New Mexico’s Second Oral Health Access Summit
April 25-26, 2002
Las Cruces, New Mexico

New Mexico’s Second Oral Health Access Summit took place April 25-26, 2002, at the Best Western Mesilla Valley Inn in Las Cruces, New Mexico. One hundred fifteen individuals participated in some or all of this activity. Funding partners included: the Federal Health Resources and Services Administration/Maternal Child Health Bureau; the Kellogg Foundations Community Voices Initiative Grant to UNM Health Sciences Center (Center for Community Partnerships Reference #P-00610131); the New Mexico Dental Association; OralScan Laboratories/Sullivan-Schein Dental; and Delta Dental Plan of New Mexico.

What follows are the discussion summaries from each oral health policy breakout during the event.

FINANCE AND LEGISLATION ROUND TABLE DISCUSSION REPORT
Facilitators: Ken Padilla and Dot Ball

1) Review of Prior Oral Health Legislation (by Jerry Harrison) – Included prior legislation introduced to add dentists and dental hygienists to the New Mexico Health Service Corps; over the past two years, the legislation has been introduced in multiple pieces of legislation but has failed to be passed by both houses prior to the end of each session

2) Points of Discussion – Included identification of legislative priorities for oral health
   i) Medicaid reimbursement is a major issue at both the state and national level
      (1) To encourage providers, reimbursement levels must keep pace with inflation
      (2) Reimbursement levels need to be increased now to a level that will encourage provider participation
      (3) Physicians want to tie Medicaid rates to Medicare; this would not apply to dentists, so there is no room for coalition building on the issue
      (4) State Coverage Initiative (SCI) Phase II is considering exclusion of dental under Medicaid; some other states are excluding Medicaid dental, as well

   ii) Department of Health (DOH) Programs
       (1) New Mexico Health Service Corps (NMHSC)
          (a) Reintroduce legislation to include dentists and dental hygienists
          (b) Increase funding for the program to cover stipends by $100K
          (c) Identify a sponsor to carry the legislation
          (d) Consider recruiting from other states for NMHSC since there is no dental school in New Mexico; will require amendment to statute

       (2) DOH Professional (Community) Contracts
          (a) Identify rural shortage areas of the state to target contracts for dental services
          (b) Increase funding to the professional contracts program so that funds can be made available to more communities; target amount = $500K
          (c) Funding for the program from the state general fund is unlikely; however, tobacco funds are a possible source for this additional funding
          (d) Get communities to work with their local legislators to support additional funding for community contracts
          (e) With additional funding, the program could be more effectively marketed to communities in need as the funds are not limited to non-profit facilities (private practice providers may apply for the funds)
The Oral Health Council should support increased funding for the program from the legislature

iii) Commission on Higher Education (CHE) Programs
(1) WICHE – changes to WICHE were recommended; however, it was explained that New Mexico has no authority to make unilateral changes to WICHE regulations, as it is governed by an interstate council
(2) Regulatory change needed to include dental hygienists in CHE Loan for Service program
(3) Where possible, increase incentive amounts to more appropriate cost of living levels to encourage recruitment
(4) Require service in underserved areas in all programs
(5) Loan Repayment Program – increase allocation amounts (could reduce the number of awards and/or increase funding for the program)

iv) The University of New Mexico (UNM) Programs – Include support for an Institute of Oral Health

v) Other Oral Health Finance and Legislative Issues
(1) Education Programs – Support linking UNM Dental and other Dental Hygienist programs to community colleges around the state
(2) A memorial to improve education recruitment in New Mexico schools in the oral health professions; existing initiatives in this area that may need expansion include:
   a) DOH – Boys and Girls Health State Program for health careers
   b) Existing AHEC programs
(3) Funding to New Mexico Health Resources for recruitment
(4) Development of retention incentives
(5) Planning Areas -
   a) Identify shortage areas
   b) Recruitment into education programs in local elementary and secondary schools
   c) Expand participation by dental students and professionals in CHE programs

3) Select Spokesperson – Ken Padilla was selected to serve as the spokesperson for the group in the closing session of the day

4) Prioritization of Legislative and Finance Issues - Short Term Priorities (2002 Legislative Session)
The group identified 3 of the priority areas discussed to be addressed through legislation in the coming legislative session:
   i) Medicaid reimbursement to dentists, maintaining dental coverage and benefits under the program, and eligibility expansion for dental services
   ii) Expansion of DOH professional community contracts for dental services
   iii) Dental Education and Incentive programs –
      (1) Expand NMHSC and CHE Loan for Service and Loan Repayment programs to include dentists and dental hygienists
      (2) Expand local recruitment into dental health professional education programs
      (3) Link UNM dental and dental hygienist programs to community colleges

5) Legislative Strategies
   a) Build coalitions with other health professions to support Medicaid reimbursement
   b) Target legislators for education on oral health issues
   c) Develop PAC’s with professionals, trade associations and community based action groups to lobby local legislators on the issues
   d) Engage the Oral Health Council in endorsing legislation
The presentation was entitled **Oral Health Access at the Border**. The border counties in New Mexico are generally defined as: Dona Ana; Grant; Hidalgo; Luna; Otero; and Sierra Counties. Currently, these border counties account for 18% of New Mexico’s population.

Dr. Baez provided additional demographic data regarding the population along the US-Mexico border. This population is one that is described as experiencing rapid growth. Between 1970 and 2000, the population in the United States along the border grew almost 3-fold, to 11.4 million inhabitants. The population in Mexico also grew 39% during that same period, nearly 2 times Mexico’s national growth rate. In terms of ethnic distribution in the U.S. border area, Hispanics make up over 40 percent of the border population, 3 times the national average. Nineteen percent of the border population is at or below poverty (the national average is 13%). Seventy-three percent of border counties have dental Health Professional Shortage Areas (HPSAs) (the national average is 31%).

Following the presentation on border demographics, a discussion ensued on the fundamental processes involved in the organization of oral health services in a rapidly growing underserved area such as the US-Mexico border. It is imperative prior to initiating large-scale interventions to conduct an oral health assessment of the border area. Acquisition of information through monitoring data from independent studies and systematic inquiry via scientific research was suggested as a first step. With a properly conducted assessment, the appropriate administrative processes can be designed. Administrative processes would include management of personnel, facilities, materials, funds and other resources to conduct targeted oral health activities.

It was pointed out that public expectation is a significant factor in the analysis of an oral health program. Dr. Baez stated that, according to the World Health Organization, the outcome of such a program can be assessed at four different levels:

- **Resignation** - The predominant demand here is for emergency care, and no contact with providers beyond what is absolutely essential is desired. A fatalistic attitude to oral health may prevail.
- **Replacement** - The predominant demand is for extractions and dentures. It is appreciated that dentistry may be helpful, but the burden is placed on the provider to provide pain-free treatment to restore function and appearance.
- **Repair** - The predominant demand is for restorative dentistry, including fixed prostheses, orthodontics, and periodontal treatment. Teeth are valued and providers are expected to preserve them. It should be noted however, that continuing efforts must be made by the individual to maintain the results of treatment.
- **Prevention** - The predominant demand is for education and assistance in maintaining oral health and preventing disease. The provider is expected to supply the necessary information and treatment to minimize disease, discomfort and costs. Primary responsibility for maintaining oral health is understood to rest on the individual rather than with the provider.

The three primary factors that affect oral health status of population groups are accessibility, availability, and acceptability. It is critical for the success of any oral health program in the border area to integrate all three factors. In particular, an intentional consideration of cultural competence must be incorporated into the design of the oral health programs contemplated for the border area. In addition, the public, including individuals and public policy makers, should especially be concerned with the accessibility and affordability of health care.
Further discussion centered on the issue that a suitable oral health program objective might well be to convert a demand for episodic, rehabilitative and restorative treatment to an expectation of predominantly preventive services, and to cultivate prevention-oriented attitudes and behavior. Participants expressed the view, that at a minimum, the first efforts needed to undertake an oral health program in the border area should address emergency services, providing pain relief and palliative care.

The success of an oral health program can be determined by a properly designed, systematic evaluation process. Factors to be considered in the evaluation of a program were discussed. These factors should include the following criteria: 1) the assumed underlying health problem must be clearly identified, researched, and articulated; 2) the objectives of the program must be stated in direct relationship to the problem identified; 3) the activities that have been planned should aim directly to achieve the objectives stated; and 4) the resources that are required are sufficient to undertake the planned activities.

During the open group discussion of this session, three basic problems were identified which directly contribute to the oral health problems experienced in the border area: 1) lack of human resources; 2) prevalence of untreated caries; and 3) lack of data (surveys, oral health assessments, standardized oral health records, etc.)

Through a free flow of ideas, participants made the following suggestions: 1) increase educational efforts, including posters that would be conspicuous and would graphically convey oral health problems; 2) increase availability of mobile dental units to access more remote underserved areas; 3) promote “Train the Trainer” programs to maximize the utilization of auxiliary health care givers; 4) enhance the recruitment of dental providers by ensuring adequate compensation; and 5) design strategies that would stimulate retention of dental providers.

Collaboration with government agencies and non-government institutions or organizations was considered essential. There seemed to be agreement that the current workforce was insufficient to meet current needs; however, it was acknowledged that without a standardized baseline data set it would be difficult to assess progress, and determine whether oral health needs of the border community have been met over a period of time. Planning for future programs could not be accomplished without having adequate information on current status, treatment needs and urgency of care. These issues should be taken into consideration.

It was widely agreed that impacting the oral health problems of the border area is a daunting task. Perhaps the best approach is to set out achievable, short-term objectives for the year 2003 until a viable and systematic oral health assessment can be conducted for the region.
Dr. Betty King-Sutton, Director of North Carolina’s Medicaid Dental Program, was the featured speaker for this breakout session. Dr. King-Sutton reviewed the development and inception of North Carolina’s innovative oral screening preventive program “Into the Mouths of Babes.”

“Into the Mouths of Babes” features a package of preventive services directed towards Medicaid-eligible infants and toddlers. These services include oral screenings, dietary and oral hygiene counseling to caregivers, and the periodic application of dental (fluoride) varnish to the teeth of Medicaid-eligible infants and toddlers. What makes this program particularly innovative is that services are delivered by primary health care providers, such as pediatricians, family physicians and mid-level practitioners (nurse practitioners/physician assistants).

All providers must attend a training session. This session features a video, developed by the University of North Carolina (UNC) School of Dentistry and Public Health, showing the correct manner of fluoride varnish application. It also features instructions on how to code visits to receive reimbursement and the use of specially prepared educational materials. We viewed the video and saw samples of handouts.

Development and Inception of the Program: A Pilot Project Approach

With her years of experience as a dentist and through her employment with the North Carolina Medicaid Dental program before becoming director, Dr. King-Sutton was aware of the gaps in the North Carolina Medicaid dental service delivery system, including the method for delivering ECC prevention services to the 0-3 population. She spearheaded the drive to reach out to primary care providers and a whole host of interested agencies and individuals. A pilot project was funded by the State and begun in December 1999, which served approximately 3,200 infants and toddlers in 10 NC counties at a cost of $138,000 (approximately $45/child). Dr. King-Sutton stated that children in this age group often have the greatest need and Medicaid dental services have not reached this population in time to prevent dental disease; therefore, it seemed logical to reach out to them with special preventive services. Focusing on disease prevention would ultimately improve access to dental care, which is at a crisis level throughout the country.

Building on the success of the pilot project, Dr. King-Sutton helped craft a grant that was jointly funded by HCFA (now CMMS), HRSA and the CDC. The NC State Division of Medical Assistance was awarded a $345,000 grant in January 2001. As of February 1, 2001, the preventive dental services were available statewide to more than 236,260 eligible children ages 0-3.

“Into the Mouths of Babes” is jointly administered by the NC State Medicaid program, along with the NC Academy of Family Physicians and the NC Pediatric Society. The UNC School of Dentistry and Public Health will provide expertise in the development of educational materials, medical education design and project evaluation. Also supporting the project’s effort to get funding were the Office of Rural Health, NC Dental Society, Old North State Dental Society, Old North Medical Society, NC Medical Society, NC Academy of Family Practitioners, NC Society of Pediatric Dentistry and NC Division of Public Health. Program outcomes will be available for review when a sufficient amount of data has been collected.

After discussing the program, all Prevention Breakout participants agreed that getting a similar program in New Mexico is a priority. The hallmarks of the successful North Carolina Program were trans-disciplinary collaboration, working with NGOs, public organizations and state legislators; these elements will need to be part of a successful effort here in New Mexico.

Dr. King-Sutton stated that groups of providers from other states have come to North Carolina to learn firsthand about the program; a group of providers from Kansas just completed a stint there, during which they participated in the training program. Dr. King-Sutton extended an invitation for folks from
New Mexico to come out and see the program; we would have to provide our own travel costs, but the training would be free. Group discussion focused not only on issues surrounding ECC prevention, but comprehensive dental health care issues. The group recommendations and volunteers are listed as follows:

**Missing Persons, Partners, Populations, Politics:** We need to reach out to: obstetricians; pediatricians; family physicians; mid-level practitioners (NPs, PAs); the elderly; midwives; lobbyists; nursing homes; HSD; healthcare benefits bureau; state funding agencies.

**Opportunities:**
Improve the usage of SCHIP and Salud programs to increase access to dental care. Educate the people of New Mexico about NewMexikids – it’s not welfare!

**Challenges:**
Dental providers (why aren’t we accepting more children?); not enough dentists; preconceived notions about old Medicaid reimbursement process; biggest obstacle is money! Need to educate providers regarding provision of dental services to pregnant women and the revamped, computerized reimbursement process.

**Short-range Goals (2003 Legislative Session):**
Fluoride – ask for funding for communities which want to set aside/allocate/disburse capital improvement monies; provide accurate educational information for parents and legislators on fluoride to deal with fears and concerns (develop “Talking Points” re: Fluoridation)

**Mid-Range Goals (Calendar Year 2003):**
Develop a Speakers’ Bureau to work with communities considering fluoridation (volunteers – Amalia Torrez and James Strohschein); the Bureau would provide accurate information, education and support

**Long-Range Goals (2004 Legislative Session):**
Fluoride varnish program in 2004 (akin to North Carolina programs) – preparation/groundwork needs to occur beforehand – building a collaborative, trans-disciplinary committee akin to the North Carolina model (anticipate opposition from dentists who fear revenue loss, even though they are not currently treating this population; work with legislators to ensure they are aware of the benefits of the prevention model)

**Organizational Structure Options for Continuing Summit Activities:**
- Develop fact sheets (volunteers – Britt Catron, James Strohschein, and Sandy Roe)
- Develop population and geographically-sensitive information fact sheets (rural, urban populations, etc.)
- Targeted population – legislators, community representatives, etc.
- Disseminate Information on fluoridation, links between pre-term labor and untreated dental disease, etc.
- Continue to extend outreach and organizing efforts to groups and organizations which focus on dental issues (like Head Start)
WORKFORCE/SYSTEM CAPACITY

Representation in the Session was broad based, including representatives from: government (both federal and state); the New Mexico Commission on Higher Education; dental contractors for the New Mexico Department of Corrections; the Indian Health Service; New Mexico universities; the Health Resources Services Administration; New Mexico vocational schools; the US Army, Health Professional Recruitment; and dentists and dental hygienists. Ms. Angel Saunders, Hyde Park Communications in Washington, D.C., (the national media consultants for Kellogg Community Voices) also attended the session.

The Facilitator provided a brief background summary and opened the session for comments.

The group essentially identified barriers and offered solutions in the form of recommendations for systems change and innovation.

Suggested strategies:

- **Prepaid full ride**- Develop for New Mexico a model similar to one used for the last few years by the Department of Defense (DOD). The DOD offers full reimbursement or pay off for educational expenses for those dentists and hygienists who enlist and serve. Assignment is made for enlistees, but there are limited optional or discretionary assignments, as well. Focus is on recruitment at the various schools of dentistry to fill the program and debt relief is negotiated for the enlistee prior to active duty.

- **Reimbursement for practice set-up costs** when such practices are to serve rural communities or underserved populations. Local communities and the state might partner in such an effort. Local communities could offer tax relief while the state could assure conditional loans. Repayment on practice startup could be reduced by percentages of practice devoted to low income, uninsured or otherwise underserved populations.

- **Dental school tuition loan repayment and National Health Service Corps** program restart by HRSA could be responsive to public agencies eligible as loan repayment sites. Site assignments based on relative scoring of MUA/HPSA areas and site needs would be employed again as part of the HRSA process. Indices-reduced to prioritize placement based on HPSA standard score.

- **Review New Mexico loan repayment program** application process. Program may be more effective in attracting participants and in subsequent recruitment to rural areas, if applicants have a longer window for application or if the program would accept and grant loans on a year-round, 12-month basis. Current application deadline dates are not compatible with board exams.

- **Prorating salary and loan repayment** as incentive. Criteria of HPSA designation, distance (rurality), portion of practice devoted to uninsured, vacancy history for the site could reduce indebtedness for dental providers locating to the state.

- **Isolated dentists** serving in remote areas could be supported through a “Dentist Access Line” (DAL), modeled after the UNM Physician Access Line. Support for peer and specialty linkages should be sought to connect rural general practices to best practice, CEU, research and consultation.

- **Advanced general practice residency** was described as an efficient response to dentistry education for the state with linkages to a residency model of the 1+2 model of family physician residency training.

- **Public agency credentialing** and placement criteria should be centralized for public providers.

- **HRSA loan repayment criteria** should be modified to support circuit or multiple sites as an eligible repayment option for dentists and other providers.
• **Loan repayment credit** should be provided for locum tenens service or residencies served in support of services in HPSA-designated communities or with such populations.

• **Public/private partnerships** should be developed to involve community resources, the public and individual practitioners in setting up practice partnerships. Communities, for example, might finance facilities and the state would offer stipend support for education and training.

• **Tax incentives could be explored** not necessarily as direct tax relief, but perhaps through service in lieu of tax, with some formula based on services to the underserved. A ratio approach based on comparative reduction of gross receipts or personal income tax for service to rural or underserved populations could be pursued. Ratio would not be based on pro bono, but on actual billings/reimbursement. As an alternative, provide gross receipt tax relief for dentists across the board.

• **Future board/regulations around licensing** could revisit regional board exams and their impact on licensing by credential.

**Other Pipeline/Supply Issues:**

Several concerns were raised by the group about existing and future demands and the scarcity of modeling, community awareness and the lack of mentoring resources for the fields of oral health.

Cultivating within middle school students a purpose in the pursuit of a caring profession should receive special consideration within the AHECs and others. Mentoring, using perhaps the North Carolina model, should be explored, as should a “Health State” approach. Build on health professions that are currently in the community as outreach and role models for future students and providers. Explore an industry-community “workforce investment grant” model of enticing providers to rural areas.

**Short Range Objectives:**

• Focus on funding and amendment of NMHSC to include dentists and hygienists.

• Develop proposal for revision of the New Mexico loan repayment program calendar and funding cycles.

• Pursue HRSA model of priority assessment for assignment of health providers.

• Work with HRSA to revise regulations governing the conditions and restrictions on repayment. Include locums, residency credit and multiple site eligibility for repayment.

• Establish residency program, link program with rural mentor/preceptor network.

**Longer Term Objectives:**

• Determine gains and relative value of tax relief and other incentives for recruitment, retention and service by oral health providers to underserved communities and uninsured populations.

• Develop mentoring and outreach for recruitment of mid and high school students to oral health careers.

• Develop extension service, peer support and specialty consultation program for rural providers.
NEW MEXICO’S ORAL HEALTH PLAN

Facilitator/Presenter: Ron Romero, DDS, MPH, Dental Director, Office of Dental Health, Health Systems Bureau, Public Health Division, New Mexico Department of Health

Presentation: State Oral Health Plan, “Call to Action”

The presentation consisted of major four areas:

- Healthy People 2010: Oral Health Objectives;
- Surgeon General’s Report: Oral Health in America;
- National Oral Health Plan; and the
- State Oral Health Plan.

The Surgeon General’s Report calls for the development of a National Oral Health Plan, which includes collaborations among individuals, health care providers, communities and policy makers. The Healthy People 2010 Objectives were used to provide a set of measurable goals to guide specific strategies in the development of a National Plan. States are challenged to formulate their own plans.

The framework for the National Oral Health Plan consists of: targets (national, state and local); players (federal agencies, state organizations, grant makers, businesses, professionals, academics, researchers and the public); and strategies (to change perceptions of oral health, accelerate building and application of science, build effective health infrastructure, remove barriers to oral health services and use public-private partnerships to improve oral health). A National Oral Health Plan is expected to provide structure for coordination of activities across organizations that enable achievement of the Healthy People 2010 oral health objectives, as well as to address other oral health issues.

Using the framework from the national plan, the format and process for development of a state oral health plan was presented.

The plan outline includes:

- Policy Goals;
- Priorities;
- Recommendations; and
- Strategies.

The plan inputs include:

- Oral Health Survey of New Mexico’s Children;
- The New Mexico Oral Health Council;
- Broad based representation from partners and organizations; and a
- Steering Committee.

The plan’s five policy goals include:

- Change perceptions: oral health is integral to overall health; oral health becomes an accepted component of general health;
- Build oral health infrastructure that meets the oral health needs of all New Mexicans and integrates oral health effectively into overall health;
- Use collaborative partnerships to improve oral health;
- Remove access barriers between people and oral health services; and,
- Accelerate the building of science and evidence base and apply science effectively to improve oral health.
Steering Committee Mission is:
   - To facilitate development of the state Oral Health Plan; and,
   - To monitor the implementation and continued development of the plan.

Steering Committee Membership could include representatives from:
- Participants in the Oral Health Summit;
- The New Mexico Oral Health Council;
- Maternal & child health organizations;
- Head Start & tribal organizations;
- Primary care organizations;
- Dental professional organizations;
- Policymaking bodies;
- Academic institutions;
- State agencies;
- Community health centers; and
- Business leadership organizations.

The task for the session was to identify common priorities for incorporation into the plan. Participants made recommendations for priorities and strategies. Some of those identified included:
- Community-oriented professional education, training and practice opportunities;
- Community-based education, prevention and control programs;
- Encourage academic institutions to develop and expand oral health professional programs through the expansion of the safety net systems;
- Develop an oral health surveillance system;
- Funding and resources – e.g., examine RWJ Grant Proposal for submission;
- Outreach to private practitioners;
- Media campaign;
- Oral Health Council involvement to develop partnerships to improve the oral health of those who suffer disproportionately from oral disease; and
- Town Hall Meetings, to listen to community perspectives, react to priorities identified and to ask for input/advice on addressing priorities.

Next Steps:
- Continue to identify priorities, recommendations and strategies for policy goals;
- Create the steering committee;
- Town hall meetings (Summer 2002);
- Draft plan (Fall 2002);
- Implement plan (December 2002);
- Monitor Progress.