Result: All Florida children, youth and families have good oral health, especially those that are vulnerable

How are we doing?

Headline indicator used to measure our result:

- Florida is now at 27% in 2014, 27% of Medicaid eligible children received dental service in that year.

What is the story behind the curve of the baseline?
See cumulative notes for the group’s contribution to the story.

Who are partners who have a role to play in turning the curve?
- The group has affirmed that as partners working together we will look at the data over time and not necessarily look at one partner as being responsible for improving that data, but look at all of the partners working together to align your strategies and select strategies that are mutually reinforcing of one another, so that you are seeing improvement in this data.
- One of the critical areas that we have outlined, that we want to improve, is the alignment of actions so that various efforts that are happening across the state, can be scaled up if they are effective or include strategies that are not in place yet.

What works to turn the curve?
During each virtual meeting, current oral health plans and efforts, both state and local are featured. These stories contribute to actions that have turned the curve to improve oral health access and
utilization outcomes for Florida’s children as well as demonstrate what is now working here in Florida and in other states to turn the curve.

**What worked? How Texas turned the curve:**

*At the October 30 virtual meeting*, Dr. William Steinhauer, DDS Chairman of the Committee on Access to Care, Medicaid, and CHIP (CAMC) for the Texas Dental Association, Chairman of Dental Division, Children’s Hospital of San Antonio discussed what worked to turn the curve in Texas. He identified factors and actions that led to Texas’s significant improvement in Medicaid-eligible children’s access and utilization outcomes. He shared the following information:

- Texas is now ranked in among the top five states of providing access for dental services for children on Medicaid.
- Texas for a long time worked on improving claims processing to include:
  - Standard ADA claim form, switching to standardized ADA procedure codes, having the ability to submit claims electronically then appeals electronically.
- Changes maintained current provider network at around 1,100 dentists.
- “When there are roughly 8,000 practicing dentists in the state that really does not come close to the ideal of equal access for Medicaid children.”
- “Texas did not want a 2 tier system where if you are on Medicaid you are on a lower level tier, and everyone else gets a higher level of service. We wanted everyone to get the same level of service. We knew that could only happen if we had dentist participation. The dentists had to buy in.”
- Texas FREW lawsuit (over 20 year process) was pivotal.
  - Parents of Medicaid children came together as a class filing suit against the state of Texas to provide them with the services they were entitled to by Federal law.
- Texas’s matching fund is a 60-40 split (Federal government at 60%)
- Dr. Steinhauer’s comments regarding the FREW lawsuit included:
  - “The only common sense would be if you have a lot of doctors, MDs and DDSs, participating in the program and providing those medical and dental homes. We kept old providers although the fees were abysmal. Old providers were still participating at a decent level. The only thing left to do was to address the fees.”
  - “The court told the state they knew what you were getting into when you agreed to these items, such as medical transportation assistance for families trying to get to their medical and dental appointments, assistance with making appointments, a lot of client outreach type of services.”
  - “We saw improvement in the overall Texas Medicaid program, but we did not see improvements in the number of dentists signing up to be providers in the dental program. The legislature finally agreed to increase funding for the dental program.”
  - The state legislature did not direct how that money was to be used.
- A sub-group with about 12 committee members decided how to use a 50% increase in previous funding levels. The intent was how to use this money to attract more dentists into the Medicaid dental program and therefore for more children to be seen.
- A determination was a fee structure that approaches the 70% percentile of the usual and customary, seems to be a magic number. “We knew the amount of extra money would not allow us to move all of the fees up to the 70% percentile.”
- If raised across the board all of the fees 50%, only two procedure codes would have been at the 70%, all other codes would have been far below.
- In Texas, they began taking the most used codes and then ranked all dental procedure codes in order of most used at the top of the list to the least used, the fewest number of claims being submitted for that code at the bottom of the list. They then started at the top and raised those fees 100%, which put us at the 70% percentile.
• Took the top 40 codes being submitted and raised them 100%. These were the codes the children were already needing. The dentists were usually submitting these codes.

• Once fees were raised, there was the challenge of corporate dental chain clinics with multiple locations moving to Texas. With these “Medicaid clinics” there exists a concern that Medicaid clients are not treated in the same manner that your private pay patients would be treated.
  
  • “When you set up as a Medicaid practice, you tend to have practice models that everyone gets an 8:30am or 1:00pm appointment and you just show up and wait your turn, on a first come first served basis. That is not how we wanted Texas Medicaid clients to be treated.”

• Texas then moved from fee for service to managed care. “In that transition, organized dentistry – the Texas Dental Association, the Texas Academy of Pediatric Dentistry, the Texas Academy of General Dentistry was very insistent on the dental home model.”

• Result: 50+% of Medicaid children are receiving dental care. Goal is 80% of children are seen within 90 days of entering Medicaid dental program to include 2x a year and for younger children: 4 fluoride treatments, 4 cleanings a year, 4 visits a year

How did Texas work together and align efforts to turn the curve?

• Texas Dental Association was extremely involved from the very beginning when the state was drafting its RFP from its move to managed care.

• Organized dentistry was involved in looking at the proposals that came back from various insurance companies choosing MCNA and DentaQuest, providing critique and input to the Texas Health and Human Services Commission.

• Once contracts were awarded, the Dental Association reviewed provider enrollment contracts, for each of the companies and provide input to the state. This included evaluation of care company’s provider manuals, office manuals, providing input to the state before those manuals were approved to go out.

• The Dental Association strongly advocated for previously existing Medicaid providers, assuming that they were qualified, to be accepted into the networks of the new companies at any time during the first two years if they applied to continue being Medicaid providers and that they would be accepted.

• Texas Dental Association and Texas Association of Pediatric Dentistry had input as the program was being created yielding ownership. They instilled a policy to encourage Texas Dental Association members, Texas Academy of Pediatric Dentistry members to be Medicaid providers.

• Dentists who had never been Medicaid providers before had desire to participate in the dental home program for children under age 3.

• Texas’s network of dentists is now little over 4,000 – 50% of the practicing dentists in the state. All Medicaid children have a main dentist, a dental home - a private practice dental home. There they can receive comprehensive, continuous care – there is a great system of specialists on board for referrals.

• They formed a dentist recall case management system to contact families at every six months. Once a patient first comes for a visit to a dental home, and becomes a patient of record, then the state case management system does not keep on the case of the patient to visit a dentist every 6 months.

• “It was the state and the state legislature doing some work, and the dental community doing a lot and buying in that took us to where we are in Texas today. It was not the move to managed care that did it, it was not the fees by themselves that did it, nor improving the program alone that did it – it was all of these together that made the difference.”

• “When dentists are not doing the fillings, not doing the crowns, it reduces your expenditures which your legislature likes. Which a good argument to use when approaching your legislature – if you would let us make these changes then we would be able to make these improvements to our program and the outcome will be less disease, less expense. Prevention is always cheaper than curing.”
• Case management included: Every month when Medicaid issued new cards, envelope stuffers with dental issues were there at least 3-4 times a year stressing the importance of getting a child to the dentist. There was also a system in place where if a dentist had a Medicaid patient, a patient of record, if the parent was having difficulty keeping the appointments or not bringing their child back for treatment then we could forward that information to the state.

• Texas Medicaid used case workers that would contact the parents mostly by telephone. On rare occasions, a knock on the door.

At the October 30 virtual meeting, Florida’s DentaQuest Foundation funded grassroots oral health networks also presented their work. The DentaQuest Foundations has funded grassroots and community based organizations that have not previously been involved in oral health in six states, including Florida, Arizona, California, Pennsylvania, Virginia, and Michigan.

Mr. Santiago Bunce, Vice President for Community Building of Catalyst Miami from the Miami Dade Oral Health Network.
• Catalyst Miami works in the area of health and well in prosperity including enrollment in ACA, SNAP, KidCare, and other health programs.
• Goal of grassroots initiative to build a network needed to educate communities, and develop the appropriate strategies including cultural and behavioral shifts that are needed, and build a network that can influence policy - educating, connecting and influencing.
• Partners include: New Florida Majority, South Florida Voices for Working Families, Nova Southeastern University has a school of medicine, and a school of Dental Medicine, Community Health of South Florida, Consortium for a Healthier Miami Dade.
• Using Results-Based Accountability
• At oral health equity summit in October, gathered collective intelligence from the community that is being used to inform the work

The Miami-Dade Oral Health Network (MDOHN) goals:
1. Build a grassroots network that views oral health as a social justice and health equity issue.
2. Develop an awareness of the relationship between oral health and justice.
3. A shared understanding of the current oral health reality and disparities in Miami-Dade County.
4. Build alignment on the behavioral & cultural shifts necessary to positively impact oral health.
5. Develop strategies that yield policy and systems change to address existing disparities and inequalities.
6. Continuously set clear and attainable action steps for our grassroots work in oral health in Miami-Dade County for 2015-2016.

Ms. Marissa Davis, Program Coordinator for the Tampa Bay Healthcare Collaborative.
• Tampa Bay Healthcare Collaborative is a membership-based non-profit organization. Members include the Health Department, other non-profit organizations, and health and social service organizations throughout Tampa Bay.
• TBHC hosts quarterly meetings to foster collaboration and an annual wellness conference once a year on a trending healthcare topic.

Tampa Bay Achieving Oral Health Equity (AOHE) goals include:
1. Build a network of community stakeholders committed to achieving oral health equity.
2. Conduct a regional community assessment regarding oral health and identify gaps.
3. Catalog existing oral health services, programs and resources.
4. Promote and improve the public perception on the value of good oral health.
5. Communicate the importance of interprofessional education and integrated care.
• Conducted surveys with five groups: community members, partner providers, and any non-profit providing direct services to the community, there is a survey for youth and another one for parent and legal guardians to compare the attitudes, perspectives and beliefs from both groups and dive into the data and how these groups view one another and services provided
• Key stakeholder interviews and focus groups
• Create a catalog of services, and resources for oral health information.

**How can the statewide Florida Oral Health Alliance network can help toward your local goal of grassroots level?**
• The Alliance can provide knowledge regarding how oral health has been connected to the community; share best practices and experiences, lessons learned.

**How do we get parents to value the importance of good oral health? What do you think can be helpful to build that value argument for parents?**
• Combine oral health information with exiting information such as ACA enrolment, tax prep services, prenatal care; cost benefit analysis of dental services

**What do we propose to do to turn the curve?**
See cumulative August 28 notes for the group’s contributions to date.

The Florida Oral Health Alliance is looking forward to looking at shifting from what works to what do we propose to do as an Alliance. Facilitator Deitre Epps asked presenters:

**Question: In December 2014, a federal judge ruled that Florida Medicaid program violates federal law. Florida finds itself in a similar circumstance and what would you recommend that the Florida Oral Health Alliance consider as immediate and next steps to address this specifically. Who do think they might want to engage...what do you think they should do right away as a group, and maybe what are some long term things they might consider?**

Dr. William Steinhauer:
• People at the grassroots should begin lobbying their legislature to put more money into the Medicaid program, so that these can be adjusted and you can have an adequate network of providers.
• Lobby the legislature that they are going to have to put additional monies into the program in order to fund the preventive measures that are necessary for long-term cost savings. Bundle oral health as a part of overall health.
• Focus on the importance of prevention for children by personally engaging the community and appealing to mothers.

**Question: If you have some partners in the Florida Oral Health Alliance that are interested in replicating your efforts locally, or even building upon you current work. What are some first steps, what are the costs for pulling this together, and what might they begin thinking of if they like to do similar efforts from their counties?**

• Santiago Bunce: “Begin by looking at the community based organizations locally in your area and connecting with them, then determine who they consider to be champion in the community. Very little can be done without the buy-in of the community and more importantly the effectiveness of the strategies and the solutions will be clearer, and quicker with the community input. We are all experts in our way, and the community is an expert in being a community. That would be a good place to start.”
• Marissa Davis: Identify stakeholders, who is providing, has access and is providing services, whether they are oral health or not, to the community and integrate your efforts into their existing work. Engage the community in lobbying the legislature.
• Dr. William Steinhauer: “There were several state agencies, health and human services commission, and the department of state health services, that did surveys, need surveys of Texas residents. Almost 100% of the time, the results of the surveys were dental as the number one answer. I will admit, it was mostly adults looking for some access to care, it was not specifically on children or Medicaid. Dental is a big issue for your community and if there is a way of measuring that, that would be a very effective when talking with state agencies and legislators about changing the emphasis of the Medicaid program and funding it properly. That is what Floridians want, they want dental.”

**What do we propose to do?**
For a list of proposed strategies to date, see August 20 cumulative notes.

**On October 30, Deitre Epps proposed to the group:**
• The first level of “what do we propose to do?” is at the population level change for all of Florida and improving the indicator data for all of Florida regarding Medicaid children and access to care. What should as the Florida Oral Health Alliance propose as strategies to improve that state level data?

• The second level of “what do we propose to do?” necessitates a shift to individual partners of the Alliance and how you might align your work to improve existing strategies or programs locally, that you are already a part of or could be a part of.

**Next steps and commitments to action**
At the July 31 face to face meeting, participants made commitments to action. We will be reviewing these at the next meeting.

**Opportunity for alignment:**
• The Children’s Trust, in Miami-Dade, will be working the School Based Health Alliance, which is a national organization to look at how to improve oral health access within the five largest school districts in the country. Specifically, they will be working with three communities in Florida, including Hillsborough, Broward, and Miami-Dade. These being the top school districts in the country. They will be having a meeting, on December 1 in Miami-Dade. Feel free to let Christine or Mario know, so we can facilitate the partnership and participation around the efforts to strengthen the school based work of accessing dental services.

**Commitments to action**
Part of the work of the Florida Oral Health Alliance, builds upon accountability and that means:
• Population accountability for improved oral health for all of Florida
• Performance accountability that occurs once programs are implemented to confirm that those programs are effective and are being run efficiently
• Personal accountability: As leaders, once an action commitment is made that you will follow through on it and that you are happy having a shared conversation about whether you were able to make it happen, and if not, what is happening with that action commitment that you made that may be hindering your efforts.

**At November 20 face to face meeting:**
• Discuss personal responsibility toward action commitments
• Share commitments and progress with each other
• The first step is to check in on the action commitments you made at the last meeting
• Share other actions that you will be taking between now and the next meeting on November 20, 2015.