Our result:

All Florida children, youth and families have good oral health and well-being, especially those that are vulnerable.
# Table of Contents

Acknowledgements.................................................................................................................................Page 3

Background and Call to Action..................................................................................................................Page 4

Story Behind the Baseline.........................................................................................................................Page 7

Partners.....................................................................................................................................................Page 17

What Works ..............................................................................................................................................Page 18

Headline Indicator 1: Percentage of Medicaid-eligible Children 0–20 who received any dental service

Headline Indicator 2: Percentage of Medicaid-eligible Children 1–20 who received any preventive dental service

Indicator Baselines .......................................................................................................................................Page 25

Story Behind the Curve ............................................................................................................................Page 28

What works? .............................................................................................................................................Page 30

Results-Based Accountability for Collective Impact................................................................................Page 40

Resources..................................................................................................................................................Page 43

Endnotes ....................................................................................................................................................Page 44
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Background: The oral health of Florida’s vulnerable children

The Pew Charitable Trust’s June 2013 children’s dental report entitled, In Search of Dental Care: Two Types of Dentist Shortages Limit Children’s Access to Care, ranked Florida first among all 50 states as having the highest percentage of children covered by Medicaid who did not see a dentist in 2011 – 75.5%, over 20 points higher than the national average.¹ In addition to the Pew report, Florida Medicaid reported that in 2011 only 23% of children eligible for Medicaid received any dental care with just 14% receiving preventive care. In 2015, 35% of Florida’s Medicaid eligible children received any dental services and 33% received preventive dental care. Although this shows considerable improvement over four years, Florida’s outcomes still fall behind the 2015 national average: 47% of Medicaid-eligible children in the United States received any dental service (as supervised by a dentist) and 45% received preventive dental care nationally.²

Florida’s children experience a high level of tooth decay. The August 2016 Florida Department of Health Burden of Oral Disease Surveillance Report stated that a 2014-2015 oral health survey of 26 Head Start (HS) centers across Florida found an estimated 17.8% of HS children with early childhood caries, 20.9% with untreated decay. 17.3% of these children needed early care and 4.6% needed urgent care. According to a 2013-2014 survey of third grade students from 41 Florida schools, 43.1% had caries experience, 23.4% had untreated caries, 18.3% needed early care and 4.9% needed urgent care. Overall, non-Hispanic Black children had the highest disease rates.³ Specifically, the rate of early childhood caries was highest among Hispanic children (21.1%). Non-Hispanic Black children had the highest rates of untreated decay (23.6%) and the highest rates of “need early care” (19.1%) and “need urgent care” (6.6%).⁴

In Florida, children’s oral health problems have generated significant health care spending. In 2014, $31,524,982 was spent on dental-related Emergency Department (ED) visits among children ages 0-20, representing 13.4% of total dental-related ED visit charges in the state.⁵ A new report published in the 2016 Journal of Public Health Dentistry cited that dental-related visits to the ED have increased each year between 2005 and 2014 from 104,642 to 163,900. Additionally, dental charges tripled during this period from $47.7 million to $193.4 million. Medicaid (38 percent) and self-pay (38 percent) made up the highest percentage of primary payors of dental-related ED visits in 2014.⁶

Call to action

The Florida Oral Health Alliance, a broad-based, multisector group of stakeholders, is issuing a call to action to improve access to and utilization of dental care for Florida’s most vulnerable children. As members of the Alliance, we pledge to leverage our influence, resources and ability to achieve collective impact in order to create statewide systems change. We will work together to facilitate, plan and implement strategies based on the needs of our most vulnerable children. Using a data-driven, results-based collaborative process, we, the Florida Oral Health Alliance, have designed this strategic oral health plan based on our state oral health environment. We will use CMS-416 data to track our progress. Incorporated into this plan is information provided by Florida’s Oral Health Consumer Advisory Council.
Our areas of focus include:

- Oral health education
- Barriers to dental care
- Increased funding for oral health
- Improved data collection

The result

In response to this crisis, in 2015, a cross-sector group of providers and academic, public health, philanthropic, state, community and corporate partners with an interest in children’s health formed the Florida Oral Health Alliance for the purpose of improving access to and utilization of dental care for Florida’s most vulnerable children. Convened and facilitated by the Florida Institute for Health Innovation, the Florida Oral Health Alliance (the Alliance) collaboratively crafted a result that states that “All Florida children, youth and families have good oral health and well-being, especially those that are vulnerable.” Using the framework of Results-Based Accountability™ (RBA), the Alliance employed Turn the Curve ™ thinking to develop this strategic plan for communities and stakeholders interested in increasing oral health equity and improving the oral health of vulnerable children.

Headline success indicators

To measure success toward our result, the Alliance chose the following indicators based on the best available data:

- The percentage of Medicaid-eligible children ages 0–20 who receive any dental service each year
- The percentage of Medicaid-eligible children ages 1–20 who receive any preventive dental service each year

This data is retrieved from the Center for Medicare and Medicaid Services’ (CMS) 416 report as provided by the state Medicaid agency, the Florida Agency for Health Care Administration (Florida Medicaid). “Any dental service” includes both preventive services like cleanings and sealants as well as restorative services such as cavity treatment. “Dental services” refers to services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state’s dental practice act.
Data development agenda:
At the beginning of the process (in May and July 2015), the Alliance began forming a data development agenda to include additional data that would help to track success toward our result. The data development agenda included:

- Number of children that receive unaccounted dental services (no claims)
- Number and types of services provided by CDT codes
- No show rates
- Other non-Medicaid (e.g. private, employee-sponsored) children and youth receiving preventive dental services
- Other non-Medicaid (e.g. private, employee-sponsored) children and youth receiving any dental services
- ICD-10 diagnostic data

The Florida Institute for Health Innovation report *Florida Pediatric Emergency Department Visits for Preventable Oral Health Conditions: 2012*, was originally referenced as a possible secondary indicator. In March 2016, the University of Florida published updated data to include Florida’s dental-related emergency department visits by patient county of residence, age and primary payer. [This updated data can be accessed here.](http://media.news.health.ufl.edu/misc/cod-oralhealth/docs/actionteams/data_collection/Dental_ED_Visits_ByCounty_CY2014.pdf) Because physician diagnoses alone may underestimate the frequency of ED encounters for dental conditions, the 2014 study’s operational definition of an ED visit due to a dental-related reason was based on the patient’s reported reason for seeking care (admitting diagnosis) or the physician’s primary diagnosis of the problem. The study defined the ED visit as being for a dental problem if the admitting diagnosis or primary diagnosis was coded as one of the following ICD-9-CM codes: 520 – 526.9, 528 – 528.9, 784.92, V52.3, V53.4, V58.5, or V72.2. These codes are identical to those used in a recent analysis of national ED data by the American Dental Association.¹

¹ For this report, all 2014 dental-related visits to Florida Emergency Departments (EDs) were coded for evaluation and management. Five current Procedural Terminology (CPT) codes accounted for more than 95% of the visits: 99281 (ED visit for the evaluation and management that includes problem-focused history, problem-focused examination, and straightforward medical decision-making; 9.4%); 99282 (ED visit that includes expanded problem-focused history, expanded problem-focused examination, and medical decision making of low complexity; 33.2%); 99283 (ED visit that includes expanded problem-focused history, expanded problem-focused examination, and medical decision making of moderate complexity; 44.4%); 99284 (ED visit that includes detailed history, detailed examination, and medical decision making of moderate complexity; 7.3%) and 99285 (ED visit that includes comprehensive history, comprehensive examination, and medical decision-making of high complexity; 0.9%). In addition, 29.5% of the patient visits were coded for at least one additional service or procedure during the visit. More than 560 unique CPT or Healthcare Common Procedure Coding System (HCPCS) codes were entered, although ten codes accounted for more than half of the services provided: five of those involved injection of local anesthesia or other substances (codes 96372, 96374, 64400, 64402, J1885). Other procedures in the top ten included drainage of abscesses (41800), providing prescription drugs (J8499), collection of venous blood (36415), urine pregnancy test (81025), or non-covered items or services (A9270).
Additional data accessed during the planning period includes Florida Medicaid’s Medical Managed Assistance (MMA) Dental Services Profile, a data visualization. The Dental Service Profile was designed to assess utilization of dental services for Florida Medicaid recipients enrolled in a managed care plan. Managed Medical Assistance program (MMA) enrollees were evaluated to determine if they received at least one dental service during the first year of MMA implementation, August 1, 2014 through July 31, 2015.

The data shows:

- High utilization percentages (45% – 55%) are similar to the national average of 60%
- Low utilization for two to three year olds
- High utilization in second and third graders
- Managed care profiles show how different plans serve different populations
- Need for data on special needs populations

The group stated that this data can be used in the following ways:

- Identify utilization differences by region and by county in order to target low utilization areas, race and ethnicity
- Examine higher performing areas and figure out what is working
- Target services toward parents of one to three year olds by integrating into maternal-child health programs

Also during the planning period, the American Dental Association’s Health Policy Institute (HPI) released The Oral Health Care System: A State-Level Analysis. Florida’s fact sheet revealed that only 30% of children with Medicaid coverage in Florida visited a dentist in the past 12 months in 2013 as compared to the national average of 48%. The percentage of dentists in Florida participating in Medicaid for child dental services in 2014 (30%) was also significantly lower than the national average (42%). In addition, the survey showed that oral health knowledge and attitudes differed among Florida residents based on income level. Low-income adult residents had an oral health status index of 8.5 out of 10, based on a scale of 1 being poor oral health and 10 being excellent oral health, compared to 6.6 for low-income adult residents. 51% of high-income adult Florida residents answered all of HPI’s 2015 oral health knowledge survey questions correctly compared to 43% of low-income residents. The Alliance used these new data sources to inform the plan’s story behind the baseline and strategy ideas.

**Story behind the baseline**

*Florida’s story behind children’s dental care access and utilization outcomes*

In order to design appropriate change strategies, the Alliance planning group developed a list of factors that both drive and restrict progress toward achievement of the result. From this extensive list (included below), the group prioritized six factors to be used as the impetus for strategy development.
These include:

1. There is a lack of understanding of the impact of community decisions and personal beliefs on oral health, the importance of preventive dental care and the value of oral health.
2. There is a lack of information regarding available dental services and how to access them.
3. There are available dental health services that are not being accessed.
4. Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage and benefits.
5. There is a lack of consistent collaboration from partners and stakeholders, including oral health understanding by legislators.
6. Services are not meeting the needs of the population, including special needs and children needing special procedures.
7. There is a lack of real time data that can identify which patients need dental care. Data is needed at the patient level.

We have explained each factor based on Florida’s current oral health landscape.

1. **There is a lack of understanding of the impact of community decisions and personal beliefs on oral health, the importance of preventive dental care and the value of oral health.**

Oral health education has not been integrated into all school districts and is not being discussed in many communities. School-based health education does not include oral health’s connection to overall health nor does it address how community decisions impact oral health (ex. community water fluoridation, food deserts). Parents have limited access to knowledge about how to achieve oral health. In general, groups educating communities are not exploring the importance of culture, race or ethnicity on communities’ perceptions of oral health.

To achieve oral health and prevent dental disease requires self-care, care of others, community programs, policies, laws and regulations and reimbursement structures that support evidence-based interventions and practices. Obtaining, understanding and using information to prevent oral diseases and promote oral health are essential parts of personal health maintenance; are the foundation of the skills and effectiveness of caregivers; and are imperative for policy makers in order to make effective decisions. Developing oral health knowledge includes acquiring and trusting information, skill development, grasping concepts and technique-intensive protocols, and applying them appropriately. Studies indicate that approximately 80% of dental disease falls within 25% of the population and primarily affects vulnerable populations including low income families. Individuals with less oral health knowledge are less likely to seek preventive dental care and more likely to utilize emergency care for oral health problems. Vulnerable populations lack political, social and economic power. Therefore, we feel that it is imperative to educate legislators, advocates and other change agents to increase their understanding of the importance of prevention and the value of oral health.
2. There is a lack of information regarding available dental services and how to access them.

Throughout the planning process, Alliance participants maintained that Medicaid beneficiaries, medical/dental providers and health and human services organizations lack information about comprehensive dental benefits for children available under the Medicaid program. This includes information regarding the broad range of Medicaid benefits, how to fully access these benefits through Medicaid managed care (including accessing transportation to dental appointments) and the availability and access to services for special populations (such as children with special needs or children from non-English-speaking families).

Alliance and Consumer Advisory Council discussions revealed that Medicaid beneficiaries and key stakeholders do not have the information needed to overcome barriers to dental care nor do they have information regarding grievances and appeal rights. Asset maps that list resources and available service locations have not been developed. In addition, direct service providers working with oral health consumers are not fully aware of how the dental care system works. This points to a need for an orientation that explains the Medicaid system and benefits. With the shift to Medicaid managed care, dental benefits vary from plan to plan. This causes confusion regarding CMS and Medicaid services, resulting in delays in obtaining dental services.

Several factors have contributed to this lack of information and to Florida’s poor access and utilization outcomes for vulnerable children. These include Florida’s switch from a Medicaid fee-for-service model to Medicaid managed care. Pursuant to a change in statute, in 2014, the Florida Agency for Health Care Administration (Florida Medicaid), implemented the statewide transition to managed care for most Medicaid recipients. The goal of this transition was to improve health outcomes using the strategies of care coordination and patient engagement, coupled with fiscal responsibility. Medicaid Managed Assistance (MMA) plans are required to provide comprehensive and integrated services including medical, dental and behavioral health care.

Contract requirements require them to perform a Performance Improvement Project to improve the use of preventive dental services by children, and there are contract benchmarks for preventive dental and treatment services. Some stakeholders assert that this shift has allowed for an increase in child eligibility and coverage. Others state that it has increased bureaucratic burden for providers.

3. There are available dental health services that are not being accessed.

Evidence points to numerous reasons that Medicaid enrollees choose not to use services when providers and coverage are available. Reasons include a lack of information regarding the benefits of dental treatment, long wait times and fear or distrust of available providers. A 2011 study by the Centers for Disease Control and Prevention (CDC) on dental care access among Hispanic and Latino groups found that those most likely to
underutilize dental services were poor or near poor, foreign-born or had lived in the U.S. for less than five years.viii

According to the Florida Oral Health Consumer Advisory Council, this underutilization of dental services can also be attributed to a lack of cultural competency among persons informing families about benefits and making appointments. This includes people working at insurance companies, the Medicaid agency and dental offices.

For example:
• People answering phones for insurance companies and Medicaid do not know the importance of oral health.
• Consumers are not aware of what is available to them (interpreters, transportation to appointments, etc.).
• Mandated/available services are not being communicated. For example, health plans are required by the state to find dental care for consumers “in a timely manner” which includes 30 days non-emergent and one to two days for urgent needs.

Furthermore, research shows that the use of untrained, unprofessional interpreters, such as family members, can lead to a substantially higher risk of medical errors and negative health outcomes. Since there are a shortage of oral health professionals within communities of color that share the same racial/ethnic background as the patients they serve, people of different racial and ethnic backgrounds often rely on their social referral system, avoiding healthcare professionals or insurance providers that perceivably lack the cultural competency to understand their distinct background. Additionally, racial and ethnic minorities with Limited English Proficiency (LEP) may refer to community social networks rather than oral health care experts when seeking medical advice. Improving the diversity and cultural competency of oral health professionals is essential to successfully addressing oral health needs in a growingly diverse population.ix

In 2016, HB5101 bill extended Florida KidCare coverage to lawfully-residing immigrant children, without a five-year waiting period, beginning on July 1, 2016. To date, these children were required to wait for five years before receiving any Florida KidCare benefits. This law change will provide additional enrollment opportunities into the Florida KidCare Program2, which includes health and dental benefits to children ages birth through 18 years old. This will increase the need for culturally and linguistically competent workers.

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2 Florida KidCare is the State of Florida’s high-quality, low-cost health insurance for children. The program was created through Title XXI of the Social Security Act and reauthorized in 2009. Through its four partners, including Florida Healthy Kids, the program covers children from birth through age 18.
In addition, available school-based oral health services are not being accessed because of a lack of enforcement and a low consent form return rate. In Florida, dental exams are not required for school entry. However, included on the School Entry Health Examination form it is recommended that a parent obtain a comprehensive dental exam for their child. The form provides a place for the dentist to record the finding of this exam. Florida law in section 1003.22 F.S. and section 6A-6.024 FAC requires any child who is entering a Florida school for the first time to present proof of a health examination. The exam must include a review of all body systems performed by a licensed medical provider within 12 months prior to enrollment. It is recommended that children receive a comprehensive dental exam by a dentist, but the law also requires a “gross” dental exam by a medical provider. However, this requirement is for a “gross dental exam” is not being enforced.

The Alliance planning group researched the use of “opt-out” consent for in-school dental services. The group learned that dental services and screenings are viewed as “invasive procedures” and therefore they do not qualify for inclusion on an “opt out” form like the consent process used for physical health screenings. Section 381.0056, F.S., which is the Florida law regarding the provision of school health services, requires an active consent for invasive procedures. Since these diagnostic and preventive procedures include placing a mirror or placing materials such as sealants in the mouth, Florida considers these procedures invasive and thus requires active consent. Therefore, dental care and screening require that parents “opt in” in order for their children to receive in-school dental services.

4. Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage and benefits.

According to the American Dental Association Health Policy Institute’s October 2014 Research Brief, A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services, there exists a positive relationship between Medicaid fee-for-service (FFS) reimbursement rates and utilization of dental care among publicly insured children as well as dentist participation in Medicaid. Low Medicaid FFS reimbursement is a major factor in influencing the success of Medicaid programs. Therefore, a nationwide trend in declining reimbursement rates poses a serious concern for the ability for states to offer accessible dental care services.

Thirty-nine states including Florida experienced a decline in the Medicaid-to-commercial-dental insurance fee ratio for pediatric dental services between 2003 and 2013. In 2003, Florida ranked among the top two states with the lowest Medicaid FFS reimbursement as a percentage of commercial dental insurance charges for pediatric dental care services (36.7%) and among the top 8 in 2013 (36.6%), as shown below. Florida’s reimbursement rates were significantly lower than the national average of 57.4% in 2003 and 48.8% in 2013.

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3 Students in grades kindergarten through 12th grade who are making their initial entry into a Florida school must present a record of a physical examination completed within the past 12 months. The exam record should be taken to the child’s school upon enrollment. This operates according to Florida Statute (s. 1003.22(1), F.S.). Although a specific form is not required, it is recommended that Florida’s standardized School Entry Exam form (DH 3040-CHP-07-2013) be used to document completion of a physical examination. It must be completed by a health care provider licensed in the United States to perform physical examinations. For students transferring to a Florida school, a comparable form from another state would also be acceptable, if completed within 1 year.
Top 10 States with Lowest FSS Reimbursement Rates in 2003

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Top 10 States with Lowest FSS Reimbursement Rates in 2013

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Evidence shows states that have significantly reformed their Medicaid programs, including an increase in Medicaid dental reimbursement rates, including Connecticut, Maryland and Texas, have experienced an increase in dental care use for Medicaid eligible children. Beyond improving access to dental care, increasing dental care reimbursement rates also leads to a significant increase in provider participation. We believe that this will close the growing gap in dental care utilization between low-income and high-income patients.

In the state of Florida, legislative statute (466.023 subsection 3) states that a Registered Dental Hygienist (RDH) can provide fluoride-varnish and education in a health access setting. Health access settings include schools, community health centers and health departments and increase opportunity for preventive dental care at a lower reimbursement rate. The Florida Legislature has enacted legislation to encourage health care practitioners to provide their services in public schools in accordance with s. 381.0056, Florida Statutes (F.S.). This legislation, section 381.00593, F.S., the public school volunteer health care practitioner program, includes services by a dentist or dental hygienist licensed under chapter 466, F.S.

An Alliance subcommittee contacted the Department of Education and was advised that current Florida law, section 381.0056, F.S., requires the local health department and county school district to collaboratively develop an annual school health services plan. Each school health services plan describes local strategies and responsibilities for implementing activities that promote the health and well-being of students to support their academic success. Therefore, policies and procedures for school health services, which include dental services, are developed and implemented at the local county school district level. This process may be another avenue to pursue to include dental screening and services in Florida schools.

Florida has increased its funding for community water fluoridation. The Florida Department of Health and the state’s oral health coalition, Oral Health Florida, have been working with partners to promote an increase in community water fluoridation through federally-funded community education and support for fluoridated water systems. A cost-effective method for preventing tooth decay, community water fluoridation has been shown to reduce dental decay by 25% over a person’s lifetime (AFS: http://americanfluoridationsociety.org/faq-under-const/). The Florida Department of Health assists communities as they initiate and maintain systems to fluoridate public water systems, offering information and monitoring. In Florida, adjustment for fluoride levels is a local decision by each municipality or water system. In 2013, an estimated 81% of Florida's population on public water systems had access to fluoridated water. From 2015 – 2016, the municipalities of Lake City and Wellington, Florida, restarted community water fluoridation. Collier County and the municipalities Eustis, Inverness, Port Orange, Clearwater and Boynton Beach defended attempts to cease fluoridation.

5. There is a lack of consistent collaboration from partners and stakeholders, including oral health understanding by legislators.

In Florida, multiple statewide oral health plans exist but are not being fully implemented. Local oral health coalitions increase the likelihood of implementation. However, not all regions throughout the state have local oral health coalitions. The list of current local oral health coalitions is available online: http://oralhealthflorida.org/local-coalitions/.
Barriers to forming and sustaining coalitions include:

- **Participant time:** It is difficult to find time in addition to day jobs.
- **Participant cost:** Many coalitions require participants to pay for their own travel costs.
- **Participants from organizations outside of the traditional subject base (e.g., medical providers in a dental coalition) usually want a reciprocal commitment. Thus time and cost commitment can be much higher.**
- **Many different agendas:** Each participant may have a different reason to participate and presents challenges to collaboration.
- **Administrative costs and sustainability**
- **Implementation of strategic action plans requires time and effort.**

6. **Services are not meeting the needs of the population, including special needs and children needing special procedures.**

The majority of Florida dental care offices are closed during evenings and weekends, making it difficult for parents to schedule dental visits for their children. Special needs patients face additional barriers to dental care access. A large percentage of Florida dentists will not treat this population due to the dentists’ lack of training in treating special needs patients (including very young children) and a lack of enhanced payment through Medicaid. Federally Qualified Health Centers (FQHCs) receive an enhanced rate for Medicaid and accept walk-ins and sliding scale fees, but many families cannot afford the sliding scale.

Florida does not take full advantage of service delivery models such as teledentistry and mobile/portable equipment. With advances in technology, teledentistry could be used to divert unnecessary dental procedures in EDs. Teledentistry and mobile/portable programs can bring services to the population where they are clustered rather than have the individuals go to an office. In addition, Florida has recently formed a telehealth advisory committee to make recommendations intended to increase the use and accessibility of services provided via telehealth: [http://www.ahca.myflorida.com/SCHS/telehealth/](http://www.ahca.myflorida.com/SCHS/telehealth/).

7. **There is a lack of real time data that can identify which patients need dental care. Data is needed at the patient level.**

Alliance indicator data is published annually at the population level and includes the Medicaid population only. A lack of comprehensive and updated data presents a barrier to identifying high-risk groups and to planning for updated interventions based on current needs. The ability to access real time data would help to overcome these challenges by allowing oral health stakeholders to revise interventions based on immediate needs.

The Alliance has developed its own process for ensuring open communication and the sharing of updated data and resources among participants. Throughout the planning process, during each meeting, participants were invited to update the story behind the baseline based on real-time developments and present new data as it became available. This has allowed us to maintain a clear and accurate picture of the state oral health environment.
Major gaps in data in the dental profession remain a significant barrier. Insurance carriers pay claims based on medical necessity. It is the providers’ obligation to provide the carrier with the reason for medical necessity for the procedure. One of the biggest differences between a medical claim form and a dental claim form is the required reporting of diagnosis codes. The dental profession does not currently utilize diagnostic codes such as ICD-10. Dentistry only uses procedure codes such as CDT codes. Procedure codes by themselves cannot tell you if the procedure was necessary. A procedure code with a diagnostic code ties the procedure to a diagnosis and thus shows medical necessity. It also allows for better tracking of patient care.

Additionally, in Florida, data is not shared among competing health and dental plans. This lack of access to all data allows for waste in that patients can move from plan to plan and not be restricted to limitations on services that the Medicaid program dictates.

**Additional factors that contribute to Florida’s story**

In response to Florida’s low dental service utilization numbers, Florida Medicaid worked with the Centers for Medicare and Medicaid Services’ Oral Health Initiative to improve data collection, service delivery and the use of preventive dental services in Medicaid. This included the development of a State Oral Health Action Plan, known as the SOHAP.

In 2016, Florida Medicaid began SOHAP implementation to include a single, streamlined query for CMS-416 data collection to determine how to accurately capture Medicaid-eligible recipients across both the fee-for-service and managed care delivery systems. The CMS-416 report is an annual, federal report that captures state-level data on services provided to children in Medicaid. In addition, the state reviewed coding used to create the CMS-416 report, achieved agreement on the areas where updates were required and developed and programmed a single refined query. This has resulted in a more accurate report of children’s dental visits as reflected in our baseline.

Throughout our planning process, Florida Medicaid has informed the story behind the baseline by reporting their planning and implementation activities. See appendix for Florida Medicaid updates to their Performance Improvement Projects.

Also included in Florida’s story is a decade-long lawsuit between the Florida Chapter of the American Academy of Pediatrics and the Florida Academy of Pediatric Dentists versus the state Medicaid agency, Florida Department of Health and the Florida Department of Children and Families. The State and plaintiffs settled the case in Spring 2016, and the settlement included commitments to continued improvement in dental care. For dental care, this will result in increased communication between stakeholders and state agencies in order to improve access and utilization for Florida’s Medicaid-eligible children. The settlement states that Florida Medicaid “agrees to increase access to and utilization of pediatric dental services through a combination of the following: (1) studies of and enhancements to network adequacy requirements; (2) perpetuation of Florida’s state oral health action plan (through which AHCA is attempting to develop in-depth knowledge of the barriers
to the receipt of dental care to help target interventions; (3) increased development of performance improvement projects, through which AHCA requires MMA Plans to devote resources to improved utilization of preventive dental services; (4) intensive participation in oral health coalitions; and (5) increased outreach to communicate the availability of dental services to Medicaid children.”[i]

A positive factor worth mentioning is the development of Florida’s grassroots oral health networks. Over the last two years, community advocate groups in the Tampa Bay region and Miami-Dade County began building grassroots oral health networks to include individuals who have not traditionally been involved with oral health. Representatives from these networks have also informed the story behind the baseline with a fresh, person-centric perspective resulting in creative strategies that address the authentic needs of families. The Florida Institute for Health Innovation has formed an Oral Health Consumer Advisory Council comprised of individuals living and working at the grassroots level in Florida communities. The Council meets monthly and provides information about barriers to dental care to the Florida Alliance. This council has informed the Alliance planning process and their suggestions are included herein.
Partners with a role to play

To implement strategies from this plan, additional partners will need to be engaged.

Current Partners

Agency for Health Care Administration (Florida Medicaid)
Bower Lyman Center for the Medically Complex Child
Broward County Schools
Caridad Center
Catalyst Miami
Children’s Legal Services
Children’s Services Council of Broward County
Children’s Services Council of Palm Beach County
The Children’s Trust
Clear Impact
Dental Health and Wellness
DentaQuest (Florida)
Florida Association of Community Health Centers
Florida Agency for Health Care Administration (Florida Medicaid)
Florida CHAIN
Florida Community Health Worker Coalition
Florida Dental Association
Florida Department of Health in Broward County
Florida Department of Health Public Health Dental Program
Florida Department of Health in Palm Beach County
Florida Department of Health in Pinellas County
Florida Legal Services
Florida Healthy Kids
Health Care District of Palm Beach County
Health Choice Network
Jessie Trice Community Health Center, Inc.
Liberty Dental Plan
Miami-Dade College School of Health Sciences Dental Hygiene Program
Nova Southeastern University School of Dental Medicine
THE PLAYERS Center for Child Health at Wolfson Children’s Hospital
Premier Community Health Care Group - Pasco County
Project Link
Special Olympics Florida
Tampa Bay Healthcare Collaborative
United Way of Broward County

The Alliance identified the following organizations, entities and groups as potential partners who have a role to play in improving oral health access and utilization outcomes for children.
Potential Partners

Academic institutions		Legislature
Advocacy organizations		Medical health plans
American Academy of Pediatricians	Medical providers (Pediatricians, OB/GYN, nurses)
Catholic councils			Medical societies
Chamber of Commerce - Employers	Medikids
Community centers			NAACP
Community oral health consumers: Parents	Navigators
Department of Children and Families	Nonprofits
Faith-based organizations		Florida Academy of Pediatric Dentistry
Florida Academy of Pediatric Dentistry	Oral health coordinators (several sites)
Florida Area Health Education Centers	Pediatricians
Florida Association of Community Health Centers	Professional associations
Florida Association of Insurance Plans	Public health education campaigns (FDOH)
Florida College of Emergency Physicians	Regional, state or local medical societies
Florida Dental Hygiene Association	School-based oral health programs
Florida Department of Education	School boards
Florida Hospital Association	School nurses
Florida School Based Health Alliance	Sealant programs
Federally Qualified Health Centers	Social services
Grassroots organizations		Statewide and local oral health coalitions and entities
HMO/Insurance companies		Tribal councils
Human services providers/social services	United Way

What works

The planning group compiled a list of evidence-based interventions with links to source materials that can be referenced by communities when implementing the strategies in this plan. This is included on pages 18 - 24. It includes strategies and resources that have been used successfully in other states and in Florida.

School-based oral health services

In Florida, school-based dental sealant programs have been shown to be an effective oral health measure to reduce tooth decay in children, removing some of the barriers to preventive dental care for children from vulnerable populations. School-based sealant programs improve access to dental care through the detection of dental caries and increased referrals to appropriate dental care. Some in-school oral health programs include teeth cleanings, age-appropriate oral health instructions and the application of fluoride varnishes. Nationally, Florida ranks low for our percentage of Medicaid children
receiving dental sealants. In Florida, county health departments, federally qualified health centers, dental hygiene schools and local oral health coalitions provide in-school oral health services. In 2014, the Florida Department of Health began its initiative “Sealing Sunny Smiles Across Florida” to increase school-based sealant programs.

Another example of a successful Florida school oral health initiative is the collaboration between the Children’s Trust and Nova Southeastern University School of Dental Medicine: HealthConnect School-Based Oral Health and Smiles Across Miami, an oral health education program for school health and human service personnel. The Also successful, the “Seals on Wheels Mobile Dental Program” is a school-based sealant program sponsored by the Florida Department of Health in Miami-Dade County and the Health Foundation of South Florida. This mobile dental health program provides preventive dental care services to 2nd and 7th grade public school children in Miami-Dade County. Targeted schools have a high percentage of children receiving free and reduced meals and are located in a non-fluoridated area of Miami-Dade County. Dental services provided include oral screenings, oral hygiene instructions, teeth cleanings, prophylactics, fluoride varnish treatments, x-rays and sealants. AppleTree dental in Minnesota provides another best practice example of mobile/portable programs.

**Dental exam requirement for school entry**

The American Academy of Pediatric Dentistry (AAPD) and American Dental Association (ADA) recommend an oral health examination prior to matriculation into school may improve school readiness by providing a timely opportunity for diagnosis and treatment of oral conditions.

- Twelve states have adopted this practice.
- Georgia found that a strong determinant of compliance with the dental screening mandate was the presence of school nurses. Communities with strong school nurses may provide the necessary follow-up and/or screening when it is not available elsewhere.
- Pennsylvania: 28 PA Code 23.3(a)* states “Dental examinations shall be required on original entry into school and in grades three and seven.” Dental screenings have shifted from being school-based to 70% completion in private dental offices.

**Addressing barriers to oral health care**

The Health Foundation of South Florida’s Healthy Smiles Initiative is an oral health program that maximized community resources to increase coordination of preventive and curative services in early childhood. This initiative was a collaborative partnership that included the Children’s Trust, Health Foundation of South Florida, the DentaQuest Foundation, Borinquen Health Care Center, Community Health of South Florida and Miami-Dade County Community Action Agency Head Start. The Children’s Trust provided four dental stations and related equipment for this project to serve 2,400 children in Head Start centers throughout Miami-Dade County. Borinquen Health Care Center (Borinquen) and Community Health of South Florida (CHI) are Federally Qualified Health Centers (FQHCs) and anchors for the project, providing the dental exams and treatment. Restorative services were provided on-site or at the health center’s home dental clinics.

**Dental care benefit enrollment and community outreach**

**Insure Kids Now!** The Connecting Kids to Coverage National Campaign works nationally with outreach grantees and partners including government agencies, community organizations, health care providers, schools and others to reach children and teens who are eligible for Medicaid and the Children’s Health Insurance Program (CHIP), but are not enrolled. A vast collection of tools and messages, Insure Kids Now! includes a [toolkit for oral health](#) as well as flyers, posters for dentists, materials in other languages and social media messages around the “think teeth” campaign. These messages can help encourage families to enroll in dental coverage and secure care.
The Children’s Dental Health Project provides multiple resources on children’s oral health, including toolkits, policy brief reports, oral health fact sheets and policy change talking points.

Center for Medicare and Medicaid Services (CMS) Oral Health Initiative has a toolkit, tear pads, flyers and posters in multiple languages. They also have a library of archived trainings.

Reaching Ohio’s Ethnic Minority Children: Summary Report and Recommendations to Increase the Enrollment of Eligible Asian, African, and Latino Children in Medicaid and CHIP includes best practice examples to increase Medicaid enrollment of refugee children. It highlights the importance of peer messengers and trusted communicators.

Community Catalyst provides best practices for American Indian and Alaska Native Outreach and Enrollment Efforts.

New Guide: Using Schools to Reach Uninsured Families from the Center on Budget and Policy Priorities (CBPP) includes best practices on school-based outreach and enrollment.

Interprofessional oral health education Innovations in Oral Health Toolkit published by Northeastern University, Bouve College of Health Sciences, is a three-year interprofessional education program to prepare health professionals with team-based competencies to integrate oral health as an essential element of healthcare and promote the integration of oral health in primary care settings such as community health centers, school-based programs, and clinics.

Additional Florida initiatives that have worked to improve outcomes include: Premiere Healthcare’s Pasco County “ER diversion” referral program and Dental Health and Wellness’s primary care provider oral health education program.
**What do we propose to do?**

This strategic plan was created by the Florida Oral Health Alliance as a blueprint for communities and stakeholders who want to take action at state and local levels to improve the oral health of vulnerable children.

The Florida Alliance intends for this plan to be implemented in two ways:

- The Florida Oral Health Alliance plan will be disseminated widely to statewide oral health stakeholders. These stakeholders will be asked to convene regional groups to plan a collaborative approach to community-wide intervention and/or engage in specific strategies to improve oral health within their own organizations.

- Florida Oral Health Alliance partners will continue to convene and to engage in collaborative leadership work to implement specific strategies from the plan.

Alliance partners will form subcommittees based on focus areas to implement strategies at the state and local levels. Subcommittees will engage additional partners in the community who have a role to play in improving access to and utilization of dental care for vulnerable children. These self-facilitating and sustaining subcommittees will use data-driven decision-making to drive their work. Collaborative leadership and the collaborative decision-making process dictate that it is the group that will ultimately choose, craft and approve strategy implementation and indicators of success.

**Strategy ideas based on what works**

The strategy ideas in this plan are meant to be used by communities as suggestions for action. Communities should design action steps according to their particular needs and environments. Some strategies are best implemented at a local level while others require statewide collective action. Evidence-based examples can be found in the section entitled “what works.” Strategies that have been prioritized by the group are notated **.

Using RBA, the group rated each strategy idea according to its specificity, leverage, values and feasibility/reach.

- **Leverage**: How much difference will the proposed strategy/action make on results, indicators, and turning the curve?
- **Specificity**: Is the idea specific enough to be implemented?
- **Values**: Is it consistent with our community values?
- **Reach**: Is it feasible and affordable?

The Alliance suggests that implementation subcommittees be organized according to four focus areas. They include:

- Oral health education
- Barriers to dental care
- Increased funding for oral health
- Improved data collection
The strategy ideas include:

1. **Create and consistently implement oral health education and messaging in the community for parents and guardians regarding the importance of oral health prevention and how it relates to educational attainment.**  
   **Focus area – Oral Health Education**  
   Action steps:  
   a. Explore best practices for successful oral health campaigns (Ex: Children’s Dental Health Project).  
   b. Explore best practices for successful oral health education initiatives.  
   c. Identify what oral health messaging and education exists in Florida and nationally  
   d. Partner with schools in order to increase oral health education in schools.  
   e. Provide patient/consumer-education to include: 1) information about the importance of oral health 2) information regarding dental benefits and how to access services 3) information about how community decisions impact oral health 4) information to help share concerns and personal stories with policymakers.  
   f. Work with community residents to educate policymakers to increase their awareness of the importance of oral health, to encourage them to include oral health in policy and appropriations and to increase funding for oral health.

2. **Encourage and incentivize the provision of inter-professional education and training for medical and allied health professionals regarding oral health to include oral health screenings and risk assessment and placement of fluoride varnishes.**  
   **Focus area – Oral Health Education**  
   Action steps:  
   a. **Utilize online trainings including but not limited to the American Academy of Pediatrics, the University of Florida School of Dentistry, Nova Southeastern University School of Dental Medicine.**  
   b. Increase training in oral health education, screening and fluoride varnishes for nurses, nurse practitioners and physician’s assistants.

3. Develop Emergency Department diversion programs.  
   **Focus area – Barriers to Oral Health Care**  
   Action steps:  
   a. Link hospital emergency departments (ED) to appropriate dental services.  
   b. Use health plan and dental plan reports to identify Medicaid members who have had an ED visit for a dental related issue in order to prevent future utilization of ED for emergency dental services.  
   c. Provide a full time employee in the ED to provide a dental referral and appointment for patients to avoid repeat ED visits for oral health services.  
   d. Facilitate transportation for patients when needed.  
   e. Convene statewide workgroup to include state agencies (Florida Medicaid, medical and dental associations), Medicaid managed care plans, Florida Alliance of Health Plans and hospitals for the purpose of reviewing different models of ED diversion programs.

4. Increase outreach efforts by managed care plans to improve access to dental care by aligning with community stakeholders to maximize local resources. Stakeholders include hospitals, school districts,
academic and medical and allied health training institutions, health providers, state and county agencies, and various community groups such as charities, foundations and other non-for-profits.

**Focus area – Barriers to Oral Health Care**

**Action steps:**

a. Partner with managed care companies to leverage their outreach to increase oral health education in low utilization counties.

b. Increase family, caregiver and community knowledge of available services and how to access them by creating local “champions” within the education system, faith-based, community health organizations, technology and medical providers.

c. To implement, begin by focusing on counties with both a higher volume of Medicaid-eligible children and low utilization.

5. Utilize primary care/pediatric providers so that children can receive medical and dental treatment on the same day.

**Focus Area - Barriers to Oral Health Care**

**Action steps:**

a. Place dental hygienists in pediatricians’ offices to provide fluoride varnish and assist with dental referral and follow up.

b. Leverage dental schools to provide services in pediatricians’ offices.

c. Increase utilization among pediatricians, licensed social workers, WIC, Healthy Mothers programs.

6. Advocate for required oral health exams for school entry

**Focus area - Barriers to Oral Health Care**

**Action steps:**

a. Promote use of existing school health form to ensure oral health screening prior to school entry.

b. Investigate the current use of the school oral health exam form.

c. Research existing statutes and rules in other states that require mandatory oral health exams and screening.

d. Recommend the amendment of the existing school health forms to require oral health exam by a dentist prior to entry.

7. Expand school-based oral health programs through sharing best practices already in place.

**Focus area - Barriers to Oral Health Care**

**Action steps:**

a. Identify current school-based oral health programs.

b. Promote incentive programs to increase the rate of affirmative consent for the school-based oral health services.

8. Promote management of caries by using new prevention models in the dental delivery system.

**Focus area – Need for Increased Funding**

**Action steps:**

a. Investigate new prevention models such as use of silver diamine fluoride and teledentistry.

b. Share new models with different stakeholders to improve access to dental services.

c. Florida Medicaid change fee schedule to reallocate funds to incentivize prevention.

d. Investigate different reimbursement models in the dental delivery system (e.g. prevention-focused models).
9. Establish real time data collection systems to include sharing between plans, medical care, dental care and schools in order to assess needs and address barriers.

**Focus area – Improved Data Collection**

a. Modify the existing monthly summary of Medicaid Managed Care complaints, posted at [http://Florida Medicaid.myflorida.com/medicaid/statewide_mc/program_issues.shtml](http://Florida Medicaid.myflorida.com/medicaid/statewide_mc/program_issues.shtml) to include a separate section on children’s dental care complaints.

b. Request that Florida Medicaid prepare a monthly narrative summary of child dental complaints, which identifies plan, geographic location, specific type of problem (e.g. no provider or provider too far, appointment not timely, prior authorization problem, identification of services denied) and how the complaint was resolved. Share this information with the Alliance, Medicaid Managed Care plans, medical and dental schools and other interested parties.

c. Share dental histories among different managed care plans because patients change plans.
INDICATORS

HEADLINE INDICATORS

1) Percentage of Medicaid-eligible children receiving any dental service
2) Percentage of Medicaid-eligible children receiving any preventive dental service
Indicator baselines

Three in seven Florida children are covered by Medicaid at some point every year. The Medicaid program provides health insurance for 2.14 million Florida children (April 2016). We believe that substantial improvement in the provision of care to Florida’s Medicaid-eligible children is a formidable first step toward eradicating dental disease in Florida’s children.

Headline Indicator #1: Percentage of Medicaid-eligible Children 0 – 20 who received any dental service

About Headline Indicator #1:

This headline indicator was taken from national and state CMS-416 form. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services. Data for children ages 0-20 was retrieved for item 12a: CMS Total eligibles receiving any dental services between the years 2011-2015. For more information on form items: [http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf)
Headline Indicator #2: Percentage of Medicaid-eligible Children 1 – 20 who received any preventive dental service

About Headline Indicator #2:

Our headline indicator was taken from national and state CMS-416 form. Data for children ages 1-20 was retrieved for item 12b minus <1: CMS Total eligibles receiving any preventive dental services between the years 2011-2015. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services. Data for children ages 1-20 was retrieved for item 12a: CMS Total eligibles receiving any dental services. For more information on form items: [http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf)
Story Behind the Curve

Prioritized Factors:
1. There is a lack of understanding of importance of preventive care and value of oral health (parents and legislators).
2. There is a lack of information regarding available services and how to access them.
3. There are available dental health services that are not being accessed.
4. Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage and benefits.
5. There is a lack of consistent collaboration from partners and stakeholders, including oral health understanding by legislators.
6. Services are not meeting the needs of the population, including special needs and children needing special procedures.
7. There is a lack of real time data that can identify which patients need dental care. Data is needed at the patient level.

The prioritized factors above were taken from the following list of factors that are contributing to improvement and factors which are restricting improvement in our baseline.

Positive Factors Contributing to the Baseline:
1. Efforts on behalf of community organizations that focus on oral health
2. School-based services that provide oral care
3. FQHCs that focus on oral health while achieving oral health equity
4. An increase in efforts throughout Florida to improve access to dental care
5. Increase in awareness of the importance of oral health
6. Grassroots efforts directed at improving oral health
7. Florida Medicaid added an additional billing code so that health access settings can now bill Medicaid.
8. The state has recognized poor results in Florida as evidenced by a Florida Supreme Court ruling and settlement. Florida Medicaid has agreed to do the following to improve access and utilization of children’s dental care.
   - Studies of and enhancements to network adequacy requirements
   - Perpetuation of Florida’s state oral health action plan (through which AHCA is attempting to develop in-depth knowledge of the barriers to the receipt of dental care to help target interventions)
   - Increased development of performance improvement projects, through which AHCA requires MMA Plans to devote resources to improved utilization of preventive dental services
   - Intensive participation in oral health coalitions
   - Increased outreach to communicate the availability of dental services to Medicaid children.
9. HB5101 that “Extends Florida KidCare coverage to lawfully-residing immigrant children, without a five-year waiting period, beginning on July 1, 2016.”

Negative Factors Contributing to the Baseline
1. An exclusion of certain populations, primarily undocumented population in state
2. Insufficient data of Emergency Department visits for basic care that did not receive preventive services
3. An increase of local and community initiatives but not many statewide initiatives
4. A limited reimbursement system that pays for treatments but not for preventative services
5. Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage, and benefits
6. An ineffective and realistic oral health policy focus in the state
7. A lack of integration between physical medicine and oral health
8. Health education does not include how oral health connects to overall health
9. An isolated approach between private providers and public collaborative efforts
10. A lack of follow up case management systems for patients and members, continuation of care, and post-op
11. Inadequate number of providers in care network and access points
12. There is a lack of consistent collaboration and disparity from partners and stakeholders
13. Low or poor oral health literacy exists. There is a need to increase parental education and overall oral health literacy.
14. Available dental services are not being accessed
15. There is a need to work consistently and improve the data
16. Payment to dentists (fees) for preventative services is low which leads to a lack of quality providers
17. Limited pool of money for Medicaid that has to be used effectively and that has led to fraud
18. Lack of asset maps that capture known resources and services locations
19. Fragmented knowledge especially about advocacy and outreach
20. Competing priorities have reduced access to oral health care (example – competing priorities in schools, parents have competing priorities (life getting in the way) – have reduced ability for them to get access).
21. Dental office/clinic hours do not meet needs if closed during evenings and weekends
22. Some dentists will not treat special needs patients because the dentists 1) are not trained and 2) receive no enhanced payment for this through Medicaid. (FQHCs receive an enhanced rate for Medicaid and accept walk-ins and sliding scale fees, but many families cannot afford sliding scale).
23. Health plans are required by the state to find dental care for consumers “in a timely manner” which includes 30 days non-emergent and one to two days for urgent needs.
24. Stakeholders working with oral health consumers are in need of an orientation regarding the Medicaid system. Benefits vary from company to company.
25. Some parents are fearful of fluoride which is a part of in-school oral health services.
26. There is a lack of cultural competency among people working at insurance companies, Medicaid agency and dental offices who are informing people about benefits and making appointments.
27. People answering phones for insurance companies and Medicaid do not know the importance of oral health.
28. Consumers are not aware of what is available to them (interpreters, transportation to appointments, etc.).
29. Confusion exists over mandated requirements for the gross dental exam requirements and forms for health screenings for school entry.
30. Preventive care is not considered in some cultures.
31. Families are stressed and worrying about fulfilling basic needs such as food and housing, priorities that compete with oral health care.
32. According to the American Dental Association (ADA) Health Policy Institute, three major issues prevent Florida adults from seeking dental care: 1) cost, 2) fear and 3) inconvenience, location and time. 60% of Florida’s adults stated they do not see a dentist because of cost.
33. There is an intergenerational negative correlation between oral health difficulties and attitudes about oral health. Parents with low value or awareness of oral health do not prioritize their children’s visits.
34. A new article by the American Dental Association suggests that because hospital Emergency Departments are being reimbursed by Medicaid and other insurance for unnecessary dental services, the hospital has no incentive to divert these patients. The article states that hospitals want to divert non-paying patients, but not necessarily patients that pay or have some sort of coverage to pay for services.
**What works:**

The following ideas serve as a guide for people working at both state and local levels. We recommend that communities and stakeholders design and implement additional strategies and identify partners based on their needs, demographics and environments. Each idea addresses one of the prioritized factors included in the “story behind the data/baseline”. To assist with designing community-specific strategies, we have referenced the best and promising practices listed in the column entitled “what works”. In addition, we have noted strategy ideas prioritized by the Florida Oral Health Alliance planning team.

<table>
<thead>
<tr>
<th>Prioritized factor</th>
<th>Strategy ideas</th>
<th>What works: Evidence-based best practices</th>
<th>Partners with a role to play</th>
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</thead>
</table>
| Lack of understanding about the importance of preventive care (including legislators) | 1. Create and consistently implement oral health education and messaging in the community for parents and guardians regarding the importance of oral health prevention and how it relates to educational attainment. **Focus area — Oral Health Education**  
**Action steps:**  
a. Explore best practices for successful oral health campaigns (Ex: Children's Dental Health Project)  
b. Explore best practices for successful oral health education initiatives.  
c. Identify what oral health messaging and education exists in Florida and nationally  
d. Partner with schools in order to increase oral health education in schools  
e. Provide patient/consumer-education to include: 1) information about the importance of oral health 2) information regarding dental benefits and how to access services 3) information about how community decisions impact oral health | **Smiles Across Miami** is a local effort led by the Nova Southeastern University School of Dental Medicine and funded by the Children's Trust. This PowerPoint provides an overview of oral health challenges facing the U.S., the impact of oral health disease on children and the shortage of dental care providers in Florida. It also spotlights several initiatives to address oral health problems by increasing access to dental care for underserved communities.  
**Focus Area: Oral Health Education**  
**Focus Area: Barriers to Oral Health Care**  
**The Innovations in Oral Health Toolkit** offers instructions on how to incorporate a sustainable interprofessional oral health education program at your institution.  
**Smiles for Life** is an online program offering extensive educational resources for inter-professional training and CEUs with the goal of integrating oral health and primary care. | Nova Southeastern University School of Dental Medicine  
Children’s Dental Health Project  
Florida Dental Association  
Workforce Development  
Florida Chamber of Commerce  
Florida Department of Education  
Cell phone carriers  
School-based Health Alliances  
MORE Health  
Florida Association of Community Health Centers (FACHC)  
Make Healthy Happen  
Miami-Dade campaign Tampa Bay Healthcare Collaborative |
| Lack of understanding of importance of preventive care and value of oral health (parents and legislators) | 2. **Encourage and incentivize the provision of inter-professional education and training for medical and allied health professionals regarding oral health to include oral health screenings and risk assessment and placement of fluoride varnishes.**  
*Focus area – Oral Health Education*  
**Action steps:**  
   a. **Utilize online trainings including but not limited to the American Academy of Pediatrics, the University of Florida School of Dentistry, Nova Southeastern University School of Dental Medicine**  
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**Children’s Oral Health** offers oral health education and training for medical professionals in the form of online modules, training videos and quality improvement resources from The American Academy of Pediatrics (AAP). | Nova Southeastern University (model)  
Academic institutions  
Medical providers (pediatricians, OB/GYN, nurses)  
Allied health providers  
The Children’s Trust  
Children’s services councils  
Regional, state or local medical societies  
Medical health plans |
<table>
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<th>Services are not meeting the needs of the population</th>
<th>Lack of information regarding available services and how to access them</th>
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<tbody>
<tr>
<td>3. Develop Emergency Department diversion programs</td>
<td>4. Increase outreach efforts by managed care plans to improve access to dental care by aligning with community stakeholders to maximize local resources. Stakeholders include hospitals, school districts, academic and medical and allied health professions.</td>
</tr>
<tr>
<td>Focus area – Barriers to Oral Health Care</td>
<td>The National Network for Oral Health Access (NNOHA) provides resources and learning opportunities including training and networking events, aimed at strengthening the oral health safety-net system.</td>
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<tr>
<td>Action steps:</td>
<td>Local partners as identified by the community which may include:</td>
</tr>
<tr>
<td>a. Link hospital emergency departments (ED) to appropriate dental services.</td>
<td>Florida hospital associations</td>
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<tr>
<td>b. Use health plan and dental plan monitoring encounters (to identify Medicaid members who have had an ED visit for a dental related issue) in order to flag dental codes to prevent future utilization of ED for emergency dental services.</td>
<td>Medicaid Health plans</td>
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<tr>
<td>c. (Health and dental plans) make follow up calls to assist members with finding a dental provider.</td>
<td>Florida Dental Association</td>
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<tr>
<td>d. Provide a full time employee in the ED to provide a dental referral and appointment for patients to avoid repeat ED visits for oral health services.</td>
<td>Florida MEDICAID</td>
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<tr>
<td>e. Facilitate transportation for patients when needed</td>
<td>Florida Association of Community Health Centers (FACHC)</td>
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<tr>
<td>f. Convene statewide workgroup to include state agencies (Florida Medicaid, medical and dental associations), Medicaid managed care plans, Florida Alliance of Health Plans and hospitals for the purpose of reviewing different models of ED diversion programs.</td>
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<tr>
<td>The Association of State &amp; Territorial Dental Directors’ (ASTDD) webpage provides numerous best practice approaches around Emergency Department (ED) Referral Programs for Non-traumatic Dental Conditions.</td>
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<tr>
<td>In addition, the following ASTDD resource, Best Practice Approaches for State and Community Oral Health Programs, describes ED Referral Programs for Non-traumatic Dental Conditions as a best practice, assesses its effectiveness as a public health strategy, and uses examples to illustrate successful, innovative implementation.</td>
<td></td>
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<tr>
<td>Oral Health Matters, the DentaQuest online blog, provides expert advice and information on best practices in dental care.</td>
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<td>Action steps:</td>
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<tr>
<td></td>
<td>a. Partner with managed care companies to leverage their outreach to increase oral health education in low utilization counties.</td>
</tr>
<tr>
<td></td>
<td>b. Increase family, caregiver and community knowledge of available services and how to access them by creating local “champions” within the education system, faith-based, community health organizations, technology, and medical providers.</td>
</tr>
<tr>
<td></td>
<td>c. To implement, begin by focusing on counties with both a higher volume of Medicaid-eligible children and low utilization.</td>
</tr>
</tbody>
</table>

**Example materials:**

- **Workforce Innovation to Increase Access to Dental Care** is a webinar describing two types of newly developed dental team members (Community Dental Health Coordinators and Dental Therapists/Advanced Dental Therapists) and how they are utilized in health centers.

- **Access to Partnerships** highlights opportunities for utilizing allies to leverage resources and expertise toward a shared goal of increased oral health access.

In addition, visit: [http://www.nnoha.org/resources/5607-2/](http://www.nnoha.org/resources/5607-2/), for an archive of all past webinars and presentations.

**Heros**

- Hospitals
- Faith-based organizations
- Nonprofits

**Florida Association of Health Plans**

- Florida Medicaid
- American Academy of Pediatricians
- Florida Academy of Pediatric Dentistry
- Florida Dental Association
- Florida College of Emergency Physicians
- Medical Societies
- Florida Association of Community Health Centers (FACHC)
- United Way
- Florida Dental Hygiene Association
- Florida Area Health Education Centers
- Catholic councils
- NAACP
- Tribal councils
<table>
<thead>
<tr>
<th>Services are not meeting the needs of the population, including special needs and children needing special procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of understanding about the importance of preventive care (including legislators)</td>
</tr>
</tbody>
</table>
| **5. Utilize primary care and pediatric providers in order for children to receive medical and dental treatment in the same day.**

**Focus area - Barriers to Oral Health Care**

**Action steps:**

- Place dental hygienists in pediatricians’ offices to provide fluoride varnish and assist with dental referral and follow up.
- Leverage dental schools to provide services in pediatricians’ offices.
- Increase utilization among pediatricians, licensed social workers, WIC, Healthy Mothers programs.

**Policy on Mandatory School-entrance Oral Health Examinations** offers recommendations for school oral health exams from the American Academy of Pediatric Dentists (AAPD).

**Putting School Screenings in Context** is an article on the Children’s Dental Health Project’s blog, Teeth Matter, presenting information on the importance of dental screenings and their potential to address the immediate oral health needs of students.

**State Laws on Dental “Screening” for School-Aged Children** is a policy brief developed by the Children's Dental Health Project and the Association of State and Territorial Dental Directors summarizing state dental screening laws in 11 states and D.C.

**Integration of Oral Health into Primary Care Practice** is a report from The U.S. Health Resource Services Administration (HRSA) whose recommendations serve as guiding principles and provide a framework for the design of a competency-based, interprofessional practice model to integrate oral health and primary care.

**Premier Community HealthCare Group, Inc. in Pasco County** is leveraging the use of Electronic Medical Records (EMR) and integrating oral health screenings into wellness visits. They have integrated an oral health exam into the existing exam of head, ears, eyes, nose and throat to include the oral cavity and have added a section to the EMR to notate fluoride varnish. The MA, RN, ARNP are providing dental care treatment and billing for eligible services using the CPT code 99499 with modifier V07.31.

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| Florida Department of Health |
| Florida Department of Education |
| Florida Association of Counties |
| Florida Association of Community Health Centers |
| County Health Departments |
| Florida Dental Hygiene Association |
| Florida Dental Association |
**Lack of information regarding available services and how to access them**

There are available dental health services that are not being accessed.

<table>
<thead>
<tr>
<th>6. Advocate for required oral health exams for school entry</th>
<th>Sealing Sunny Smiles Across Florida provides an overview and lessons learned from the 2014 Florida Department of Health initiative aimed at increasing the number of children who receive dental sealants and promoting evidence-based prevention strategies to achieve optimal oral health for all Floridians.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus area - Barriers to Oral Health Care</strong></td>
<td><strong>School-based Dental Sealant Programs</strong> is a CDC resource offering best practices and recommendations for dental sealant programs.</td>
</tr>
<tr>
<td><strong>Action steps</strong></td>
<td>This <a href="#">ASTDD resource</a> also provides best practice approach reports for school-based dental sealant programs.</td>
</tr>
<tr>
<td>a. Promote use of existing school health form to ensure oral health screening prior to school entry.</td>
<td>The Florida Department of Health website offers additional information on the Sealing Sunny Smiles Across Florida initiative including the dental sealant FAQs and an infographic on ROI.</td>
</tr>
<tr>
<td>b. Investigate the current use of the school oral health exam form.</td>
<td>The following websites offer information on Florida mobile dental units and schedules:</td>
</tr>
<tr>
<td>c. Research existing statutes and rules that in other states that require mandatory oral health exams and screening.</td>
<td>- <a href="#">The Brevard Health Alliance</a></td>
</tr>
<tr>
<td>d. Recommend the amendment of the existing school health forms to require oral health exam by a dentist prior to entry.</td>
<td>- <a href="#">Healthcare Network of Southwest Florida</a></td>
</tr>
<tr>
<td></td>
<td>- <a href="#">Manatee County Rural Health Services</a></td>
</tr>
<tr>
<td></td>
<td>- <a href="#">Suncoast Community Health Centers</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Expand school-based oral health programs through sharing best practices already in place.</th>
<th>Florida Department of Health Florida Department of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus area - Barriers to Oral Health Care</strong></td>
<td>Florida Chapter of American Academy of Pediatrics (FL-AAP)</td>
</tr>
<tr>
<td><strong>Action steps</strong></td>
<td></td>
</tr>
<tr>
<td>a. Identify current school-based oral health programs.</td>
<td><strong>Sealing Sunny Smiles Across Florida</strong> provides an overview and lessons learned from the 2014 Florida Department of Health initiative aimed at increasing the number of children who receive dental sealants and promoting evidence-based prevention strategies to achieve optimal oral health for all Floridians.</td>
</tr>
<tr>
<td>b. Promote incentive programs to increase the rate of affirmative consent for the school-based oral health services.</td>
<td><strong>School-based Dental Sealant Programs</strong> is a CDC resource offering best practices and recommendations.</td>
</tr>
</tbody>
</table>

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This [ASTDD resource](https://www.astdd.org) also provides best practice approach reports for school-based dental sealant programs.

The [Florida Department of Health website](https://www.floridahealth.gov) offers additional information on the Sealing Sunny Smiles Across Florida initiative including the dental sealant FAQs and an infographic on ROI.

AD Henderson School in Boca Raton, Florida, implemented a successful strategy to increase consent form returns.

### Focus Area: Increased Funding for Oral Health

<table>
<thead>
<tr>
<th>Action steps</th>
<th>The following sites offer resources and information on value-based reimbursement and its impact on dental health care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Investigate new prevention models such as use of silver diamine fluoride and teledentistry.</td>
<td>- <a href="https://www.chc.org">The Role of Value-based Reimbursement in the Dental Safety Net: What CHC Dental Practices Should Know About Trends in Accountable Oral Healthcare</a></td>
</tr>
<tr>
<td>b. Share new models with different stakeholders to improve access to dental services.</td>
<td>- <a href="https://www.chc.org">Dental Care in Accountable Care Organizations: Insights from 5 Case Studies</a></td>
</tr>
<tr>
<td>c. Florida Medicaid change fee schedule to reallocate funds to incentivize prevention.</td>
<td></td>
</tr>
<tr>
<td>d. Investigate different reimbursement models in the dental delivery system (e.g. prevention-focused models).</td>
<td></td>
</tr>
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</table>

Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage, and benefits.

Managed care companies
Florida Dental Association
FLORIDA MEDICAID Health Choice Network

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Focus area – Need for Increased Funding

- **Promote management of caries by using new prevention models in the dental delivery system**

8. **Action steps**

   - a. Investigate new prevention models such as use of silver diamine fluoride and teledentistry.
   - b. Share new models with different stakeholders to improve access to dental services.
   - c. Florida Medicaid change fee schedule to reallocate funds to incentivize prevention.
   - d. Investigate different reimbursement models in the dental delivery system (e.g. prevention-focused models).
| Lack of information regarding available services and how to access them | Establish real time data collection systems to include sharing between plans, medical care, dental care and schools in order to assess needs and address barriers. **Focus area – Data Collection**  
- Modify the existing monthly summary of Medicaid Managed Care complaints, posted at [http://Florida Medicaid.myflorida.com/medicaid/statewide_mc/program_issues.shtml](http://Florida Medicaid.myflorida.com/medicaid/statewide_mc/program_issues.shtml) to include a separate section on children’s dental care complaints.  
- Request that Florida Medicaid prepare a monthly narrative summary of child dental complaints which identifies plan, geographic location, specific type of problem (e.g. no provider or provider too far, appointment not timely, prior authorization problem, identification of services denied) and how the complaint was resolved. Share this information with the Alliance, Medicaid managed care plans, medical and dental schools and other interested parties.  
- Share dental histories among different managed care plans because patients change plans. | Florida Department of Health  
Local oral health coalitions  
School districts |
### Partners

**Who are the partners that have a role to play to address the prioritized factors?**

The Florida Oral Health Alliance created an extensive list of groups that have a role to play in improving the oral health of Florida’s vulnerable children. In addition, they have described some of the ways that specific stakeholders can join this effort.

<table>
<thead>
<tr>
<th>Grassroots organizations</th>
<th>Faith-based organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Oral health consumers: Parents</td>
<td>Navigators</td>
</tr>
<tr>
<td>Advocacy organizations</td>
<td>Medikids</td>
</tr>
<tr>
<td>School boards</td>
<td>Special Olympics Florida</td>
</tr>
<tr>
<td>School nurses</td>
<td>Florida Department of Education</td>
</tr>
<tr>
<td>Community centers</td>
<td>Human services providers/social services</td>
</tr>
<tr>
<td>Public health education campaigns (FDOH)</td>
<td>WIC</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>Legislature</td>
</tr>
<tr>
<td>FQHCs</td>
<td>Social services</td>
</tr>
<tr>
<td>HMO/Insurance companies</td>
<td>Children’s Services Councils</td>
</tr>
<tr>
<td>Professional associations</td>
<td>Department of Children and Families</td>
</tr>
<tr>
<td>Florida Association of Insurance Plans</td>
<td>Nova Southeastern University</td>
</tr>
<tr>
<td>Florida School Based Health Alliance</td>
<td>Academic institutions</td>
</tr>
<tr>
<td>Medical health plans</td>
<td>Medical providers (Pediatricians, OB/GYN, nurses)</td>
</tr>
<tr>
<td>Florida Hospital Association</td>
<td>Florida Agency for Health Care Administration</td>
</tr>
<tr>
<td>The Children’s Trust</td>
<td>(FLORIDA MEDICAID)</td>
</tr>
<tr>
<td>Children’s services councils</td>
<td>Oral health coordinator (several sites)</td>
</tr>
<tr>
<td>Regional, state or local medical societies</td>
<td>American Academy of Pediatricians</td>
</tr>
<tr>
<td>Chamber of Commerce - Employers</td>
<td>Florida Academy of Pediatric Dentistry</td>
</tr>
<tr>
<td>Faith-based organizations</td>
<td>Florida Dental Association</td>
</tr>
<tr>
<td>Nonprofits</td>
<td>Florida College of Emergency Physicians</td>
</tr>
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<td>Florida Association of Community Health Centers</td>
<td>Medical societies</td>
</tr>
<tr>
<td>United Way</td>
<td>Catholic councils</td>
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<tr>
<td>Florida Dental Hygiene Association</td>
<td>Tribal councils</td>
</tr>
<tr>
<td>Florida Area Health Education Centers</td>
<td>Florida CHAIN</td>
</tr>
</tbody>
</table>

Partners are continuing to commit to implementation actions. For example, **Florida CHAIN (Community Health Action Information Network)**, will leverage its vast statewide network to assist the Alliance in widely disseminating to consumers and providers information regarding: 1) Alliance strategies for improving dental care for low income children and; how to get involved in local community efforts around this initiative. A statewide consumer health advocacy organization dedicated to improving the health of all Floridians, **Florida CHAIN’s** priorities include promoting access to quality and affordable health care for those who are uninsured, underinsured, and supported by government programs. They approach advocacy from a consumer perspective, engaging patients, community members, advocacy leaders, consumers, lawmakers, and health care providers to participate in health access campaigns, including ensuring that Florida’s children get and keep the health care they need. **The Tampa Bay Healthcare Collaborative (TBHC)** will contribute to this strategic plan in two specific ways. First, it will continue to build a grassroots network across the state of Florida. TBHC will work with this network of grassroots stakeholders to ensure that the consumer voice is represented as this group determines what specific programmatic and policy actions it will pursue together. Second, TBHC will work
with partners and stakeholders across the state to facilitate effective collaboration. TBHC will host a meeting of key state-level oral health stakeholders who have or are developing strategic/action plans during fall 2016 to explore how they could potentially leverage and support each other’s work.

**Implementation**

To implement this plan, Alliance subcommittees will use data driven decision-making in our work. Collaborative leadership and the collaborative decision making process dictate that it is the group that will ultimately choose, craft and approve strategy implementation and indicators of success.

**Performance Measures**

**How will partners measure the effectiveness of their efforts?**

It is recommended that partners continue working according to the RBA framework. This requires that performance measures answer the questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

| Performance measures relate specific program efforts to outcomes |
|---|---|
| **Input Effort** | **Quantity** | **Quality** |
| How much did we do? | How well did we do it? |
| **Is anyone better off?** |
| **Output Effect** | **Quantity** | **Quality** |
| How much change/effect did we produce? | What quality of change/effect did we produce? | % |
Results-Based Accountability™ for Collective Impact

The Florida Oral Health Alliance created this plan using the framework of Results-Based Accountability™.

What is Results-Based Accountability™?
Mark Friedman, in his book, *Trying Hard Is Not Good Enough*, defines Results-Based Accountability™ (RBA) as a disciplined way of thinking and taking action that can be used to improve the quality of life in communities and the performance of programs, agencies and service systems.

Why use RBA?
- Moves groups from talk to action quickly
- Provides and promotes the use of a common language among stakeholders
- Addresses barriers to innovation
- Builds collaboration and consensus
- Uses data to ensure accountability for populations and programs

How does it work?
RBA starts with the ends (results) and works backwards to the means to achieve the results.

What do we mean by “result”?
The quality of life conditions of well-being that we want for the community as a whole

How does this plan measure success?
Population indicators measure the quality of life conditions that we want for the community as a whole. These are different than performance measures. Performance measures are used to evaluate the effectiveness and impact of programs. This strategic plan was created based upon population indicators only. Community programs and Alliance partners will design their own performance measures to ensure accountability and assess effectiveness and impact.

The difference between population indicators and performance measures:

<table>
<thead>
<tr>
<th>Population Indicators</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators are about whole populations.</td>
<td>Performance measures are about client populations.</td>
</tr>
<tr>
<td>Indicators are usually about peoples’ lives, whether or not they receive any service.</td>
<td>Performance measures are usually about people who receive service.</td>
</tr>
<tr>
<td>Indicators are proxies for the well-being of whole populations, and necessarily matters of approximation and compromise.</td>
<td>Performance measures are about a known group of people who get service and conditions for this group can be precisely measured.</td>
</tr>
</tbody>
</table>

For a more detailed description of how the RBA framework aligns with the five key conditions needed to achieve collective impact, see the white paper by Deitre Epps of the Results Leadership Group entitled *Achieving “Collective Impact” with Results-Based Accountability™*. 
Timeline

The following timeline includes an outline of work completed by the Alliance between May 2015 and July 2016 and highlights our progress achieved through utilization of the RBA framework for collective impact discussed above.

**May 2015:** Florida Oral Health Alliance held kickoff meeting at Children’s Services Council of Palm Beach County. Group crafted the result and chose success indicators.

**July 2015:** Alliance confirmed indicators, began to tell story behind the baseline, highlighted existing Florida oral health plans and programs including Florida grassroots oral health equity initiatives (Catalyst Miami and Tampa Bay Healthcare Collaborative), Oral Health Florida, Florida Department of Health Public Health Dental Program, Florida Dental Association, Dental Health and Wellness, and received Florida Medicaid update on their State Oral Health Action Plan (SOHAP).

**August 2015:** Deputy Director of Florida Medicaid Justin Senior discussed Florida’s shift from fee-for-service to Medicaid managed care. Juliette Fabian from the Children’s Trust presented the Miami-Dade HealthConnect in-school oral health project and Dr. Ana Karina Mascarenhas from Nova Southeastern University School of Dental Medicine discussed their oral health interprofessional education program Miami Smiles.

**October 2015:** Data subgroup formed a data development agenda. Pediatric dentist, Dr. William Steinhauer discussed what worked in Texas to improve oral health access and utilization outcomes for children on Medicaid.

**November 2015:** Alliance met in Tampa and was introduced to Florida Medicaid lawsuit, discussed story behind data and began prioritizing factors.

**January 2016:** Alliance began meeting monthly. Florida Medicaid began serving as a Tallahassee virtual meeting hub. The group reviewed new Medicaid managed care dental care data visualization showing improved outcomes. The group confirmed prioritized factors, began discussing focus areas, integrated Oral Health Consumer Advisory Council feedback into the strategic plan.

**February 2016:** Alliance proposed six preliminary strategies including interprofessional oral health education, messaging through community champions, value-based payment, advocating for mandatory oral health exams for school entry.

**March 2016:** Alliance added special needs children to prioritized factors, integrated Oral Health Consumer Advisory Council feedback regarding need for cultural competency and oral health knowledge among people working phones and providing information to consumers.

**April 2016:** Florida Medicaid presented an update regarding SOHAP implementation including their data collection improvements. The group discussed the story behind the need for "mandatory" dental exams for school entry and added three additional strategies.

**May 2016:** Florida Chapter of the American Academy of Pediatrics, Dr. Tommy Schechtman discussed the lawsuit settlement. The group proposed a new strategy of placing Registered Dental Hygienists in pediatricians' offices and updated mandatory dental exams strategy to align with Florida’s policy environment. Subcommittee convened to research dental exams for school entry and obtained information from the Florida Department of Education regarding existing school health exam form and school entry exam requirements.
**June 2016:** The group clarified Registered Dental Hygienist supervision requirements, condensed and prioritized strategies and added a Tampa virtual hub.

**July 2016:** Subcommittee condensed strategies and focus areas.

**August 2016:** Alliance finalized the strategic plan.
Resources

Community Water Fluoridation:

Florida Department of Health Oral Health Surveillance Reports

Surveillance Reports
Florida’s Burden of Oral Disease Surveillance Report
Oral Health Status of Florida’s Third Grade Children 2013-2014

American Dental Association Health Policy Institute
The Oral Health Care System: A State-by-State Analysis American Dental Association Health Policy Institute
Florida’s Oral Health Care System

ADA HPI Report: Florida’s Oral Health and Well-Being

CMS 416 reports
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic- and- Treatment.html

Florida Medicaid data visualization series (including dental care)
https://ahca.myflorida.com/medicaid/Finance/data_analytics/data_series.shtml

Florida Medicaid performance improvement progress

Florida Medicaid State Oral Health Action Plan
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html

Information about Plans In your Region
http://www.flmedicaidmanagedcare.com/SelectCounty.aspx

The Medicaid State Region Map

SMMC Online Provider Directory

Health Plan Report Card

Florida School Entry Health Exam - Form DH3040-CHP-07-2013 (and Instructions)
Endnotes


