

Appendix 2: Final Report of Delaware Oral Health Coalition 2015 Annual Meeting

The DOHC 2015 annual meeting was held on September 18, 2015. Using the Logic Model planning process, the four Action Groups reached consensus to focus future efforts on the identified objectives below:

Oral health for children beginning at age one.

- Integration of oral health into primary care
 - Training for primary care providers on oral health evaluations, anticipatory guidance, and preventive care
 - Promote referrals from primary care to dentists
 - Unified information campaign for parents

Board Recommendations to Consider:

- Promote the integration of oral health into primary care practices.
- Support modifications to the Medicaid reimbursement policy that would allow for physicians and dentists to apply two applications of fluoride varnish annually by the dentist and the physician.
- Support payment to FQHCs for the application of fluoride varnish that is equivalent to payment to private physicians.
- Promote the use of the Delaware First Smile messages and grassroots network for children.

Oral health care coverage available to all Delawareans on Medicaid

- Stakeholder Engagement and Education
- Policy changes to include oral health in Medicaid coverage for eligible adults through State Innovation Model/Delaware Center for Health Innovation (SIM/DCHI) framework

Board Recommendations to Consider:

- Promote issue to DCHI Board for its consideration to develop a comprehensive review of the cost and financing of dental care for adults who do not have dental insurance.
- Educate stakeholders about the importance of oral health for general health.

Standard and unified messages on Oral Health

- Develop a united message for all stakeholders to use
- All stakeholders understand and deliver unified message

Board Recommendations to Consider:

- Promote the usage of the Oral Health Literacy plan for adults to DOHC stakeholders and partners.
- Create and execute a grassroots campaign to promote oral health for policymakers, stakeholders, and consumers of health care.

Given the nature of the activities, the participants did not have sufficient time for comprehensive

discussion about objectives and priorities. The board should take this limitation into account, and the board members and Action Groups may discuss other objectives identified at the annual meeting based on their content expertise and knowledge for next steps.

At the DOHC annual meeting, the desire to have real concrete actions completed in a timely manner was made clear. Focusing all of the groups' efforts on the identified priorities will facilitate the development of concrete action plans.

Expertise from the Action Group members, along with supporting technical assistance from the Central Operations Group (COG), will develop the action plans to achieve these priorities.

A discussion of each topic, specifically activities already underway which could support new initiatives, is below. Readers are encouraged to review this discussion to learn what has been done and is currently planned for these recommendations.

Discussion

1. Oral health for children beginning at age one.

Integration of oral health into primary care

- Training of primary care providers on oral health evaluations, anticipatory guidance, and preventive care
- Promotion of referrals from primary care to dentists
- Unified information campaign for parents

a. Dental Medicaid Services for Children Provided by Primary Care Physicians

Delaware has the best dental Medicaid coverage for dentists in the United States and more than two-thirds of Delaware dentists participate in the program. However, the utilization of services is only about 50%, and the utilization for children under age three is approximately 16%. The American Preventive Services Task Force has recently issued a recommendation that physicians include an oral health evaluation with preventive services into their well-child visits for children under age five. The provision of these services by physicians will help to reduce tooth decay for these children who do not have a regular dentist.

Effective July 1, 2015, the Delaware Medical Assistance Program (DMAP) began reimbursing approved medical providers for the topical application of fluoride varnish. Approved providers can bill once every six months, when completed on the same day as an approved Medicaid well-child visit for children between ages six months through age five. Only Physicians, Physician Assistants, Certified Registered Nurse Practitioners, and Clinical Nurse Specialists who successfully complete the free online Smiles for Life Fluoride Varnish course (Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling) can complete the oral health screening and apply the fluoride varnish.

b. Reimbursement for fluoride varnish includes the following:

- a) Oral health screening to be completed prior to application of fluoride varnish
- b) Completion of the Oral Health Risk Assessment Tool

- c) Application of Topical Fluoride Varnish
 - d) Oral health and dietary education
 - e) Referral to a dental home for children who have a moderate or high risk assessment
- c. Billing Procedure for Fluoride Varnish
- Fluoride varnish is a benefit outside of the Managed Care Package and must be billed to the DMAP for reimbursement. This service is covered one time in six months and must be completed at the same visit as a Medicaid well-child visit, using CPT code 99188. All claims billed for this code must include the certificate serial number for the [Smiles For Life Course 6](#) and indicate one of the following codes D0601- Low caries risk, D0602- Moderate caries risk, D0603- High caries risk, based on an oral health assessment in the comment section. Paper claim submissions using a 1500 form will need to place this information in box 19.
- d. Coordination of Care
- a) When referring a child to a dental provider, the primary care provider should instruct the member to inform the dental provider the date the fluoride varnish was completed.
 - b) During a well-child visit, the primary care provider should inquire with the guardian of the member if they have a dental home and have seen a dentist in the last 6 months.
 - c) CPT code 99188 and CDT code D1206 are used interchangeably and can only be billed one time in a six-month period, regardless of whether the dentist or the physician applies the fluoride varnish.
 - d) The American Academy of Pediatric Dentistry recommends all children see a dentist by their first birthday.
 - e) Two cleanings per year by a dentist are also covered for children through these programs.
 - f) Currently, FQHC dental clinics are not reimbursed for these services.

Source: Delaware Medical Assistance Program. 2015. *3rd Quarter Special Bulletin*. Retrieved from: [Delaware Medical Assistance Program. 2015](#)

The detailed tables of Delaware Medicaid and CHIP covered services are included in Appendix 1, Dental Benefits for Children in Medicaid, Delaware ([Insurekidsnow](#)). If it is determined by the Children Action Group that additional services should be covered, a recommendation could be developed for the DOHC board to support this by working with Medicaid. The Action Group could recommend future actions to address this.

- e. DPH and DMMA Training and Referral Network
- The Delaware Medicaid Dental Program and the Division of Public Health have made significant efforts in the last four years to promote age 1 dental visits. All of the Medicaid dental provider offices were contacted to explain this mission and seek cooperation from the dental community. Many general dental provider practices agreed to see children age one and above. The immediate goal was for a general dentist to complete an examination and refer to a pediatric dental provider if the infant needed specialized care.

The intent of this outreach was to assure access for members because educational

materials were being sent by DPH as part of its First Smile Delaware. Medicaid sends out materials to every enrolled member with children instructing them to see a dentist by age one. It provides oral health guidance for infants, toddlers and children with the dental provider link or list.

The focus had not included assisting Medical providers with fluoride varnish as reimbursement of physicians for fluoride varnish was not approved until recently. The Division of Public Health is planning to provide a promotion and training program with Nemours Foundation for the medical community regarding fluoride varnish applications. If a parent neglects taking the child to the dentist, a fluoride varnish application from the primary provider will assist in providing some protection to the teeth. This campaign also encourages medical providers to prescribe fluoride supplements to children who are fluoride deficient. Medicaid Medical providers are required to provide educational information about oral health. Guidance was given where to get free dental educational materials.

As of January 1, 2016, Medicaid is requiring the Managed Care Organizations to provide promotion, outreach and training for physicians. Furthermore, it appears that physicians will have to provide the fluoride varnish and evaluation with referrals as a matter of their contract with the MCO. Medical Plans have also been doing dental outreach because they understand the fiscal impact of neglected oral health.

Barriers to be addressed in order for these efforts to be successful:

- a) Inadequate number of pediatric dental providers to accommodate all children referred from primary care providers.
- b) Inadequate training of general dentists and dental hygienists to see children at age one or before.
- c) Inadequate training for office staff. If a provider has indicated they accept Medicaid or children age 1, but when the member contacts the office they are told to wait until the child turns age 3, the guardian will likely not try to contact a dentist again until the child is in pain.
- d) Inadequate training for primary care physicians and nurses to be comfortable with the application of fluoride varnish; providing families with educational materials and referral sources to dental providers that will see the child; and following-up with families at the next well child visit.
- e) Lack of coordination within the health care community to make dental providers feel part of the overall health of an individual. Having physicians refer to dentist is a great way to start the dialog and provide early child hood oral health education. However, dental providers should inquire about their medical health and refer to a medical provider if they feel the member would benefit. Reinforcement for medical and dental on both sides makes the message more consistent, reinforces the importance of overall health, and provides better outcomes.

Promotion of and support of training programs and a physician referral network by the DOHC Board with its various partners is important and could be part of the Action Groups' next steps. The application of Fluoride Varnish by physicians is a measure

included on the Delaware Center for Health Innovation (DCHI) scorecard, and DCHI funding might be available for the training and physician referral network. The DOHC board could collaborate with various stakeholders to promote these programs to the DCHI for additional support.

f. Unified Information Campaign for Parents

For current activities and discussion regarding the “Unified information campaign for parents,” see discussion of Unified Message strategy #3 below, including the current 2012 “The First Smile Delaware Campaign.”

Board Recommendations to Consider:

Promote the integration of oral health into primary care practices.

- Support modifications to the Medicaid reimbursement policy that would allow for physicians and dentists to apply two applications of fluoride varnish annually by the dentist and the physician.
- Support payment to FQHCs for the application of fluoride varnish that is equivalent to payment to private physicians.
- Promote the use of the Delaware First Smile messages and grassroots network for children.

2. Oral health care coverage available to all Delawareans on Medicaid

- Stakeholder Engagement disseminating existing resources
- Policy changes to include oral health in Medicaid coverage for eligible adults through SIM/DCHI framework

The affiliation of DOHC with DPH does not permit the DOHC to actively advocate for legislation that is not supported by the Governor’s Recommended Budget. However, the DOHC can provide education for its members that does not represent advocacy.

Poor oral health among U.S. adults, especially vulnerable populations, costs the U.S. health care system hundreds of millions of dollars per year through avoidable oral health-related visits to the emergency department. However, oral health is oftentimes left out of efforts to meet the Triple Aim: enhancing population health, improving patient care, and containing per-capita costs. To address the issue, the following strategies were suggested for incorporating oral health into patient-centered medical homes, accountable care activities, and comprehensive reform efforts: covering adult dental services in Medicaid; building connections between oral health care and medical care in service delivery, professional education, and licensing; and incorporating oral health into health reform efforts. Refer to a document titled ‘Oral Health and the Triple Aim’ for more details (Appendix 2, Oral Health and the Triple Aim, Evidence and Strategies to Improve Care and Reduce Costs, NASHP 2015, [NASHP Oral-Triple-Aim](#)). Another attached document titled ‘Medicaid Coverage of Dental Benefits for Adults’ provides an overview of adult dental benefits in Medicaid by state, as of February 2015 (Appendix 3, [Medicaid Coverage of Dental Benefits for Adults, MACPAC 2015](#)).

For policy lessons and themes from seven states that expanded adult dental benefits in Medicaid, refer to the attached policy brief titled ‘Adult Dental Benefits in Medicaid: Recent experiences

from Seven States’ (Appendix 4, [Adult Dental Benefits in Medicaid, Recent Experiences from 7 States, NASHP 2015](#))

The Institute of Healthcare Improvement (IHI) recommends rates of unmet dental needs in measuring experience of care. However, given the significant impact of poor oral health on one’s general health and the U.S. health care system, access to oral health such as having a usual source of oral health and access to preventive care should be measured as well. DOHC may release a brief that can include the necessity of Medicaid adult dental benefits, the current status of the Medicaid adult dental benefits, other states’ experiences, or the fiscal cost and benefits. This brief can be submitted to the DCHI for its review.

Board Recommendations to Consider:

- Promote issue to DCHI Board for its consideration to develop a comprehensive review of the cost and financing of dental care for adults who do not have dental insurance.
- Educate stakeholders about the importance of oral health for general health.

3. Standard and unified message on Oral Health

- Develop a united message for all stakeholders to use
- All stakeholders understand and deliver unified message

One of the goals identified at the DOHC annual meeting was to “develop a united message for all stakeholders to use.” Messaging to parents about children’s oral health has previously been developed and is included in the *First Smile Delaware* Resource Guide. Current plans and initiatives in Delaware that should be considered in relationship to delivering a standard and unified message on dental health are *First Smile Delaware* and the Delaware Oral Health Plan.

In 2012 Delaware Division of Public Health launched *First Smile Delaware*, a campaign aimed at improving oral health literacy and behaviors throughout the state. *First Smile Delaware* includes resources for both parents and providers. The main goals of the campaign are to: Raise the profile of oral health issues throughout the state of Delaware; Decrease the prevalence of dental disease within the state, particularly among children; and Motivate health care providers and key influencers to place a greater value upon oral health issues and initiatives.

Messaging to parents about children’s oral health has previously been developed and is included in the *First Smile Delaware* Resource Guide. Through the *First Smile Delaware* website parents can search for a family or pediatric dentist. In addition, *First Smile Delaware*’s 12-page Resource Guide lists dental health clinics including eligibility information, lists pediatric dental offices in Delaware that accept Medicaid, and includes important messaging about promoting dental health in children (See Appendix 5, [Delaware Oral Health Resource Guide](#)).

In the 2014 Delaware Oral Health Plan, goal #1 is to “increase the awareness of the importance of oral health to general health across all sectors of the Delaware population, to build both systems and individual behavioral change.” This goal includes two recommended actions. First, increase the oral health literacy of all Delaware residents. Second, utilize proven strategies to achieve behavior change to support improved oral health. DPH has developed an Oral Health

Literacy Plan for adults that includes messaging and a tool kit for stakeholders to use in their organization. This plan includes a grassroots strategy to promote oral health behaviors and access to regular dental care. Future efforts of the DOHC Oral Health Literacy Work Group should align with these existing initiatives.

Board Recommendations to Consider:

- Promote the usage of the Oral Health Literacy plan for adults to DOHC stakeholders and partners.
- Create and execute a grassroots campaign to promote oral health for policymakers, stakeholders, and consumers of health care.

Plan for Next Steps:

Next steps include:

- Approval of the three priority objectives by the DOHC Board.
- Creation of a 2-3 month meeting schedule by Action Group Chairs with assistance from the Central Operations Group to complete Action Plans.
- Develop dashboard for posted minutes and project plans.
- Promotion of the action plans to DOHC members and identified stakeholders.

Appendices Summary and Key Findings

Appendix 2. Oral Health and the Triple Aim, Evidence and Strategies to Improve Care and Reduce Costs ([NASHP Oral-Triple-Aim](#))

Poor oral health among the U.S. adults, especially vulnerable populations, costs the U.S. health care system hundreds of millions of dollars per year through avoidable oral health-related visit to the emergency department. However, oral health is oftentimes left out in efforts to meet the Triple Aim – enhancing population health, improving patient care, and containing per-capita costs. To address the issue, the following strategies were suggested for incorporating oral health into patient-centered medical homes, accountable care activities, and comprehensive reform efforts: covering adult dental services in Medicaid; building connections between oral health care and medical care in service delivery, professional education, and licensing; and incorporating oral health into health reform efforts.

This brief describes research on oral-systemic linkages, state-level experiences with incorporating oral health into reform strategies, and promising local examples. It will also describe next steps for states wishing to incorporate an oral health strategy into their reform efforts.

Appendix 3. [Medicaid Coverage of Dental Benefits for Adults](#)

‘Medicaid Coverage of Dental Benefits for Adults’ provides an overview of adult dental benefits in Medicaid by state, *as of February 2015*.

Key Points

- Medicaid programs are required to cover dental services for children and youth under age 21 but there are no minimum coverage requirements for adults. As a result, adult dental benefits vary widely across states. For example, as of February 2015:
 - 19 states provided emergency-only adult dental benefits for non-pregnant, non-disabled adults;
 - 27 states covered preventive services;
 - 26 states covered restorative services;
 - 19 states covered periodontal services;
 - 25 states covered dentures;
 - 25 states covered oral surgery;
 - 2 states covered orthodontia; and
 - 9 states placed an annual dollar limit on covered dental services.
- States change Medicaid coverage of adult dental benefits on a regular basis, cutting benefits when budgets are tight and expanding them when more funds are available.
- Initiatives to improve access to dental services include using mobile clinics and telehealth technologies, increasing the number of providers serving Medicaid enrollees, and funding demonstrations to encourage Medicaid enrollees to increase dental utilization. For example:
 - In 2014, the Health Resources and Services Administration supported 238 school-based health center oral health activities through capital grants.

- The National Health Service Corps and some states offer student loan repayment assistance to dentists who commit to working in high-need, underserved, or rural areas.
- Minnesota and Alaska have amended state scope-of-practice laws to allow mid-level dental practitioners to provide dental services.

In this document, see also [TABLE 2-1](#). Types of Adult Dental Services Covered for Non-Pregnant, Non-Disabled Adults under Medicaid, 2015 and [TABLE 2-2](#). Medicaid Dental Benefits for Non-Pregnant, Non-Disabled Adults by State, as of *February 2015*.

Efforts to Improve Access to Dental Services

Like other forms of health coverage, dental coverage increases access to care, and most low-income adults with dental coverage receive their coverage through Medicaid. Federal law does not mandate dental coverage for adult Medicaid beneficiaries, so despite the strong link between oral health and physical health and the significant burden of oral disease among low socioeconomic groups, state Medicaid programs vary considerably in the dental services they offer adults. Even within states, Medicaid dental benefits can vary from one year to the next, making it difficult for beneficiaries and their providers to know what services are covered. Variability in covered services can affect continuity of care for some patients, potentially resulting in lost opportunities for prevention and early treatment.

Providers, advocates, researchers, and others have worked on multiple ways to improve access to dental health services for adult enrollees of Medicaid. Examples of innovative projects include the following:

- Bringing dental care into the community through coordination between the Health Resources and Services Administration and community health centers.
- Funding demonstration projects to study innovative ways to improve Medicaid enrollee use of preventive dental care.
- Expanding access in dental shortage areas through the use of technology.
- Expanding the number of dentists serving Medicaid enrollees through provider incentives.
- Expanding the number of dentists providing services to Medicaid enrollees through loan repayment models.
- Amending state scope-of-practice laws to allow for additional members of the dental health team.

Appendix 4. [Adult Dental Benefits in Medicaid, Recent Experiences from 7 States](#)

This policy brief summarizes policy lessons and themes about why seven states—California, Colorado, Illinois, Iowa, Massachusetts, Virginia, and Washington—have taken action to add, reinstate, or enhance their Medicaid adult dental benefit and how they are implementing it.

Key Findings

- There is growing recognition of the importance of oral health as it relates to overall health—including pregnancy, avoidable emergency room utilization, and chronic conditions such as diabetes and heart disease—as well as employability. These data points, as well as personal

experiences with individuals who cannot access routine dental care, resonated with key state decision-makers.

- Policymakers generally support providing adult dental benefits to Medicaid enrollees, but prioritizing spending on the benefit can be challenging, given the need of states to balance limited resources with many competing priorities.
- Engagement by high-level state policymakers, including legislative leaders, governors' staff, and Medicaid agency leadership, along with active legislative outreach by dental associations and oral health coalitions is important to raise the profile of the issue.
- In many states, enhancements are progressing incrementally. In some states the benefit is being extended only to certain groups of enrollees such as pregnant women or the Medicaid expansion population. In other states the benefit is capped with a dollar limit.
- Many states expanding their adult dental benefit have done so by building on improvements made to their children's dental coverage programs over the last decade. This includes leveraging existing contractual relationships, provider networks, and care coordination efforts.
- States' decisions on adult dental coverage were affected by their broader work on implementing health reform. Enhanced federal funding through the Affordable Care Act's Medicaid expansion motivated action in several states. Some states are also beginning to consider how dental services may fit into payment and delivery system reform efforts such as the State Innovation Models Initiative.

Table. Actions Taken on Adult Dental Benefits in Seven States

State	Legislative or Administrative Vehicle	Date Implemented	Benefits and Populations Covered
California	State budget, AB 82 (2013)	May 2014	Reinstated most benefits for all Medicaid-enrolled adults, with \$1,800 annual “soft cap” that can be exceeded when medical necessity is proven. Additional services covered for pregnant women.
Colorado	SB 242 (2013)	April 2014	Introduced benefits for all Medicaid-enrolled adults, with \$1,000 annual cap. Dentures are exempt from the cap.
Illinois	State budget, SB 741 (2014)	July 2014	Reinstated benefits for all Medicaid-enrolled adults. Additional preventive services covered for pregnant women. (Gov. Rauner’s proposed FY2015 budget would cut the rates paid for adult dental services.)
Iowa	Section 1115 Medicaid waiver	May 2014	Introduced “earned benefit” to Medicaid expansion population; individuals who establish a regular source of care qualify for more expansive benefits.
Massachusetts	Annual state budgets	January 2013 March 2014 May 2015	Reinstated services for all adults incrementally – first fillings for front teeth, then all fillings, then dentures. Additional services covered for persons determined eligible through the Department of Developmental Services.
Virginia	Governor’s Healthy Virginia plan (2014)	March 2015	Introduced dental benefit for adult pregnant women over age 21.
Washington	FY 2013-2015 biennial operating budget	January 2014	Reinstated extensive benefits for all Medicaid-enrolled adults.

Appendix 6. [Medicaid Adult Dental Benefits: An Overview, Fact Sheet, October 2015](#)

The Affordable Care Act provides new opportunities for states to leverage federal dollars and extend dental access to low-income adults through Medicaid expansion. A state can offer a dental benefits package to its expansion population that is either the same or different than what is provided to its base Medicaid population. Dental benefits covered by state Medicaid programs typically fall into three general categories:

- **Emergency Only:** Relief of pain under defined emergency situations.
- **Limited:** Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure for care is \$1,000 or less.

- **Extensive:** A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least \$1,000.

Nearly all states (46) and the District of Columbia offer some dental benefit to their base adult Medicaid population. Thirty-three states cover services beyond defined emergency situations (e.g., uncontrolled bleeding, traumatic injury), and among those, 15 offer extensive services. The majority of states currently expanding Medicaid — 29 out of 31 — plan to offer the same dental benefits package to both their base and expansion populations.

Table. State Medicaid Coverage of Adult Dental Benefits by Type of Beneficiary Population (Base or Expansion)

Dental Benefits Category	New Offered to Medicaid Base Population	Offered to Medicaid Expansion Population
No Dental Benefits	4 states: AL, AZ , DE , TN	4 states: AZ, DE, MT, ND
Emergency-Only	14 states: FL, GA, HI , ID, ME, MD , MS, MO, NV , NH , OK, TX, UT, WV	5 states: HI, MD, NV, NH, WV
Limited	18 states: AR , CO , DC , IL , IN , KS, KY , LA, MI , MN , MT , NE, PA , SC, SD, VT , VA, WY	10 states: AR, CO, DC, IL, IN, KY, MI, MN, PA, VT
Extensive	15 states: AK , CA, CT, IA , MA, NJ , NM , NY , NC, ND , OH, OR , RI , WA, WI	12 states: AK, CA, CT, IA, MA, NJ, NM, NY, OH, OR, RI, WA

Notes: Bolded states have decided to expand Medicaid eligibility under the ACA. DC is included as a state. Montana and North Dakota offer different categories of benefits to their Medicaid base vs. expansion populations. Idaho offers limited Medicaid dental benefits beyond emergency care to pregnant woman and adults with disabilities and/or other special health care needs. Maryland's contracted managed care organizations provide a limited dental benefit to adult Medicaid beneficiaries who are enrolled in managed care.

State Strategies to Increase Dental Coverage and Access for Adults

States are engaging in a variety of strategies to promote adult coverage and access to oral health care. These include tailoring oral health literacy campaigns to educate eligible adults about coverage options; developing coalitions of likeminded partners to build political support; and expanding the dental workforce to include mid-level providers such as dental therapists, who can be trained and licensed to perform preventive care and routine restorative procedures.

Appendix 7. [Engaging Stakeholders to Improve Dental Coverage and Access for Medicaid-Enrolled Adults](#)

Although comprehensive dental coverage is required for children served by Medicaid, dental benefits are optional for adults, leaving a vulnerable gap in benefits for much-needed services.

By engaging relevant stakeholders, states and other organizations with a vested interest can improve dental service access—a critical step for improving the oral health of this population. This brief describes a stakeholder engagement approach that states and organizations committed to improving oral health can use to improve dental coverage and access for low-income adults. It also describes key steps that states and other oral health organizations can take to engage stakeholders in advancing oral health improvement goals— moving beyond what one organization can achieve on its own.

Stakeholders in the adult oral health arena include:

- State Medicaid agencies and dental plans/payers;
- Oral health, primary care, and dental safety-net providers and their professional associations;
- Oral health coalitions, foundations, and patient advocacy groups;
- Hospitals and dental schools;
- Recipients of services and their family members or caregivers; and
- State and local policymakers.

Stakeholder engagement is the process by which organizations communicate with and involve other entities and individuals with a shared interest in an issue to identify and work toward common goals. By focusing on mutually defined objectives, establishing continuous open communication, and coordinating efforts, organizations can build the consensus needed to address challenges.

The Role of Stakeholder Engagement in Adult Oral Health Improvement

Many of the barriers impeding adults’ access to oral health care are deeply rooted and difficult to overcome, calling for the coordinated efforts of various stakeholders to effect change. Stakeholder participation can increase public awareness, support the planning and implementation of improvement strategies, and help to ensure that efforts are effective and sustainable.

Stakeholder engagement in the Medicaid oral health arena can help to:

- Mobilize resources and capabilities
- Garner cross-sector perspectives
- Highlight the importance of oral health
- Prioritize areas for improvement
- Align and increase the “signal strength” of messages

Steps to Effective Stakeholder Engagement

Actively engaging stakeholders is a continuous process through which an organization can work toward its overall oral health vision. A formal, systematic stakeholder engagement approach can help ensure alignment between this vision and the efforts undertaken to achieve it. Key steps of a stakeholder engagement process are as follows:

1. Assess engagement history, capacity, and potential.
2. Define the engagement objectives, scope, and outputs.
3. Identify stakeholders.
4. Analyze identified stakeholders.

5. Select engagement strategies.
6. Engage with stakeholders and communicate activities.
7. Evaluate and report on the engagement.