Oral Health Florida Leadership Council Meeting
Friday, December 4, 2015, 2015
12:00pm – 1:00pm (EST)

Meeting Results:

By the end of the meeting participants will:

- Update Operating Principles
- Establish Legislative Platform/Agenda
- Celebrate the addition of Partner Associations
- Update Florida's Oral Health Roadmap
- Establish new OHF branding

Agenda:

I. Call to Order – 1:50pm
II. Roll Call
    a. Voting Members in Attendance: Tami Miller, Ben Browning, Scott Tomar, Lilli Copp, Ed Zapert, Nancy Zinser, Frank Catalanotto, Christine Hom for Roderick King, Nancy Sawyer (Phone), and Beth Genho (Phone)
    b. Consultants/Non-Voting Members in Attendance: Ana Karina Mascarenhas, Beth Kidder, Megan Thompson (AHCA), Elicia Cooley (AHCA)
    c. Action Team Leads in Attendance: Christina Vracar, Claudia Serna, Bob Macdonald, and Deborah Nastelli
III. Establish a Quorum – Established
IV. Adoption of Agenda – Approved
V. Approval of Meeting Summary Notes – October 16, 2015
    Approved with amendment
VI. Meeting Decisions
    a. Operating Principle Amendments
        i. Ben Browning motion to change composition of Leadership Council (instructions given – in favor of Option 1 vote yes; in favor of Option 2 vote no)
            1. Option 1 – 5 yes; Opposed – 4 no
            Motion adopted by majority vote (Exhibit A)

    b. Legislative Platform/Agenda
        i. Ben Browning motion to approve the following:
            1. 1 pager back and front to share with legislature

2. Agree to support bills
    a. SB 580/ HB 595
    b. SB 234/ HB 139
3. Develop a cover letter for legislature

Motion adopted, unanimously

c. Florida's Oral Health Roadmap Updates
    i. General consent motion to accept the following Roadmap changes:
        1. Change wording of Indicator 1.2a by striking "costs" and inserting "charges"
        2. Update Roadmap with Turn the Curve Reports for each indicator

        Motion adopted, unanimously (Exhibit B)

VII. Unfinished Business
    a. FDOH, PHDP CWF Training Grant – Second Year
        i. Currently waiting for FDOH approval.

VIII. New Business
    a. OHF Branding
        i. Ben Browning motion to refer back to Zona Gale for more examples incorporating logo colors by December 15, 2015.

        Motion adopted, unanimously
    b. 2016 OHF Conference – FPHA is July 26-29th at Florida Hotel

        Deferred OHF Conference date decision to email ballot
    c. American Network of Oral Health Coalitions (ANOHC)
        i. Next meeting at the National Oral Health Conference April 17-20, 2016.
        ii. State Oral Health Coalition Comparison Tool link on ANOHC website. http://sohct.org/state-comparison-tool

IX. Announcements
    a. OHF General Membership Meeting –Emergency Department OHF session recap with Representative Pigman– Date TBD – December or January
    b. OHF Leadership Council Conference Call – February (date selected via meeting doodle)

X. Adjournment – 2:35pm

Operating Principles

ARTICLE I
NAME, VISION & PURPOSE

Section 1.1 Name
The name of the coalition shall be Oral Health Florida, hereinafter referred to as "Oral Health Florida."

Section 1.2 Vision
The vision of Oral Health Florida is that all people in Florida will achieve optimal oral health and well-being.

Section 1.3 Purpose
The Oral Health Florida coalition is comprised of a broad based group of agencies, institutions, organizations, communities, stakeholders, policymakers, leaders, and other individuals whose mission is to promote and advocate for optimal oral health and well-being of all persons in Florida. This mission is accomplished through the implementation of the State Oral Health Improvement Plan.

ARTICLE II
MEMBERSHIP

Section 2.1 Eligibility
Oral Health Florida shall be open to any public or private organization, agency, institution, or individual residing or providing services in the State of Florida that demonstrates affirmative interest and concern to promote, protect, and improve the oral health of all people in Florida.

Section 2.2 Terms of Membership
Any public or private organization, agency, institution, or individual interested in becoming a member of Oral Health Florida.

- Group – A public or private organization, agency, institution, or other group.
- Individual – A person who is not appointed to represent a public or private organization, agency, institution, or other group.

Section 2.4 Member in Good Standing
A member in good standing is a member who agrees to uphold the vision and purpose of Oral Health Florida, and whose Oral Health Florida membership registration is updated annually or more frequently as needed.

Section 2.5 Resignation of Member

A member shall notify the Leadership Council in writing of his or her resignation from Oral Health Florida. Resignation shall take effect upon receipt of such notice, unless the notice specifies a future date.

ARTICLE III
LEADERSHIP COUNCIL

Section 3.1 Composition

The Leadership Council shall be composed of 19 members: 13 of these members will have voting rights and 6 will have ex-officio non-voting status.

The 13 voting members include a representative from each of the following public or private organizations, agencies, or institutions:

1. Florida Association of Community Health Centers
2. Organized Dental Association
3. Florida Dental Hygiene Association
4. Florida Public Health Association
5. College of Dentistry in Florida
6. Florida Allied Dental Educators

In addition, seven of the 13 voting members are considered Member-at-Large with two of these representing local coalitions that focus on oral health.

All voting members may present one proxy to act as a representative in their absence. Only one proxy may be appointed per voting members.

Members with ex-officio status that have no voting rights include:

1. Florida Agency for Health Care Administration
2. Florida Board of Dentistry
3. Florida Department of Health Public Health Dental Program
4. Florida Department of Health County Dental Programs
5. Colleges of Dentistry in Florida
6. Florida Institute of Health Innovation.

Consultants may be appointed as deemed necessary by a majority vote of the Leadership Council. Consultants to the Leadership Council will not have voting rights.

Leadership Council may alter its committee composition as is deemed necessary through revision to the Operating Principles.

Section 3.2 Members-at-Large

Any Group of Oral Health Florida in good standing and not representing one of the six listed organizations in Section 3.1 is eligible to serve on the Leadership Council as a Member-at-Large. Any individual Member of Oral Health Florida in good standing and not officially representing one of the six listed organizations in Section 3.1 is eligible to serve on the Leadership Council as a Member-at-Large. Any current Group or Individual Member of Oral Health Florida may nominate another Oral Health Florida General Member for these positions and may also nominate him or herself.

All nominations for the Members-at-Large positions will be presented to and verified by the Leadership Council that the Group or Individual is a member in good standing. Members of the Leadership Council shall elect the Member-at-Large members from these nominations.

Members-at-Large shall serve two year terms. The Members-at-Large not representing local coalitions shall serve terms which are staggered from one another. For the first term only, and in order to establish staggered terms, the six organization members of the Leadership Council shall designate which Members-at-Large shall serve a one year term and which Members-at-Large shall serve a two year term.

Section 3.3 Officers

The officer of Oral Health Florida shall have a Chairperson and Vice-Chairperson. The Chairperson and Vice-Chairperson shall each be members of the Leadership Council as a prerequisite before a majority vote elects that member into position. A majority vote of the Leadership Council is necessary to elect a Leadership Council member into the Chairperson and Vice Chairperson positions.

The Chairperson is the principal officer for the Leadership Council. The Chairperson shall be elected biennially by the Leadership Council during the Annual Oral Health Florida Meeting and shall hold office for a period of two years thereafter. The Chairperson shall perform all duties incident to the office of Chairperson. Chairperson responsibilities include:

1. Presiding at Oral Health Florida Leadership Council meetings, general state-wide coalition meetings, and other meetings conducted by Oral Health Florida;

2. Coordinating with Leadership Council members and the Oral Health Coalition Manager to develop an agenda for all applicable meetings;
3. Representing Oral health Florida at public events as necessary.

The Vice Chairperson shall serve a two-year term and shall assume the Chairperson position in the absence of the Chairperson, or in the event of his or her disability, inability, or refusal to act. The Vice Chairperson shall become Chairperson upon the conclusion of the current Chairperson's two-year term upon approval of the Leadership Council. At this time, the Leadership Council shall confirm the Vice Chairperson as the new Chairperson and elect a new member as Vice Chairperson.

Section 3.4 Leadership Council Responsibilities

The Leadership Council provides administrative oversight for Oral Health Florida. Its responsibilities include, but are not limited to:

1. Approving changes or revisions to the State Oral Health Improvement Plan;
2. Establishing the formation of Governance Committees, Action Teams, and Sub-Committees;
3. Appointing chairpersons for Governance Committees, Action Teams, and Sub-Committees;
4. Inviting any institution, agency, public or private organization or individual to provide expert guidance to Governance Committees, Action Teams, and Sub-Committees, as needed;
5. Establishing and approving operating procedures for all Governance Committees, Action Teams, and Sub-Committees;
6. Ensuring that the content of the Oral Health Florida website is factual and consistent with the State Oral Health Improvement Plan;
7. Approving any Governance Committees, Action Teams, or Sub-Committees report prior to publication;
8. Voting on any issue that may come up before the committee;
9. Attend Oral Health Florida Leadership Council and general meetings;
10. Exercise authority to establish fees.

Section 3.5 Governance Committees

The Leadership Council shall establish Governance Committees, not limited to advocacy, communications, membership and meetings. The Leadership Council shall also appoint

the chairs and members, and determine the responsibilities of each Governance Committee.

Section 3.6 Voting & Quorum

Voting is limited to members of the Leadership Council. A 2/3 vote for all policy issues are required and a majority vote for all other issues shall constitute a quorum for the transactions of business. No one person may have more than one vote. A member may not vote in those situations in which the member has a conflict of interest.

Section 3.7 Resignation of Removal of Officers

An officer shall notify the Leadership Council in writing of his or her resignation from the Council. Resignation shall take effect when the Leadership Council receives such notice, unless the notice specifies a future date.

The removal of officers shall occur either by request from the person that holds that office or by a majority in favor of removal by the Leadership Council.

ARTICLE IV
ACTION TEAMS & SUB-COMMITTEES

Section 4.1 Type of Action Teams and Sub-Committees

The Leadership Council shall determine the different type of Action Teams and Sub-Committees and identify the focus area for each one.

Section 4.2 Composition

Each Oral Health Florida Action Team and Sub-Committee shall have a minimum of five members. Membership on each Action Team and Sub-Committee shall be self-selected from the General Membership or by the request of the Leadership Council, Action Team, or Sub-Committee Chairperson.

Section 4.3 Action Team & Sub-Committee Chairpersons

The Leadership Council shall act on the recommendation of the Chairperson for each Action Team and Sub-Committee by the existing members of each Action Team and Sub-Committee.

Section 4.4 Action Team & Sub Committee Chairperson Responsibilities

The Chairperson of each Action Team or Sub-Committee shall serve as the principal organizer and facilitator for Action Team or Sub-Committees meetings.

Section 4.5 Resignation and Removal of Action Team and Sub-Committee Chairpersons

An Action Team or Sub-Committee Chairperson shall notify the Leadership Council in writing of his or her resignation as Chair. Resignation shall take effect when such notice is received, unless the notice specifies a future date. The removal of an Action Team or Sub-Committee Chairperson shall occur either by request from the person that holds that office or by a majority in favor or removal by the Leadership Council.

ARTICLE V
MEETINGS, COMMUNICATION & REPORTS

Section 5.1 Types of Meeting

Oral Health Florida shall hold three different types of meetings.

1. General – This type of meeting invoices the entire Oral Health Florida membership. General meetings shall be held at a minimum two times annually with one being held electronically and the other being held face-to-face.
2. Leadership Council – This type of meeting involves the Leadership Council only. Leadership Council meetings shall be held at a minimum four times annually with two meeting being held electronically with a minimum of one being held face-to-face.
3. Governance Committees, Action Teams, and Sub-Committees – These types of meetings involve corresponding Governance Committees, Action Teams, and Sub-Committee members. Governance Committees, Action Teams, and Sub-Committees will meet at a minimum once a quarter with all meetings being held electronically, although face-to-face meetings when possible will also satisfy the quarterly requirement.

Section 5.2 Notice of Meetings

The Leadership Council shall determine the time and format of General Meetings and the Leadership Council meetings.

The Chairperson for each of the Governance Committees, Action Teams, and Sub-Committees shall determine the time and format of associated meetings. The notice for all meetings stating the format or place, day, and time duration of any meeting shall be delivered individually by electronic mail to each member.

Section 5.3 Meeting Agenda and Summary Notes

Agendas will be disseminated by the Chairperson for the Leadership Council, Governance Committees, Action Teams, and Sub-Committees at least one week prior to the meeting and summary notes will be disseminated at least two weeks after meetings.

Section 5.4 Communicating with Members

All communication to members of Oral Health Florida shall be transmitted electronically or by U.S. mail.

Section 5.5 Website

A website will be maintained and used to highlight a calendar of Oral Health Florida meetings and to provide other relevant information.

Section 5.6 Reports

The Leadership Council will approve all reports prior to publication.

ARTICLE VI
PARLIAMENTARY AUTHORITY AND AMENDMENTS

Section 6.1 Parliamentary Authority

The current edition of *Robert's Rule of Order* shall govern the proceedings of Oral Health Florida in all cases to which they are applicable.

Section 6.2 Amendments

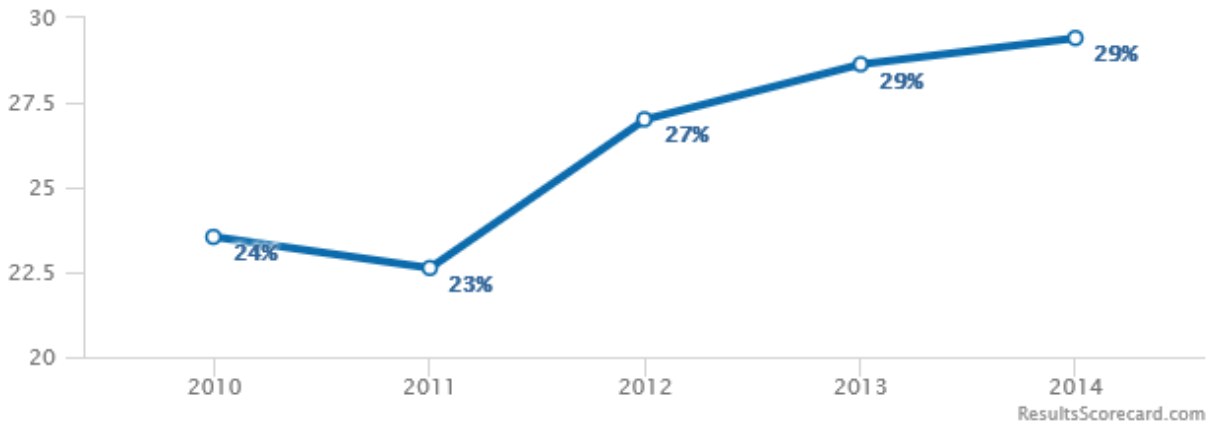
Members of the Leadership Council may offer alterations or amendments, which include, but are not limited to repealing sections or adding language to the Operating Principles. The Leadership Council may only adopt alterations or amendments by two-thirds vote with prior notice and three-quarters vote without prior notice at any Leadership Council meeting. The Leadership Council shall distribute final changes to the Operating Principles electronically to the Oral Health Florida membership.

TURN THE CURVE EXERCISE
POPULATION – ANY DENTAL SERVICE
Worksheet

Result: All people in Florida will have optimal oral health and well-being
Focus Area: Improved Access to Quality Oral Health Care
Indicator 1.1a: Percentage of Medicaid/CHIP eligibles enrolled at Least 90 Days receiving Any Dental Services

Baseline: How are we doing? Graph of historic baseline (5 years) and forecast if no change in effort (3-5 years).

CMS 416/ EPDST Report Dental – FY 2010-2014
Any Dental Service



Story behind the baseline: *Consider possible root causes and proximate causes (the obvious).*

New INFORMATION	**New INFORMATION**
Positive/contributing factors that are supporting progress - There is a typo on the graph, 2013 should be 28% - Move outreach by prepaid dental plans and managed care plans - Legislation to allow hygienists to perform service in health access setting - Increase in dental providers through managed care plan	**Negative/restricting factors that are hindering progress** - This does not reflect data collection improvements - Dental hygienists have not been able to fully use their expanded scope of practice - Recipients not always aware they have a dental benefit

Prioritize the root causes *according to which have greatest influence on progress and therefore most critical*
NEW ROOT CAUSES?

Root cause #1: Lack of perceived integration of oral health into primary care	#2
Root cause #2: Lack of value of oral health – messaging/oral health literacy as evidence based	#1
Root cause #3: Lack of access to preventive services	#3
Root cause #4: Lack of a clear understanding of health inequity in oral health	#4

Partners to improve progress:
NEW PARTNERS?

- Medicaid health plans
- Early Learning Coalitions
- School Nurses
- American Academy of Pediatrics
- Academy of Family Physicians
- Florida Association of Community Action Agencies
- Children's Services Councils
- WIC
- Head Start
- Oral Health Alliance
- Department of Juvenile Justice

What works to turn the curve?

- *What would it take? Consider what could work to do better.*
- *Does option address a root cause? Is it evidence-based or innovative idea?*
- *Does it have a no-cost/low-cost option?*

NEW WHAT WORKS?

- More education of consumers to seek services
- Setting up transportation and appointments
- Continued outreach to physicians to conduct preventive services and connect patients to dentists

Confirm strategies: *What do we propose to do?*
Apply criteria to each strategy*: Leverage, Feasibility, Specificity, Values*
NEW STRATEGIES?

Root cause addressed by strategy	**Strategy and criteria**	**Action steps**	**Possible partners**
- Lack of value of oral health care	- Education of consumers and physicians	- AHCA consumer engagement project - Marion county training physicians on fluoride varnish	- FIHI - Health plans
- Setting up appointment and transport	- Health plans provide case management	- AHCA continue to work with health plans on their dental PIPs	- Miami community dental health coordinators training program

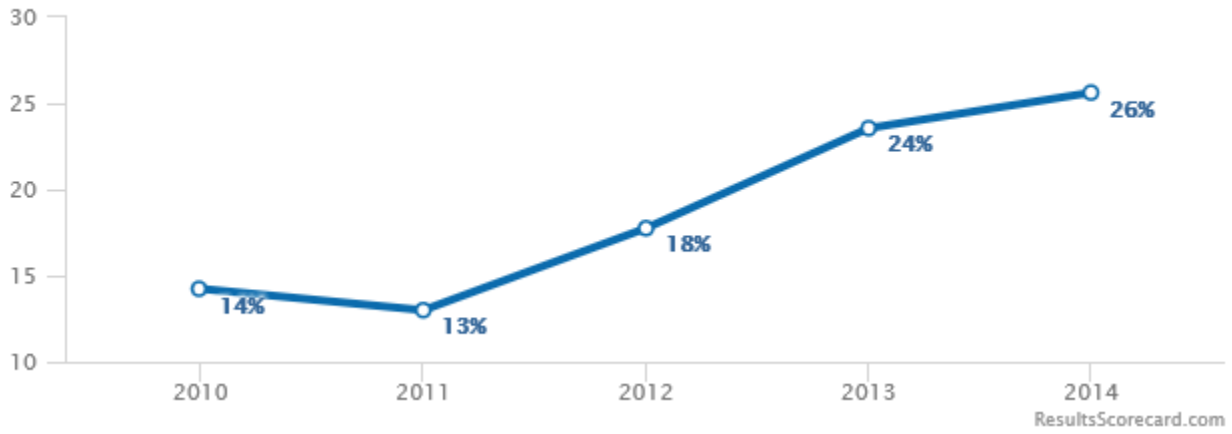
Suggested format per RBA guide: Header and description of strategy

TURN THE CURVE EXERCISE
POPULATION – PREVENTIVE SERVICES
Worksheet

Result: All people in Florida will have optimal oral health and well-being
Focus Area: Improved Access to Quality Oral Health Care
Indicator 1.1b: Percentage of Medicaid/CHIP Eligibles Enrolled at Least 90 Days Receiving a Preventive Dental Service

Baseline: How are we doing? Graph of historic baseline (5 years) and forecast if no change in effort (3-5 years).

CMS 416/ EPDST Report Dental – FY 2010-2014



Story behind the baseline: *Consider possible root causes and proximate causes (the obvious).*

New INFORMATION	**New INFORMATION**
Positive/contributing factors that are supporting progress - Support of managed care - More preventative dental services are being done than expected - Data issues identified - New data run being generated - Increase in school based sealants/varnish programs - Begin consumer engagement component - Non-dental providers and funders contributing	**Negative/restricting factors that are hindering progress** - Dental programs are closing - Lack of knowledge about plan – how to enroll - Nurses – scope of practice and supervision - Grant/foundation programs not capturing data – not being billed

Prioritize the root causes *according to which have greatest influence on progress and therefore most critical*
NEW ROOT CAUSES?

Root cause #1: Lack of perceived integration of oral health into primary care
Root cause #2: Lack of value of oral health – messaging/oral health literacy as evidence based
Root cause #3: Lack of access to preventive services – 17 counties, no school based programs 25%
Root cause #4: Lack of a clear understanding of health inequity in oral health

Partners to improve progress:
NEW PARTNERS?

- Association of School Health Nurses
- Non-dental/(scope of practice)/Supervision
- Inter-professionals
- Social workers/case managers (community navigator)
- School districts/PTA's

What works to turn the curve?

- *What would it take? Consider what could work to do better.*
- *Does option address a root cause? Is it evidence-based or innovative idea?*
- *Does it have a no-cost/low-cost option?*

NEW WHAT WORKS?

- Physicians and nurses
- Media campaigns (sealant video)
    - Text messages – existing models
- Dental companies 2x2x2x Ad campaign.

Confirm strategies: *What do we propose to do?*
Apply criteria to each strategy*: Leverage, Feasibility, Specificity, Values*
NEW STRATEGIES?

Root cause addressed by strategy	**Strategy and criteria**	**Action steps**	**Possible partners**
- Access to preventive service - Integration of oral health into primary care	- Scope of practice and supervision of nurses in schools - Hygienists get Medicaid numbers - Dental Health services reimbursable through FQHC's and Health Access Settings and non-for-profit groups - Mandatory oral health screening for school children	- MQA - Current legislation	- Association of School Nurses - DOE

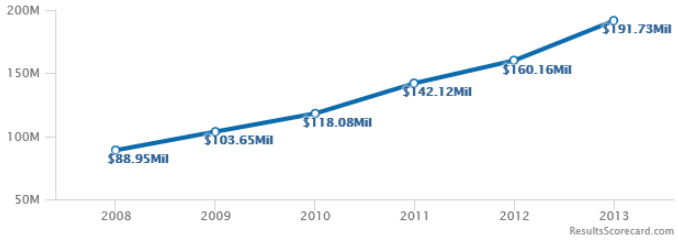
Suggested format per RBA guide: Header and description of strategy

TURN THE CURVE EXERCISE
POPULATION – EMERGENCY DEPARTMENT ~~COSTS~~ CHARGES AND VISITS
Worksheet

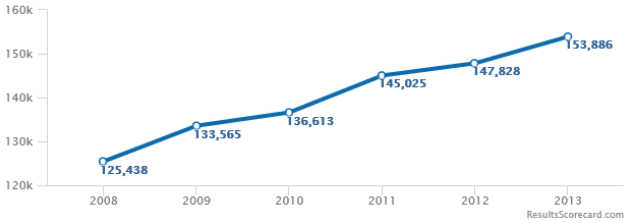
Result: All people in Florida will have optimal oral health and well-being
Focus Area: Improved Access to Quality Oral Health Care
Indicator 1.2.a: Total emergency room ~~costs~~ charges due to ambulatory oral health conditions
Indicator 1.2.b: Total number of emergency room visits due to ambulatory oral health conditions

Baseline: How are we doing? Graph of historic baseline (5 years) and forecast if no change in effort (3-5 years).

AHCA ED Discharge Data- Charges



AHCA ED Discharge Data- Visits



Story behind the baseline: *Consider possible root causes and proximate causes (the obvious).*

New INFORMATION	**New INFORMATION**
Positive/contributing factors that are supporting progress - There are some ED diversion programs in Florida - Low income pool funds are going away which gives incentive for hospitals to treat in the ED	**Negative/restricting factors that are hindering progress** - Hospitals may have incentives to see dental problems - Florida has large population that doesn't qualify for Medicaid but cannot afford dental care

Prioritize the root causes *according to which have greatest influence on progress and therefore most critical*
NEW ROOT CAUSES?

Root cause #1: Insufficient community dental resources and consumer knowledge of dental resources
Root cause #2: Limited oral health literacy especially regarding resources and use of emergency departments
Root cause #3: Limited adult Medicaid dental benefits that are inadequate in meeting the needs of the public
Root cause #4: Lack of providers who participate in Medicaid
Root cause #5: Lack of a clear understanding of health inequity in oral health

Partners to improve progress:

NEW PARTNERS?

- Florida Hospital Association
- Emergency Room Physicians
- Academy of Emergency Medicine

What works to turn the curve?

- *What would it take? Consider what could work to do better.*
- *Does option address a root cause? Is it evidence-based or innovative idea?*
- *Does it have a no-cost/low-cost option?*

NEW WHAT WORKS?

- Promising models in other states – e.g. pay it forward

Confirm strategies: *What do we propose to do?*

Apply criteria to each strategy*: Leverage, Feasibility, Specificity, Values*

NEW STRATEGIES?

Root cause addressed by strategy	**Strategy and criteria**	**Action steps**	**Possible partners**
- #1 limited knowledge of resources - #3 - Population that is uninsured	- Easily accessible dental resources list for each county - Expand Medicaid start dental coverage in Florida - Introduce new ED diversion models	- - Advocacy - Grant funding to implement and examine models	- County dental programs - Coordinate oral health coalitions - Organized dentists - Dental hygine

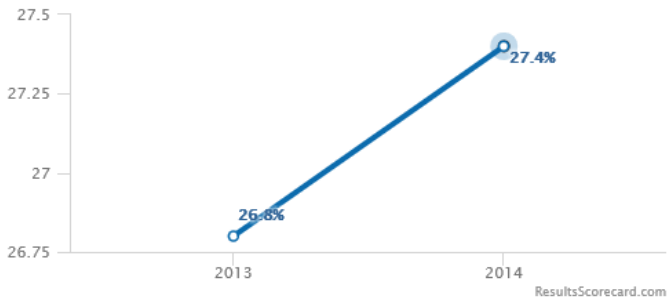
Suggested format per RBA guide: Header and description of strategy

TURN THE CURVE EXERCISE
POPULATION – SEALANTS
Worksheet

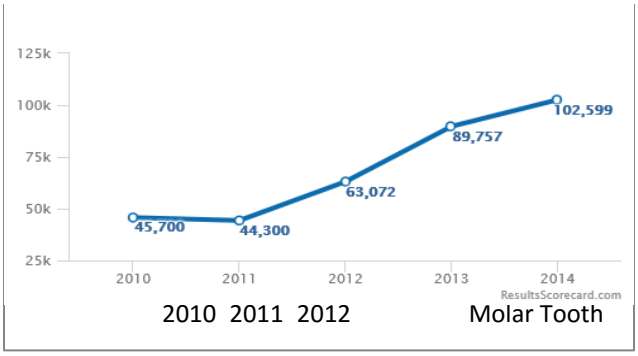
Result: All people in Florida will have optimal oral health and well-being
Focus Area: Improved Access to Quality Oral Health Care
Indicator 1.3a: Percentage of Florida schools with school-based sealant programs
Indicator 1.3b: Total eligible enrolled for at least 90 days receiving a sealant on permanent molar tooth
Indicator 1.3c: Percentage of Medicaid/CHIP eligible receiving a sealant on permanent molar tooth

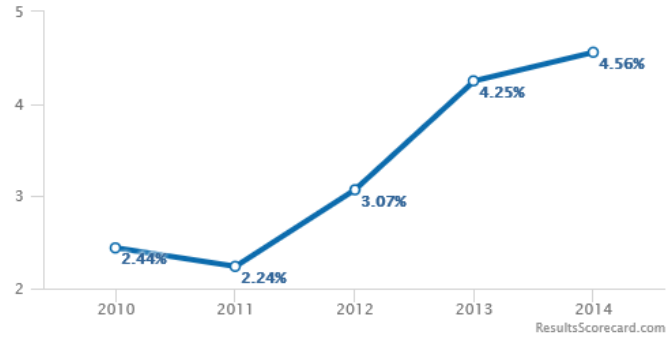
Baseline: How are we doing? Graph of historic baseline (5 years) and forecast if no change in effort (3-5 years).

Percentage of Florida schools with school-based sealant programs (2013-2014)



CMS 416/ EPDST Report Dental – FY 2010-2014





Story behind the baseline: *Consider possible root causes and proximate causes (the obvious).*

New INFORMATION	**New INFORMATION**
Positive/contributing factors that are supporting progress - Training on seals at FDHA symposium - Providing current and requested technical assistance and guest speakers on conference calls - Collecting statewide data across agencies including children served, schools accessed, and dental indicators by county	**Negative/restricting factors that are hindering progress** - Startup funds for new programs in counties without School Based Sealant Programs - Continued technical assistance for streamlined data collection statewide

Prioritize the root causes *according to which have greatest influence on progress and therefore most critical*
NEW ROOT CAUSES?

Root cause #1: Lack of awareness and support of sealant programs.
Root cause #2: Low oral health literacy
Root cause #3: Lack of statewide adoption for standardizing sealant data (SEALS)

Partners to improve progress:
NEW PARTNERS?

- National Assembly of School Nurses
- School based health alliance
- Primary care
- Health plan organization

What works to turn the curve?

- *What would it take? Consider what could work to do better.*
- *Does option address a root cause? Is it evidence-based or innovative idea?*
- *Does it have a no-cost/low-cost option?*

NEW WHAT WORKS?

- Portable equipment
- Low costs
- Dental hygiene workforce model

Confirm strategies: *What do we propose to do?*
Apply criteria to each strategy*: Leverage, Feasibility, Specificity, Values*
NEW STRATEGIES?

Root cause addressed by strategy	**Strategy and criteria**	**Action steps**	**Possible partners**
- Low oral health literacy	- Consumer engagement survey through AHCA - Quality improvement and quality assurance in schools.	- Training about sealants	- National assembly of school based healthcare. - Primary care and health plans
- #3	- Continued training on use of seals and standardized data collection utilizing the Basic Screening	- Schedule trainings at statewide oral health meetings	- School bases health alliance - Children's dental health project

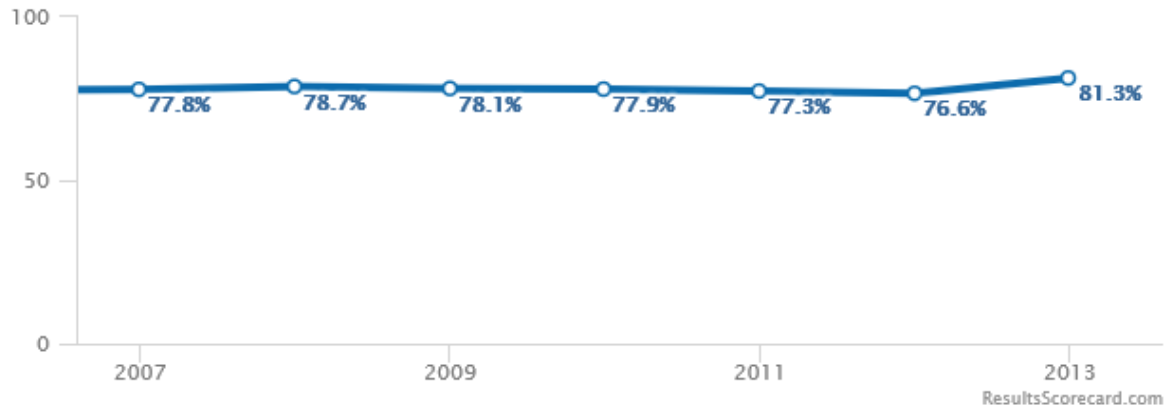
Suggested format per RBA guide: Header and description of strategy

TURN THE CURVE EXERCISE
POPULATION – CWF
Worksheet

Result: All people in Florida will have optimal oral health and well-being
Focus Area: Increased access to community water fluoridation
Indicator 2.1: Percentage of population on community water systems receiving fluoridated water

Baseline: How are we doing? Graph of historic baseline (5 years) and forecast if no change in effort (3-5 years).

Florida Department of Health, Florida CHARTS



Story behind the baseline: *Consider possible root causes and proximate causes (the obvious).*

New INFORMATION	**New INFORMATION**
Positive/contributing factors that are supporting progress - Department of Heath monies for startup cost - Education - FDA and FDHA market positive efforts - Medical and Dental	**Negative/restricting factors that are hindering progress** - Anti-fluoridation activists misinformation engineers and scientists

Prioritize the root causes *according to which have greatest influence on progress and therefore most critical*
NEW ROOT CAUSES?

Root cause #1: Insufficient funds in state and local budgets to support fluoridation – in state and local budgets to support CWF. Overall funding of block grant has been decreased but money is still not being spent. Need to increase knowledge of funds.
Root cause #2: Lack of proactive educational campaigns and community mobilization – (Move to #1) increase positive fluoridation by having Dr. Johnny Johnson do a webinar and on social media (Claudia- we are working on it)
Root cause #3: Lack of a clear understanding of health inequity in oral health – Lack of understanding of systemic disease link to oral health. How good oral health lowers the cost of healthcare.

Partners to improve progress:

NEW PARTNERS?

- More collaboration with the medical profession

What works to turn the curve?

- *What would it take? Consider what could work to do better.*
- *Does option address a root cause? Is it evidence-based or innovative idea?*
- *Does it have a no-cost/low-cost option?*

NEW WHAT WORKS?

- Separate fluoridation web paper for the consumer
- Social media presence increase
- Increase webinars

Confirm strategies: *What do we propose to do?*
Apply criteria to each strategy*: Leverage, Feasibility, Specificity, Values*
NEW STRATEGIES?

Root cause addressed by strategy	Strategy and criteria	Action steps	Possible partners
- #1	- Increase funding	- Advocate support from other organizations	
- #2	- Coordinate educational programs - Increase programs and webinars		
- #3	- Increase social media	- Create website just for fluoridation facts. - YouTube video about water fluoridation	

Suggested format per RBA guide: Header and description of strategy