluate models that provide direct care to low-income populations such as the University of Maryland Baltimore College of Dental Surgery’s Dental Fellows Program and the Maryland Dent-Care Loan Assistance Repayment program to determine what resources are necessary to expand them and what is the value of expanding them.
- Develop guidelines to define a dental public health clinic and specify what services must be provided to be designated as a dental public health clinic.
- Increase the number of dentists and dental hygienists practicing in Maryland who serve low- income and other vulnerable populations.
- Increase the number, quality, and capacity of dental care safety net clinics in FQHCs and in other clinics, including local health departments.
- Build a network of dental professionals that have the skills to treat children, individuals with special health care needs (children and adults), adults and the elderly.
- Increase the number of Dental Health Professional Shortage Area Designations.
- Develop a standardized oral health case management process that can be easily duplicated.
- Develop a data driven evaluation of dental public health to determine effectiveness and to help define success.
- Seek funding for new initiatives.

Potential Partners: Maryland Department of Health and Mental Hygiene – Family Health Administration, Maryland Dental Society, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Hygienists Association, Judy Centers, Maryland Higher Education Commission, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Chronic Hospitals, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Maryland Department of Aging, Governor’s Office of Children, Youth and Families, Social Services – Caseworkers

Priority Area II
Oral Health Policy Analysis and Development - Local and State Level

Why: Good oral health is more than clinical services. The development of clear and relevant policy ensures the efficient and appropriate use of funding to address oral health issues for all Marylanders.

How:

- Advise the Department of Health and Mental Hygiene on oral health issues that affect specific target populations.
- Create and maintain an oral health surveillance system for use by policy makers and program planners.
- Disseminate scientifically proven policies and oral health interventions that prevent oral diseases to the public, healthcare providers, legislators, and others interested in oral health.
- Provide technical assistance to communities seeking to implement community water fluoridation or fluoride rinse, tablet or varnish programs.
- Assess, evaluate and disseminate information about successful local oral health programs so that they can be replicated in other communities.
- Integrate oral health promotion in existing programs, both inter and intra agency, that engage individuals at high-risk for oral diseases.
- Collaborate with State partners to develop policy to increase oral health services.
- Conduct an annual review of Behavioral Risk Factor Surveillance Survey (BRFSS) to determine functionality
- Conduct a study to determine the financial benefit gained from dental public health activities and use these results to guide policy decisions.
- Seek funding for new initiatives.

Potential Partners: Maryland Department of Health and Mental Hygiene – Family Health Administration, Maryland Dental Society, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Hygienists Association, Academy of General Dentistry, Local Health Departments, Maryland Medicaid, Local Government, Administration on Aging.

Priority Area III
Oral Health Education for Patients, Providers and Others

Why: Since dental disease occurs frequently and treatment is more expensive than prevention, educating patients and providers on proven intervention strategies has both health and economic benefits for children and adults. Educating the public on good oral hygiene and nutrition behaviors, community water fluoridation, tobacco cessation programs, and examinations for oral cancers can result in improved oral health for all individuals.

How:

- Develop a comprehensive statewide oral health education and awareness program for children and adults.
- Strengthen and expand the Maryland Oral Cancer Prevention, Education and Training Initiative.
- Provide prenatal oral health education to all pregnant woman.
- Provide Anticipatory Guidance/Risk Assessment tools to non-dental professionals.
- Develop and evaluate a comprehensive oral health school health curriculum for all grades, including Head Start.
- Provide training to organizations working with children and families.
- Link oral health messages to routine medical appointments for children and adults such as immunizations and physicals.
- Develop a speakers bureau to educate non-dental professionals about oral health
- Develop, implement, and evaluate oral health education programs for at risk groups including but not limited to the elderly, individuals with special health care needs, medically challenged, HIV/AIDS, African American men, adults, homeless, and the undocumented.
- Seek funding for new initiatives.

Potential Partners: Maryland Dental Hygienist Association, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Higher Education Commission, Office of Primary Care and Rural Health, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Med Chi, Nurses, Nurse Practitioners, Physicians, Physician Assistants, Maryland Department of Human Resources, Head Start, Office of the Maryland WIC Program, Governor's Office of Children, Youth, Families, Obstetricians/Gynecologists, faith based organizations

Priority Area IV
Establishing Linkages and Ensuring Coordination of Oral Health

Why: The creation of strong and diverse partnerships ensures that oral health messages will be introduced and incorporated into a wide variety of pre-existing programs designed to reach those individuals most at risk.

How:

- Identify and actively pursue additional funding sources to support oral health activities and programs.
- Establish and maintain working relationships with key partners in the dental community both within DHMH and outside of DHMH.
- Serve as a coordinator for distributing information to advocates via newsletter, email, and website.
- Provide guidance to the Oral Health Advisory Committee.
- Develop and strengthen state and local coalition building.
- Recruit and retain qualified Office of Oral Health staff for program support.
- Work to incorporate non-dental groups in the promotion of oral health.
- Establish partnerships with private industry and corporations.
- Seek funding for new initiatives.

Potential Partners: Maryland Dental Hygienist Association, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Med Chi, Nurses, Nurse Practitioners, Physicians, Physician Assistants, Maryland Department of Human Resources, Head Start, Office of the Maryland WIC Program, Governor's Office of Children, Youth, Families, Obstetricians/Gynecologists, funding organizations, faith based organizations