

State Dental Summits: An Evaluation

Executive Summary

The Association of State and Territorial Dental Directors

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Background

In the winter and spring of 2003, the Association of State and Territorial Dental Directors (ASTDD) evaluated 17 “state dental (oral health) summits” conducted between April 2001 and December 2002. The summits were partially funded by the Health Resources and Services



Administration (HRSA), Maternal and Child Health Bureau (MCHB), with support from the Centers for Medicare and Medicaid Services (CMS), through a cooperative agreement with ASTDD. This document provides a report of the findings and recommendations of this evaluation. The purposes of the evaluation and this report are to:

- Enhance understanding of whether or not these oral health summits were successful in moving forward oral health agendas in the states;
- Help the federal agencies supporting these summits better understand how funds were utilized and how the funding eventually affected oral health activity in the states;
- Provide assistance to oral health stakeholders in the states as they plan future dental summits.

ASTDD provided approval, disbursement and tracking of MCHB funds; technical assistance to the state summit planners regarding meeting format, content, collaborative planning and facilitation strategies, ideas for leveraging other resources; and posting of summit reports on the ASTDD website (www.astdd.org) and on the MCHB supported Oral Health Resource Center website (www.mchoralhealth.org). Technical assistance regarding public health dental practices, Medicaid policies and procedures, and pediatric dental issues also was available from HRSA/CMS Oral Health teams in each federal region.

The dental summits were perceived by the supporting agencies as potentially facilitating statewide problem solving around oral health issues, especially for children. The expected outcome was development of collaborations between policymakers, the private dental community, state health programs, and safety-net providers that would ultimately lead to long-term strategies and actions for improving oral health and dental access.

Evaluation Design and Methods

ASTDD consultants and a Summit Evaluation Advisory Committee designed and pre-tested two written questionnaires that were distributed primarily by e-mail to individuals representing important oral health stakeholder organizations in the 17 states. One questionnaire contained “opinion questions” for response by selected “Key Stakeholders” from each state. A second, longer questionnaire containing both “opinion questions” and “logistic questions” was sent only to the person identified as the ASTDD “Primary Contact.” The Primary Contact identified 3-5 other Key Stakeholders who would receive a questionnaire. These individuals were selected from a broad array of partners: personnel of state Medicaid programs and the State Children’s Health Insurance Programs (SCHIP), dental and dental hygiene professional associations, safety-net providers, state public health and oral health programs, staff from the Governor’s office, state legislators, rural and primary care associations, dental and medical professionals, health professions schools, foundations, advocacy and minority group representatives, and others.



The questionnaires used a “multiple-choice” format, often with Likert scale questions, with space provided for limited comments. Table 1 summarizes the range of issues about summit logistics and organization that were explored in the questionnaires.

Table 1. Questions About Logistics and Organization of the Dental Summits	
What was the summit’s duration?	Was administrative support available?
How many persons participated?	Was the application process burdensome?
Was satellite/videoconferencing available?	Who provided “in-kind” assistance?
Was a Head Start Forum held concurrently?	What were the planned summit goals?
What organizations provided funding?	How did states evaluate their summits?
What was the budget?	How were summit results disseminated?
What barriers had to be overcome before, during and after the summit?	Did the state participate in NGA Oral Health Policy Academies?
How were funds expended?	Was this the first state summit?
Was funding adequate?	What notable events catalyzed the summit?
How was background material developed?	Was assistance of federal and ASTDD staff helpful?
Who participated in pre-summit planning meetings?	What advice may be offered to future summit planners?

Table 2 lists questions that explored opinions and ideas about the processes and outcomes of the dental summits.

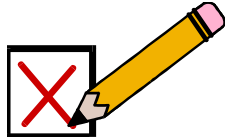
Table 2. Questions About Opinions of Summit Outcomes and Processes	
Was the summit dependent upon one or two people or organizations?	Did it affect Medicaid/SCHIP policies and procedures?
Were all critical stakeholders included?	Did it affect health professional licensure, training, loan programs or education?
Were any stakeholders unfairly represented?	Did it affect community-based or school-based oral health programs?
Was there a balance of plenary and small group sessions?	Did it affect analysis or collection of oral health data or research?
Were summit facilitators helpful?	Did it expand oral health promotion, prevention or treatment programs?
Did the Summit fit into a logical sequence of events in the state?	Did it affect state oral health infrastructure or strategic plans?
Was it held at an appropriate date/time?	Did certain topics receive too much, too little of the correct amount of attention at the summit?
Did it affect coalition development?	What were the most positive outcomes?
Did it affect work groups or committee formation?	What were the biggest disappointments?
Did it affect application to NGA Academies?	How would you improve the summit?
Did it affect visibility of oral health among the public, policymakers, news media?	Was the summit useful in furthering the state's oral health agenda?
Did it effect state legislation?	What is your organizational affiliation?

Questionnaires were sent to 156 individuals, including 17 Primary Contacts and 139 Key Stakeholders. A purposive, rather than random method of identifying potential respondents was used to help assure respondent knowledge about the issues being evaluated. The response rate was 100% for the Primary Contacts and 90% for all survey participants.

Responses from Primary Contacts to “logistic” questions are reported by number and percent of total responses to each question. “Opinion” data, however, are analyzed in two ways:

1. Using a “*state consensus*” process, where consensus was considered to have been achieved when *more than* 50% of the respondents in a specific state made the same response on a particular question, and
2. Reporting the combined percent responses of all respondents to each opinion question to identify trends; the respondent’s state was ignored in this analysis.

Results



Responses of Primary Contacts to “Logistic Questions”

Summit Application and Planning

- Most said the application process was “not very difficult,” while 2 indicated that the process was “moderately difficult.”
- 12 felt that the federal Regional Office staff was “very helpful,” and four said they were “somewhat helpful.” 48% indicated that ASTDD technical assistance was “very helpful,” three said “somewhat helpful,” two said “not helpful,” and five said “not applicable.”
- 13 noted this was the first statewide summit, and 14 identified events that had precipitated the summit: the prior work of oral health coalitions, task forces, review teams, or statewide oral health initiatives; participation in related conferences; the influence of federal initiatives; release of the Surgeon General’s report on oral health, and changes in the state’s oral health infrastructure, such as Medicaid fee increases or appointment of a new State Dental Director.
- 9 had applied to attend a National Governors Association (NGA) Oral Health Policy Academy, with 7 actually attending (5 prior to the summit and 2 after the summit.)
- In addition to HRSA/ASTDD, a mean of 3.5 other organizations/agencies also provided financial support for the summits.
- The greatest summit expenditures were for conference facilitators (23%) and refreshments (18%); since federal funds could not be used for refreshments, it was important for states to find other sources of support.
- The average dental summit budget was \$16,299, with a median of \$10,000, and a range of \$8,000-\$54,598.
- In-kind assistance was used for several purposes in 15 states; an average of 2.4 organizations provided such assistance.
- An average of 8 organizations per state participated in pre-summit planning meetings.
- Over 90% collected written documents and materials prior to the summit; 8 had surveyed prospective participants to obtain source information.

Summit Format and Attendance

- All but 1 state identified multiple summit goals.
- 11 summits lasted 1 full day; 4 were 1.5 days in length, and 2 occurred over 2 continuous days.
- Only 1 reported using satellite/videoconferencing; 7 recommended against use of such alternative participation methods, while 5 viewed such methods positively, and 5 had no opinion.
- 8 reported that summit attendance was 100-149 individuals, with other states reporting smaller or larger attendance levels.
- 59% used event planners/administrative support; 9 used unpaid facilitators, 8 used paid facilitators (1 of these used both types).
- 10 encountered problems *before* the summit began. Problems were noted in three areas: summit personnel, participation of state government, and relations with dental health professional associations. Only 3 noted any problems encountered *during* the summit, and 5 listed problems that arose *after* the summit ended.
- In evaluating their summits, 15 used “participant evaluation forms,” 3 used “post-conference surveys” and 9 used “follow-up meetings.”
- Summit results were disseminated in multiple ways.
- Primary Contacts also provided suggestions for future summit planners for what they “should” and “should not” do in planning for and conducting a dental summit.

Responses of Primary Contacts and Key Stakeholders to “Opinion Questions”

1. **General thoughts about summits:** Although there was some dissenting opinion, there was substantial consensus among respondents in each state that:
 - The summits would not have occurred without the hard work of one or two key individuals.
 - Critical stakeholder organizations were included in the summits.
 - There was no unfair representation, nor an imbalance of views.
 - Plenary and small group discussions generally were balanced.
 - Summit facilitators were helpful.
 - The summits were an appropriate next step in the sequence of state events related to oral health.
 - The summits were held at an appropriate time and day of the week.

2. Influence on oral health outcomes:

- Of 20 possible outcomes included in the questionnaires, only three were cited by a consensus of respondents in a majority of states as having been strongly influenced by the summits:
 - Enhanced coalition development and/or broadening of stakeholder partnerships.
 - Heightened visibility of oral health among policymakers,
 - Stimulation of the development of oral health committees, work groups and task forces.

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

- Respondents viewed other oral health-related outcomes as having been influenced by the summits, but fewer states achieved a consensus and only a plurality of respondents were in agreement. These outcomes included:
 - Heightened awareness of oral health issues among the media (weak);
 - Enhanced visibility of oral health among the public (strong),
 - Development of state legislation (weak),
 - Creation/expansion of community-based clinical programs (strong),
 - Creation/expansion of school-based programs (strong),
 - Use of existing data (strong) and
 - Expansion of oral health prevention programs (strong).
- Little positive consensus was noted for other outcomes.
- 25% felt the summit did not influence changes in Medicaid policies or procedures, oral health professional licensure, training and education, loan repayment or scholarship programs, or the state government's oral health program infrastructure.

3. Level of attention paid to nine oral health issues or topics:

- A consensus of the respondents in *all* states agreed there was the correct amount of discussion about “access to services.”
- Slightly fewer states achieved consensus that the attention paid to the topics of “advocacy,” “workforce,” and “oral health promotion” was appropriate.

- In several states a majority believed there was too little or no discussion of “research” and “legislation.”

4. Follow-up summits:

- Although more than 75 percent of respondents said that a follow-up summit would be useful in furthering a state’s oral health agenda, many respondents also placed qualifiers on this view.

5. Other comments: Respondents also described the most positive features or outcomes of the summits; indicated the biggest summit disappointments or “turn offs,” gave their recommendations for summit improvement, and shared many additional comments (all are summarized in the appendix of the full report.)

- It was especially important to “have a participatory, inclusive planning process,” with “all key stakeholder groups engaged early on in the planning stage.”
- A number of respondents cited “lack of adequate time” as one of the major disappointments of the summit. There is a trade-off in getting good participation for one day, versus less participation if the summit is held over two days.”
- Respondents generally agreed that paid or non-paid facilitators were helpful in keeping summit discussions on track, although some indicated that facilitators were either unskilled, unfamiliar with the issues, or had their own biases in directing the discussion.
- Ethnic communities, seniors, disability groups, legislators, policy level decision makers, the medical profession, and public school and dental hygienist educators often were noted as groups inadequately represented. In some states, groups cited over-representation by Head Start programs, dental hygienists, not-for-profit advocacy groups and state health agencies. Private sector dentists were viewed as under-represented.
- To address concerns about communication gaps and lack of follow through, respondents suggested using a newsletter; posting summit information on an Internet web site; planning for a post-summit evaluation or mail survey; and use of the core planning group to help carry out summit ideas and actions.

Recommendations

Based on the results of this evaluation, the perceptive comments of respondents, and the experiences and insights of ASTDD Summit Evaluation Committee members, the

Committee provides the following recommendations for future dental summit planners and HRSA MCHB, as appropriate:



1. Utilize an inclusive and diverse pre-summit planning process to gain support from as many key stakeholder groups as possible.
2. Obtain consensus about summit goals. For example, is the summit directed at information transfer, coalition building and sharing views, or is it directed at strategic planning and establishing action steps? A combination of the two goals may be too ambitious for the available time and expertise of those in attendance. A clear goal may help inform the pre-summit planning committee about the appropriate summit format and the number and types of participants to be invited.
3. Spend as much time as necessary—as much as 6-12 months—in strategic planning and consensus building before setting an actual summit date.
4. When a consensus about a controversial issue cannot be achieved during the pre-summit phase (e.g., scope of practice for dental hygienists) and it appears that the issue may be sufficiently divisive to disrupt progress on other issues, request that the leaders of the groups agree to defer or defuse the issue during the summit.
5. Facilitators can help keep participants on tasks, assist in defusing divisive discussions, vet recommendations for plausibility, and provide advice on methods for developing consensus and prioritizing strategic plan action steps. Professional facilitators are useful, but expensive, and need to be knowledgeable about oral health terminology and issues; orient facilitators to your state's oral health issues prior to the summit. A combination of oral health issue experts and facilitators may be useful in directing small group sessions.

6. Unless the day of the week/time for the summit is selected carefully, it may be difficult for non-public employees, especially private sector health professionals to participate. Planners should consider selecting a day of the week/time, including weekends, that facilitates private sector provider attendance without hampering attendance by public sector or consumer representatives.
7. The length of the summit and attendance by participants may be inversely related. Most summits have been scheduled for one or one-and-a-half days in length.
8. Devote as much summit time as possible to discussions of state specific issues, rather than national oral health issues. If a national focus is desired, ask speakers to relate their broader remarks to the state's issues.
9. Carefully balance plenary and small group breakout sessions so that input from stakeholders is maximized, especially when developing strategic plans or action steps.
10. While MCHB funding support (\$5,000) has been critical in stimulating dental summits and in leveraging other funding contributions, no state found the \$5,000 to be sufficient for meeting all summit expenses. It is likely that the summit budget will be about \$15,000, or more. Non-federal support will be needed. Use "in-kind" support when possible.
11. Use paid professional facilitators (recommended with the caveats above) and provide refreshments. These items will likely be the most costly items in the summit budget.
12. When deciding on site location for the summit, assure that the available space will enhance both plenary and small group discussions; carefully assess environmental details, e.g., acoustics, lighting, room temperature. Consider using an "event planner" to assist in managing logistics, participant registration, securing accommodations, travel arrangements, etc.

13. Use of video- and teleconferencing may increase the number of stakeholders able to participate, especially in large, rural states with long travel distances, but may hinder group decision making, priority setting, and networking.
14. Offer participants a view of “what comes next.” At a minimum, this might include identifying participants who wish to continue to work on committees or work groups. Send participants a summary of the proceedings as soon as possible after the summit or post it on a Website. Use a newsletter or develop an electronic listserv to continue dialogue among participants about summit-related issues. If you say you will follow through on something, do it!
15. Evaluation of the summit may be enhanced by surveying participants (by e-mail to reduce costs) shortly after the summit has been held. Solicit additional ideas that participants may not have had a chance to express during the summit, or which occurred to them after the summit.
16. Evaluation of short- and long-term summit outcomes entails conducting an assessment three to six months after the summit, then again at intervals over a period of several years to accommodate the lengthy timeframe needed for passage of legislation and promulgation of regulations.

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