Meeting Results

- A shared understanding of each individual’s progress on their commitments to action
- A shared understanding of how “what worked to turn the curve” in Texas may be applied to our oral health improvement efforts in Florida
- An awareness of affirmed and/or revised prioritized factors
- A plan to use “what works” to address prioritized factors
- An agreement on how to prepare to engage in mutually reinforcing activities; an opportunity to align with other initiatives and partners, including AHCA and grassroots action

The following Alliance members were present for the meeting (11/20/2015).

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Philippe Bilger</td>
<td>Florida Department of Health</td>
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<tr>
<td>Ben Browning</td>
<td>Oral Health Florida</td>
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<tr>
<td>Karen Buckenheimer</td>
<td>MORE HEALTH, Inc.</td>
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<tr>
<td>Carrie Hepburn</td>
<td>Tampa Bay Health Collaborative</td>
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<td>Johnny Johnson</td>
<td>American Fluoridation Society</td>
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<tr>
<td>Dave Meadows</td>
<td>Liberty Health Plans</td>
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<td>Douglas Manning</td>
<td>DentaQuest Foundation</td>
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<td>Jose Peralta</td>
<td>Premier Community HealthCare Group, Inc.</td>
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<td>Allison Rapp</td>
<td>Special Olympics Florida</td>
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<td>Kristal Redman</td>
<td>Dental Health &amp; Wellness</td>
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<tr>
<td>Joel Stern</td>
<td>EmCare, Florida College of Emergency Physicians</td>
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<td>Steve Zuknick</td>
<td>Florida Dental Association</td>
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Project Staff

- Deitre Epps, Facilitator Results-Based Leadership
- Christine Hom, Project Manager Florida Institute for Health Innovation
- Mario Aguilar, Project Assistant Florida Institute for Health Innovation
**Results Statement(s):** Florida Oral Health Alliance  
Result: *All Florida children, youth and families have good oral health and well-being, especially those that are vulnerable.*

**Selected Indicators:**
*Indicators= measures that help to quantify the achievement of the result.*
*(Rated as high (H), medium (M) or low (L))*

<table>
<thead>
<tr>
<th>Candidate Indicators</th>
<th>Communication Power</th>
<th>Proxy Power</th>
<th>Data Power</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Percentage of Eligible Medicaid Children Ages 0-20 Receiving Any Dental Services</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td></td>
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<tr>
<td>Number of preventable ER visits with oral health</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td></td>
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<tr>
<td>Percentage of eligible Medicaid children and youth that received preventative dental services</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td></td>
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<tr>
<td>Number of preventable oral surgeries</td>
<td>Not rated</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Percentage of counties and/or municipalities without fluoride programs</td>
<td>Not rated</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Number of restorative visits</td>
<td>Not rated</td>
<td></td>
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</tbody>
</table>

**Communication Power:** does this indicator communicate to a broad range of audiences? Would those who pay attention to your work know what this measure means?  
**Proxy Power:** Does this indicator say something of central importance about the result? Is it a good proxy for other indicators? Data tend to run in a “herd” – in the same direction. Pick an indicator that will tend to run with the herd of all the other indicators that could be used.  
**Data Power:** Is there quality data for this indicator on a timely basis? To be credible, the data must be consistent and reliable. Timeliness is necessary to track progress.

**Headline Indicators (rated as H, H, H):**
*Of the candidate indicators you listed above, which will be your headline indicator(s)?*

Headline Indicator: **Percentage of Eligible Medicaid Children Ages 0-20 Receiving Any Dental Services**

**Data Source:** Our headline indicator was taken from national and state CMS-416 form line item that reads: CMS Total eligibles receiving any dental services. Form CMS-416 is used by CMS to collect basic information on State Medicaid and CHIP programs to assess the effectiveness of EPSDT (Early and Periodic Screening, Diagnostic and Treatment). Data was retrieved between the years 2010-2014. Our trend line was added for a couple of additional years (up to 2016). Data for children 0-20 years old retrieved from Florida, Louisiana, Mississippi, Texas and National CMS 416 Data.
Florida is now at 27% in 2014, 27% of Medicaid eligible children received dental service in that year.

**Secondary Indicator:** Percentage of eligible Medicaid children and youth that received preventive dental services

Our secondary indicator was taken from national and state CMS-416 form line item that reads: CMS Total eligibles receiving any preventive dental services. Form CMS-416 is used by CMS to collect basic information on State Medicaid and CHIP programs to assess the effectiveness of EPSDT (Early and Periodic Screening, Diagnostic and Treatment). Data was retrieved between the years 2010-2014. Our trend line was added for a couple of additional years (up to 2016). Data for children 0-20 years old retrieved from Florida, Louisiana, Mississippi, Texas and National CMS 416 Data. **Data Source:** [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)

**Additional Indicator:** Number of preventable ER visits with oral health
These remaining possible indicators have not been addressed since the May 22, 2015 meeting.

**Indicator:** Percentage of counties and/or municipalities without fluoride programs  
**Data Source:** Florida Department of Health  

As of July 1, 2015, 21% (14 counties) are without community water fluoridation.

**Indicator:** Number of preventable oral surgeries  
**Data Source:** Pending Submission

**Indicator:** Number of restorative visits  
**Data Source:** Pending Submission

**Data Development agenda (rated as H, H, L):**  
Are there any candidate indicators with high communication power, high proxy power but low data power (data is not available)? This would mean that a data development agenda is needed.

**On July 31, 2015, the group identified the following data development agenda:**  
As part of their action commitment work, five members were identified to become a data subcommittee to explore alternatives to our headline indicator.

- Free dental services (no claims)  
- CDT codes (billing codes)  
- Ages  
- Additional concerns: 1) No-show and utilization rates are not captured. 2) Our headline indicator does not capture anything provided by non-dentist or someone not supervised by a dentist

**Data work group volunteers:**  
Individuals who volunteered to form a data work group included:  
*Indicates participation in data subcommittee conference call  
Farren Hurwitz, Tara Price, Dave Meadows*, Juliette Fabien, Douglas Manning*, Krista Wagner*, Phillippe Bilger*  

**Notes on missing data:**  
- Other professionals that are delivering dental services is not captured.  
- Other non-Medicaid eligible children and youth that received dental services.  
- Utilization and no show rates are not available.
• Florida shows poor results. There is a lack of understanding about the impact of dental care.
• There are children and youth who have access that are not receiving dental services.
• Reimbursement for dental services is low.
• A limited reimbursement system that pays for treatments but not for preventative services.
• No data results for lack of claim forms for free dental services.

**Turn the Curve Report as contributed on November 20, 2015**

**(POPULATION)**

**Result**

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

**Headline INDICATOR**

![Graph showing eligibility for dental services](image)

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

**Story behind the data**

**Contributed on November 20, 2015:**

- Florida Academy of Pediatric Dentistry (FAPD) and Florida Association of Pediatrics (FAAP) lawsuit ruling that state (FDOH/AHCA) was in violation of federal Medicaid law due to a failure to provide equitable medical and dental care for Medicaid covered children. Recommendations pending in December.
- One component of the ongoing litigation is around the legislature’s ability to order a raise in rates. They are currently working with language in order to work within the Supreme Court’s recent ruling that prohibits plaintiffs pursuing increase in rates.
- Having to travel long distance to reach a Medicaid provider impedes access.
- High no show rate.
- Episodic visits, due to pain.
- Need for transparent data.
- Recent improvements in oversight and accountability have led to decreases in improper resource utilization.
- Efforts on behalf of community organizations that focus on oral health
- School based services provide oral care
- FQHCs focus on oral health while achieving oral health equity
What works: (known solutions)

Contributed at the November 20, 2015 meeting:

What is our STRATEGIC plan with our ROLE, to improve the data?
What do we propose to do? Strategies for Action

At the November 20th meeting, the group presented the following strategies:

- Managed care model, carve in vs. carve out
- Compare laws and rules around delivery of dental care (eg. Mobile, DHS, school oral health exams, covered services).
- Fraud and abuse; reduce waste of care.
- Providers being where greatest needs are.
- Greater fluoridation provision.
- Improved appointment design for patients.
- Medicaid cover adult preventive.
- Dentists seeing children under age 2.
- Comprehensive oral health education and literacy.
- The number and type of dental plans offered in the state, can be simplified. (presently numerous and complicated)

Next Steps: What do we propose to do to turn the curve?

On November 20, 2015 the group identified the following additional strategies:

- Cut restrictions on scheduling.
- Availability of provider: AHCA wants 9-5pm, 5 days/week.
- Input from organized dentistry.
- Cut restriction on age by some providers.
- Getting more public to public and private partnerships for services.
- Prioritize Medicaid population.
- Address the workforce, is it adequate?

What structure would you recommend that the Oral Health Alliance consider for addressing these factors?

(Advocacy)

- Same representative over time.
- Florida OHA support of advocacy efforts (with shared resources (eg. Fact sheet)).
- Same message with individual stories of support.
- Slate of issues.
- An internal structure.
- Create a movement and advocacy message (eg. Increase rates, funding, or other).
- Advocate with AHCA regarding fee schedule, and incentivize prevention.
- To organize itself into a working structure, participants proposed that the Florida Oral Health Alliance form a programmatic initiative that focuses on creating an environment to support the result:
  1. Education
  2. Advocacy
  3. Access to care
  4. Access to delivery

Is the Alliance able to communicate to the legislature the need to provide more resources for increased reimbursement rates?

Next steps and commitments to action:
• Discussed personal responsibility toward action commitments.
• Shared commitments and progress with each other.
• The first step is to check in on the action commitments made by individuals at the last face to face meeting.

**Cumulative Turn the Curve Report**

*(POPULATION)*

This is a summary of the work to date.

**Indicator:** Total number of Medicaid eligible children age birth – 20 who are receiving any dental service

**Current:** 27%

![Image of eligible Medicaid children Ages 0-19 Receiving any Dental Services graph]

**Story behind the baseline:**

**What positive factors have contributed to the baseline?**

- Efforts on behalf of community organizations that focus on oral health
- School based services that provide oral care
- FQHC’s that focus on oral health while achieving oral health equity
- An increase in efforts throughout Florida to improve access to dental care
- Increase in awareness of the importance of oral health
- Grassroots efforts directed at improving oral health

**What negative factors have contributed to the baseline?**

- An exclusion of certain populations, primarily undocumented population in state.
- Insufficient data of ER visits for basic care that did not receive preventative services.
- An increase of local and community initiatives but not many statewide initiatives.
- A limited reimbursement system that pays for treatments but not for preventative services.
- An ineffective and realistic oral health policy focus in the state.
- A lack of integration between physical medicine and oral health.
- An isolated approach between private providers and public collaborative efforts.
- A lack of follow up case management systems for patients and members, continuation of care, and post-op.
- Inadequate number of providers in care network and access points.
- There is a lack of consistent collaboration and disparity from partners and stakeholders.
- Low or poor oral health literacy exists.
- Available dental services are not being accessed.
- There is a need to increase parental education and overall oral health literacy.
- There is a need to work consistently and improve the data.
• Payment to dentists (fees) for preventative services is low which leads to a lack of quality providers.
• Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage, and benefits.

**Story behind the baseline: Prioritized factors (contributed on July 31st 2015)**

• Lack of parent knowledge or understanding of importance of preventative care, which includes nutrition, safe sleep and oral cancer.
• Low or poor oral health literacy exists and includes factors such as cultural diets, concepts of health and value of oral health.
• There are available dental health services that are not being accessed.
• Inadequate funding does not provide access to services which leads to a low number of providers, lack of coverage, and benefits.
• There is a lack of consistent collaboration from partners and stakeholders, including oral health understanding by legislators.
• There is a need to increase requirements and gather “meaningful use” data across oral health community

**Next steps and 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.