FLORIDA'S ROADMAP FOR ORAL HEALTH

A Results-Based Strategic Plan

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Executive Summary

The future prosperity of any society depends on its ability to foster the health and well-being of the next generation. When a society invests wisely in children and families, the next generation will pay back through a lifetime of productivity and responsible citizenship.

The Problem

Since 2010, Florida has received poor ratings on multiple oral health indicators for children including an "F" for meeting policy benchmarks to ensure dental health and access for disadvantaged children and a "D" for the percentage of high need schools with access to sealant programs (less than 25%). The most recent study from the Pew Center on the States found that 75.5% of Florida's Medicaid enrolled children did not receive dental care in 2011. Florida's 75.5% places it as the lowest ranking state in the country, falling a full eight points behind the next lowest ranking state at 67%.

In addition, the DentaQuest Foundation-funded, Florida Public Health Institute's 2014 study, *Hospital Emergency Department Use for Preventable Dental Conditions: 2011 & 2012* found that more than 139,000 Floridians were treated in 2012 in hospital emergency departments for oral health conditions considered avoidable with proper preventive and restorative dental care. Charges for these visits exceeded $141 million. The 2012 visits represent a one-year 6.4 percent increase while charges climbed 22 percent yielding a cost increase of over $25 million. Among the reasons Floridians do not receive regular preventive care include lack of dental coverage for adult Medicaid patients, lack of private-practice dentists willing to accept Medicaid's low payment rates, lack of county health department resources, lack of affordable dental insurance or inability to meet high co-pays, and lack of awareness of the importance of dental health to overall health.

The health status of Floridians through a health equity lens is largely unknown. This is developing, implementing, monitoring, and evaluating work using the definition of health equity described as "the opportunity for everyone to attain her/his full health potential . No one is disadvantaged from achieving this potential because of his or her social position or socially assigned circumstance."

The Solution

In response to these troubling trends, between January 2013 and April 2014, with facilitation from the Florida Public Health Institute, the Oral Health Florida Leadership Council developed a results-based strategic plan using the evidence-based Results-Based Accountability™ (RBA) framework, a highly disciplined process developed by Mark Friedman and introduced in his book, *Trying Hard is Not Good Enough.* This model has been used internationally to help groups move from talk to action in order to achieve measureable results. This plan, Florida's Roadmap for Oral Health, supports the achievement of the result: "All people in Florida have optimal oral health and well-being" by addressing two areas of focus:
1) Improved access and utilization of quality oral health care
2) Increased access to community water fluoridation.

Headline indicators that will be used to measure success in these areas include:

- Percentage of Medicaid/SCHIP eligible children receiving any dental services
- Total emergency room costs and number of visits due to preventable oral health conditions
- Percentage of Florida schools with school-based sealant programs
- Total eligible receiving a sealant on permanent molar tooth
- Percentage of population on community water systems receiving fluoridated water

Florida's Roadmap for Oral Health takes into consideration existing Florida oral health plans and initiatives. A living document, it will serve as a blueprint for action by Oral Health Florida over the next three to five years.

The Process

From January 2013 through February 2014, during a series of four face to face meetings and numerous conference calls, the Florida Public Health Institute provided the Oral Health Florida Leadership Council with the consultation, facilitation and support needed to develop this roadmap using the framework of Results-Based Accountability™. In January 2013, the Oral Health Florida Leadership Council was introduced to the framework and began its work to develop this strategic plan.

Prior to January 2013, the Oral Health Florida Data Action Team through the development of the Florida Oral Health Surveillance Plan (State Oral Health Improvement Plan, Recommendation 3) performed a scan of all available data to measure the status of Florida's oral health. The Institute and Oral Health Florida leadership began discussing the need for a revised roadmap and then the Data Action Team identified the best available data and formed trend lines to include a forecast assuming no change in current efforts. In December 2013, during a face to face meeting facilitated by the Results Leadership Group, the Oral Health Florida Leadership Council decided that the plan would remain at the population level in order to maintain focus on the improvement of oral health for the entire state. During this January meeting, the Leadership Council confirmed the roadmap's result and decided upon three preliminary areas of focus (later consolidated into two).

In August 2013, the Leadership Council used the best available data to identify and rate population-level data indicators according to communication, proxy and data power. In December 2013, the Leadership Council began using a structured data-driven decision making process that included the identification and prioritization of factors that contributed to and restricted progress for the first headline indicator, Percentage of Medicaid/SCHIP eligible children receiving any dental services. They identified partners to engage and listed previously implemented successful interventions . Using this information, the group developed strategies for each prioritized factor and began to list action steps for each of these strategies.

Between December 2013 and February 2014, smaller work groups repeated this process for the indicators of community water fluoridation, emergency department oral health visits and spending and dental sealants. On February 13, 2014, the Leadership Council reconvened to confirm and refine the plan's strategies and action steps using a formalized proposal-based decision making process. The final first draft was completed in March and presented to the Leadership Council for confirmation in May 2014. Final document was approved in June 2014.

Oral Health Florida and the Florida Public Health Institute aim to present Florida's Roadmap for Oral Health to the Florida Department of Health and multiple stakeholders in order to garner their support and facilitate strategy implementation.

The Florida Public Health Institute and Oral Health Florida would like to thank Deitre Epps from the Results Leadership Group for her facilitation and guidance as well as the following members of the Leadership Council for hosting face to face meetings throughout this process:

- Palm Beach State College, Nancy Zinser, RDH, MS
- University of Florida College of Dentistry, Frank Catalanotto, DMD
- Special Olympics Florida , Nancy Sawyer, MEd

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Acknowledgements

Florida Public Health Institute (now Florida Institute for Health Innovation) and DentaQuest Foundation for providing facilitation of the results-based strategic planning process

Deitre Epps, Facilitator from Results Leadership Group

Results-Based Accountability™ as presented in the book *Trying Hard Is Not Good Enough* by Mark Friedman

The Planning Process Using Results-Based Accountability™

What is Results-Based Accountability™ ?

- RBA is 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 it?

- 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.

Population Accountability and Performance Accountability

- **Population accountability:** The system or process for holding people in a geographic are responsible for the well-being of the total population or a defined subpopulation
- **Performance accountability:** The system or process for holding managers and workers responsible for the performance of their programs, agencies and service systems

The strategies in this plan were developed at the population level and not at a program or agency level – meaning that this plan focuses on the improvement of oral health at the statewide and community level. As we move forward in the implementation of the plan, we will track the performance accountability of programs, agencies and the oral health service system to ensure they run efficiently and effectively.

Our Common Language

- **Result**: Conditions of well-being for an entire population
- **Indicator**: How we measure these conditions; the data that indicates achieving our result
- **Baseline**: What the measures show about where we've been and where we're headed: 1) 5-year historical trend line and 2) ***forecast*** if we maintain current level of effort
- **Story behind the baseline (or data)**: The positive and negative factors that contributed to the data
- **Strategy**: A coherent set of actions that has a reasoned chance of producing a desired effect
- **Performance measure**: Measure that tells us if our program, agency or service system is working by answering 1) How much did we do 2) How well did we do it 3) Is anyone better off

Friedman, M. (2009). *Trying Hard is Not Good Enough:*. BookSurge Publishing.

Creating the Strategic Plan: Our Results-Based Accountability™ Process

Result: All people in Florida have optimal oral health and well-being

Focus area #1: Improved access to and utilization of quality oral health care

Focus area #2: Increased access to community water system fluoridation

Decision-making process:

- Chose and confirmed result
- Identified two areas of focus that will lead to the result
- Identified existing and missing data
- Created historic and forecasting baselines (data trend lines)
- Created data development agenda
- Chose headline indicators according to criteria
- Told the story behind the baseline (trend line data), including a root cause analysis
- Listed partners
- Identified what works to improve the indicator and achieve the result
- Formed strategies according to Results Based Accountability criteria

Result: All people in Florida have optimal oral health and well-being

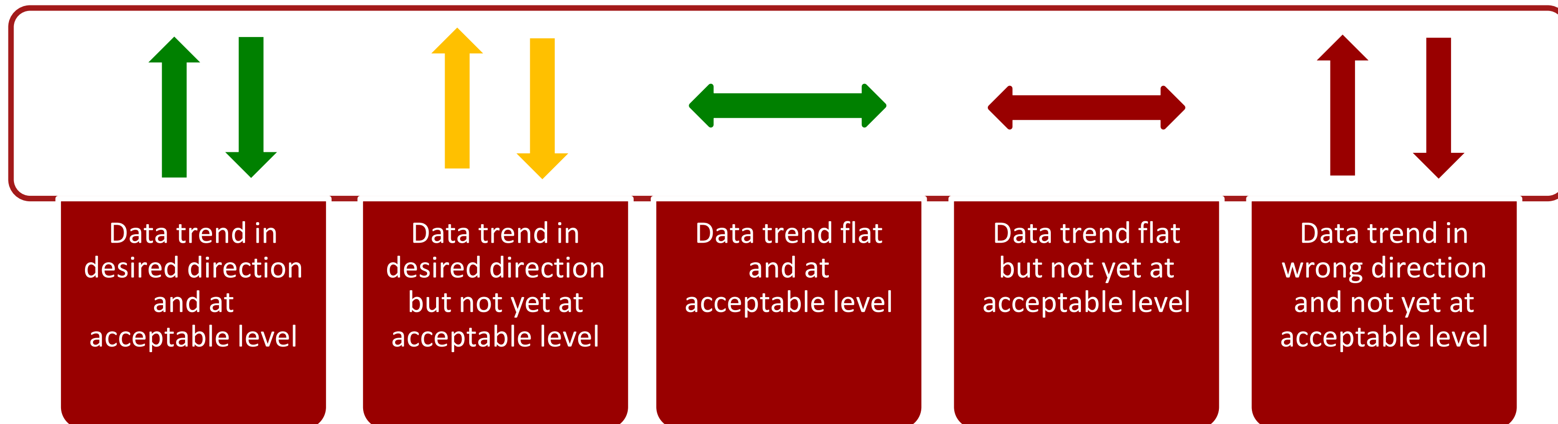
These three pages will serve as a "how to" guide for reading the indicator pages.

Why is this important?

Background and rationale for focusing on the indicator or result.

How will we know the result has been achieved?

The achievement of our result will be measured by progress on 3 – 5 community indicators in each focus area. The goal is to choose indicators that communicate well, are of central importance to the result and for which good data is available.



Notes:

- Depending on the indicator, an up or down direction may be good or not. For example, we want to see untreated tooth decay go down, but preventive dental care go up.
- In addition to the direction of a trend, the current status of an indicator may or may not be at an acceptable level. For example, the number of communities with fluoridated water may be going up, but still has not reached an acceptable level that we want to see in our community.
- Specific data charts for each headline indicator not on the Data Development Agenda are available in the Data Appendix.
- Performance measures for statewide oral health programs will align with and contribute to improving community indicators; however, programs are accountable only for their participants' improvements, not for community indicator improvements.

Stories behind the baseline (data):

Factors or causes for the baseline/data.

What positive factors have contributed to improving the baseline/data?

What negative factors that has restricted the data?

What works: Our best ideas:

Partnerships:

What critical stakeholders do we need to address the underlying factors.

Focus Area: Improved access to and utilization of quality oral health care

Innovative states and communities have been able to design programs that connect families with the preventive care needed to stay healthy. These programs have solved problems of health access and shown significant long term improvements for children and families – but many places still don't have access to these innovations.

Why is this important?

Background and rationale for focusing on the indicator.

A 2000 report by the U.S. Surgeon General called dental disease a "silent epidemic." Overwhelming numbers of individuals exhibit serious dental diseases , contributing to poor overall health, hospital emergency room visits for preventable dental conditions, missed school and work days and other consequences (1). Access to oral health care services is one of the important determinants of oral health status. The American Dental Association recently presented a data summary (2) that stated: "Utilization of dental care has declined among working age adults, particularly the young and the poor. Dental benefits coverage for adults has steadily eroded the past decade, again particularly for young and poor adults. Not surprisingly, more and more adults in all income groups are experiencing financial barriers to care". The result of this lack of access to oral health care has been labeled as a "dental crisis in America" by the United States Senate (3). Studies show that patients who are able to access dental care and receive preventive and therapeutic dental services are better able to prevent and control dental diseases such as dental caries (3). We have chosen three indicators to illustrate the level of access to oral health care services for one high risk patient group of children in Florida and one indicator to illustrate the effects of lack of access to oral health services for the general population in Florida.

1. U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: URL: www.surgeongeneral.gov/library/oralhealth

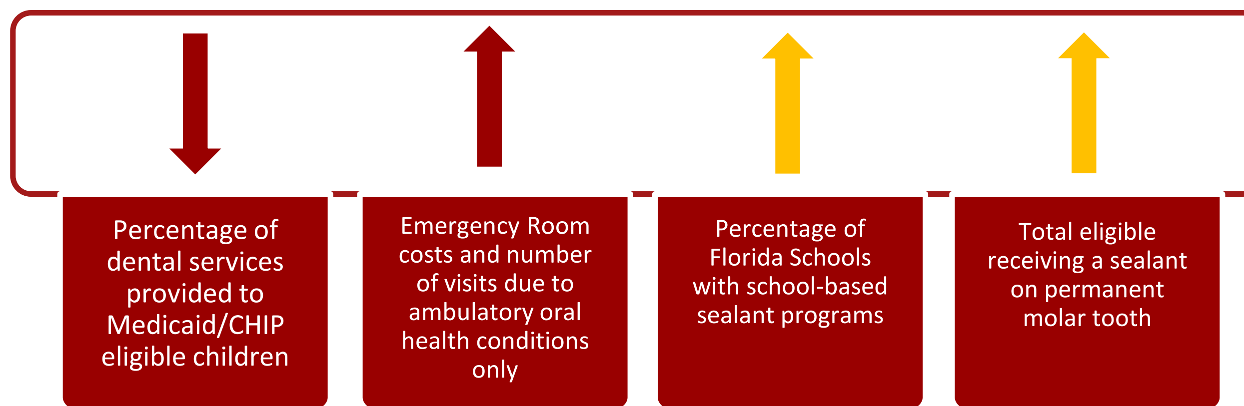
2. A Profession in Transition: Key Forces Reshaping the Dental Landscape, ADA Health Policy Resources Center. August 2013, http://www.ada.org/sections/professionalResources/pdfs/Escan2013_ADA_Full.pdf

3. DENTAL CRISIS IN AMERICA: The Need to Expand Access. A Report from Chairman Bernard Sanders Subcommittee on Primary Health and Aging ,U.S. Senate Committee on Health, Education, Labor & Pensions, February 29, 2012, http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf

4. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs, Matthew F. Savage, Jessica Y. Lee, Jonathan B. Kotch and William F. Vann, Jr. , Pediatrics 2004;114;e418-e423, DOI: 10.1542/peds.2003-0469-F

Focus Area: Improved access to and utilization of quality oral health care

How will we know this has been achieved?

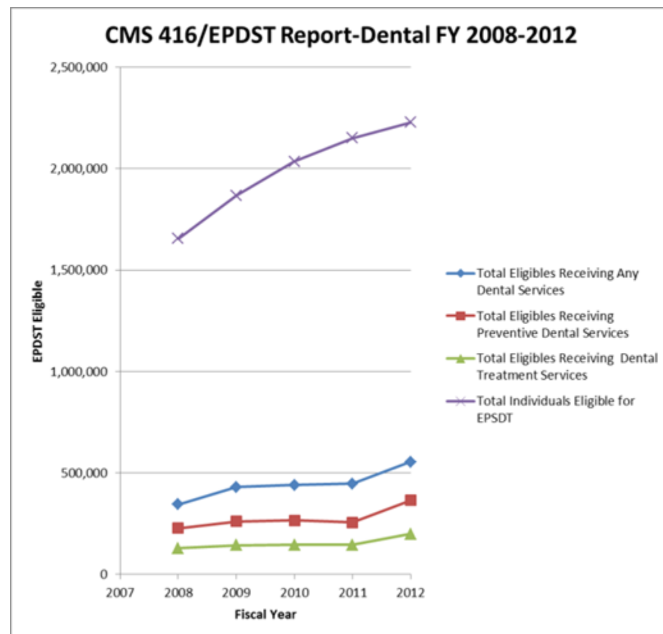


Data Development Agenda: Priorities for new or improved data
Focus Area: Improved access to and utilization of quality oral health care

- Percentage of Florida schools with school-based sealant programs
- Percentage of untreated decay in vulnerable populations (3rd Grade, Head Start, Older Adults)
- Percentage of public with access to dental care
- Rate of oral health program development
- Present all data through the health equity lens

Focus Area: Improved access to and utilization of quality oral health care

Indicator 1.1: Percentage of Medicaid/SCHIP eligible children receiving any dental services



How will we know this has been achieved?

Percentage of preventive services provided to Medicaid/CHIP eligible children will increase by 10% (from FY 2011 to FY 2015).

Fiscal Year	Total Eligible Receiving Any Dental Services	Total Eligible Receiving Preventive Dental Services	Total Eligible Receiving Dental Treatment Services	Total Eligible Receiving a Sealant on Permanent Molar Tooth	Total Eligible Receiving Dental Diagnostic Services	Total Eligible Receiving Oral Health Services provided by a Non-Dentist Provider	Total Eligible Receiving Any Dental or Oral Health Service	Total Individuals Eligible for EPSDT for 90 Continuous Days	Total Individuals Eligible for EPSDT
2008	346,018	227,548	128,921	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	1,654,843
2009	431,017	262,094	144,307	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	1,868,563
2010	440,272	266,302	146,379	45,700	420,993	33,112	469,420	1,870,235	2,035,073
2011	447,579	257,109	146,634	44,300	401,380	32,531	476,774	1,978,260	2,151,566
2012	555,465	365,159	200,248	63,072	528,892	61,810	610,210	2,057,419	2,228,923

Stories behind the baseline (data)
Focus Area #1: Improved access to and utilization of quality oral health care
Indicator 1.1: Percentage of Medicaid/SCHIP eligible children receiving any dental services

Factors that have contributed to improving the data:

- Access legislation promotes sealant programs
- CMS prepaid dental has impacted preventive services
- Additional children are being covered by Medicaid
- Fluoride-varnish is being applied in health access settings
- Collaboration between oral health and primary care is increasing
- There is greater access to information about preventive dental care
- Increased reimbursement rates
- Fluoridation has increased across the state
- Dental benefits promote preventive treatment
- Managed care companies are focused on patient outreach

Factors that restrict the data:

- There is a lack of access to preventive dental care due to its high cost and low percentage of individuals with dental insurance
- Negative perceptions about dental care, painful experiences that result from acute conditions and fear al discourage people from seeking preventive treatment
- People perceive dental care as acute and not preventive.
- Generational and cultural differences determine belief about oral health
- There is a shortage of providers because of: extremely poor Medicaid reimbursement
- There is a lack of oral health funding
- There is a lack of parental focus on children's oral health because of: lack of knowledge of importance of oral health; decreasing school oral health programs and health education
- Dental is not integrated into overall health care
- Unknown status around health equity

Potential Partnerships:

Incomplete list of critical partnerships identified to address underlying factors and garner support:

- Florida Association of Community Health Centers
- Florida Agency for Health Care Administration
- Florida Department of Health
- Florida Chapter of the AAP
- Florida Department of Education
- Florida CHAIN
- Community Catalyst
- Florida Legal Services
- Office of the Governor
- State Legislature
- Human Services Organizations
- Area Agencies on Aging
- Managed Care Plans
- Community Health Workers
- Social Workers
- Group Dental Practices
- Insurance Groups/Managed Care
- Hospitals
- Primary Care Professionals
- School Districts
- Early Childhood Coalitions
- Legislators
- Lobbyists
- Florida Head Start State Collaboration Office
- Special Olympics Florida
- Florida Dental Hygiene Association
- Tribal Councils
- National Dental Association
- National Hispanic Association
- Urban League

Prioritized factors:

Prioritized factors are the factors that we have chosen to address for greatest impact.

- Lack of perceived_integration of oral health into primary care
- Lack of value of oral health – messaging/oral health literacy as evidence based
- Lack of access to preventive services
- Lack of a clear understanding of health inequity in oral health

What Works: Our best ideas

- Increase and improve public awareness campaigns regarding oral health
- Provide continuing education for oral health providers to increase proficiency regarding the treatment of vulnerable populations
- Educate medical providers about the importance of oral health
- Advocate for higher Medicaid reimbursement for dental care
- Develop a statewide oral health surveillance plan

Recommended statewide strategies and action steps:

Prioritized factors	Strategy	Action Steps
Lack of perceived integration of oral health into primary care	• Increase awareness and education among medical providers to increase the value of oral health as a part of general health • Expand focus of school health programs to include BSS oral health screenings and prevention services that can be provided by school nurses	• Make referrals to dental providers • Assist medical patients to establish a dental home • The state is currently discussing replacing scoliosis screening with oral health screening.
Lack of value oral health – messaging/oral health literacy as evidence based	• Increase knowledge and broaden and leverage partnerships • Increase knowledge and information and broaden partnership on the value of oral health • Increase broad based support from other organizations affiliated with children's health (PTAs, PCP, head start, CMS)	• Identify effective messaging campaigns • Engage dental product corporations • Revise messaging campaigns to include cultural competency

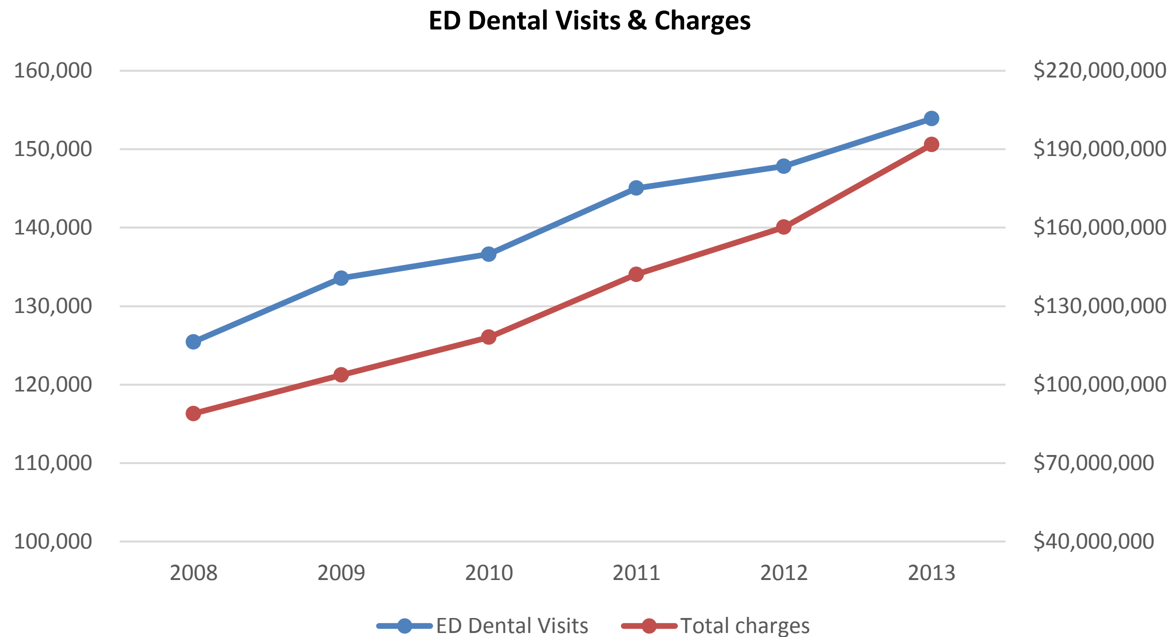
Recommended statewide strategies and action steps:

Prioritized factors	Strategy	Action Steps
Lack of providers due to low reimbursement; lack of providers due to bureaucracy and stigma	• Promote increased participation of dental providers in managed care programs to improve access to care • Promote the expansion of medical insurance reimbursement to medical providers for fluoride varnish services • Improve Medicaid program performance through policy changes • Increase awareness and education among medical providers to include health sciences and educational programs to increase the value of oral health as a part of general health	• Support a common provider application for credentialing for managed care organizations • Encourage AHCA to develop a customized participation program for Medicaid dentists (Replicate best practice models such as Texas) • Organize groups/stakeholders to create broad coalition support to increase utilization and therefore drive demand for increased reimbursement to providers • Encourage AHCA (or directly encourage managed care companies) to require managed care companies to decrease bureaucracy and increase percentage of claims that are reimbursed to providers via specific performance measures

Focus Area: Improved access to and utilization of quality oral health care

Indicator 1.2: Total emergency room costs and number of visits due to ambulatory oral health conditions

	2008	2009	2010	2011	2012	2013
Total Visit Charges to ER	$88,952,151	$103,647,663	$118,084,105	$142,120,428	$160,160,372	$191,727,312
Total Patient Visits to ER	125,438	133,565	136,613	145,025	147,828	153,886



Data source: AHCA Emergency Department discharge data. Dental-related ED visit: Primary diagnosis or primary reason for visit: ICD-9 codes 520–526.9, 528–528.9, 784.92, V52.3, V53.4, V58.5. Analysis by: Scott Tomar, DMD, DrPH

Stories behind the baseline (data)

Focus Area: Improved access to and utilization of quality oral health care

Indicator 1.2: Total emergency room costs and number of visits due to preventable oral health conditions

Factors that have contributed to improving the data:

- There is growing awareness of the "problem" and high costs of ER Visits for oral health issues
- State Medicaid (AHCA) has been charged w/ increasing access for Medicaid clients (children) which may result in an increased number of providers taking Medicaid

Factors that restrict the data:

- There is a lack of access to care for both Medicaid and uninsured adults and children
- A limited number of dentists participate in Medicaid
- There is a lack of providers who participate in Medicaid
- A lack of oral health literacy (lack of knowledge of self-care) exists
- A lack of knowledge of community dental resources exists.
- There is no follow up in the ER to refer for dental treatment.
- People use ERs as primary care physicians (for non-emergent medical and dental issues)
- There is a lack of knowledge regarding the proper use of the ER
- Limited adult dental Medicaid benefit exists in Florida
- There is a lack of resources for uninsured adults
- There is usually no definitive treatment or follow up care for dental problems in hospital emergency rooms
- There is a limited amount of sources for low cost care
- Unknown status around health equity

Potential Partnerships:

Incomplete list of critical partnerships identified to address underlying factors and garner support:

- Florida Association of Community Health Centers
- Florida Agency for Health Care Administration
- Florida Department of Health
- Florida Department of Children and Families
- Area Agencies on Aging
- Safety net providers
- Hospitals (including administrators, providers, social workers/case managers)
- Dentists and dental societies
- Consumer advocates (Florida Legal Services/legal aid
- Rural health
- At policy level: requirements for PCMH certification that requires documentation and follow up referrals for care
- US. Health and Human Services (HHS)
- Center for Medicare and Medicaid Services (CMS)
- Health Resource Administration (HRSA)
- Low income pool grants for ER navigation
- Florida Dental Hygiene Association
- Tribal Councils
- National Dental Association
- National Hispanic Association
- Urban League

Prioritized factors:

Prioritized factors are the factors that we have chosen to address for greatest impact.

- Insufficient community dental resources and consumer knowledge of dental resources
- Limited oral health literacy especially regarding resources and use of emergency departments
- There are limited adult Medicaid dental benefits that are inadequate in meeting the needs of the public
- There are a lack of providers who participate in Medicaid
- Lack of a clear understanding of health inequity in oral health

What Works: Our best ideas

- Health navigators in emergency rooms to provide case management, referral and follow up to dental resources in the community.
- Explore best practices used in other states to increase client and provider participation in Medicaid programs
- Oral health education and prevention campaign to include “when to use ER,” community health resource guides yield positive results
- Development of new payer/delivery models

Recommended statewide strategies and action steps:

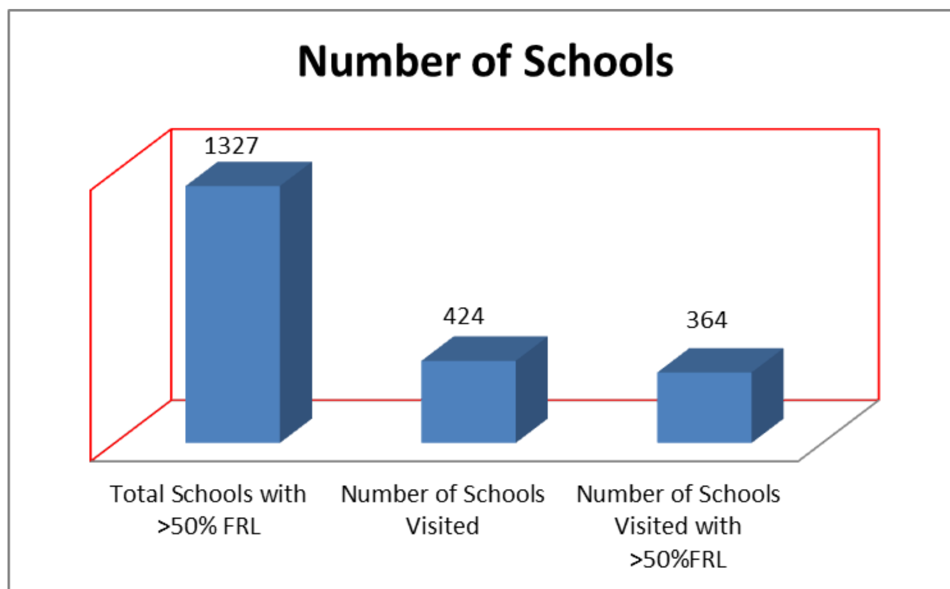
Prioritized factors	Strategy	Action Steps
Insufficient community dental resources and consumer knowledge of dental resources	• Promote health navigators into ER to follow up • Develop new payer/delivery models (e.g. explore the development of public-private partnership in the care of emergency based dental problems)	• Educate and utilize health navigators in ERs • Establish focus groups to implement navigation in the community
Limited oral health literacy especially regarding resources and use of emergency departments	• Create an oral health literacy and prevention campaign aimed at use of ER, available oral health resources, benefits/coverage	• Create education program for when/how to use ER • Create community resource guides for dental • Partner with 211 Association to incorporate statewide oral health resources into ~~their~~ its network
There are limited adult Medicaid dental benefits which are inadequate in meeting the needs of the public There are a lack of providers who participate in Medicaid	• Implement best practices used in other states to increase participation in Medicaid programs	• Identify and implement best practices for increasing Medicaid providers and expanding Medicaid benefits • Bring in national speaker to OHF about best practices • Work with AHCA to incorporate best practices into the Medicaid system

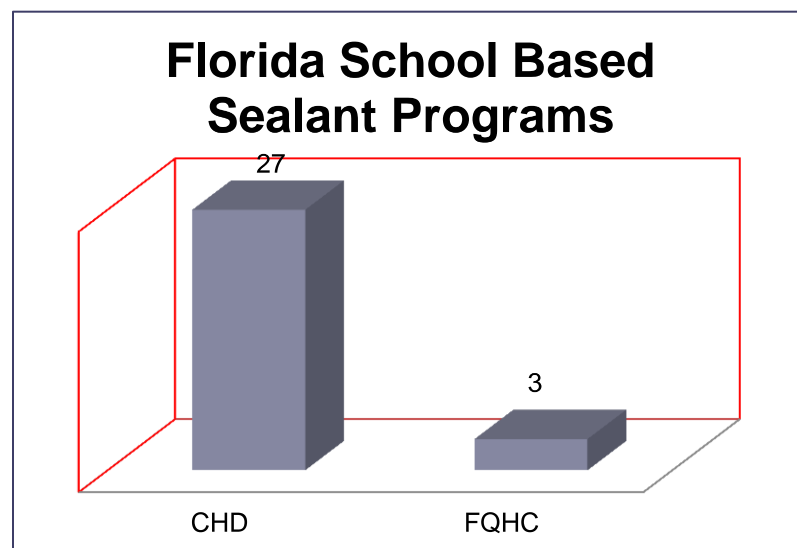
Focus Area: Improved access to and utilization of quality oral health care
Indicator 1.3a: Percentage of Florida schools with school-based sealant programs

FL School Based Sealant Programs FY 2013-2014

School-based sealant program data is not complete and is being included on the data development agenda. It was collected by the Oral Health Florida Sealant Action Team

See health access setting data for comparison

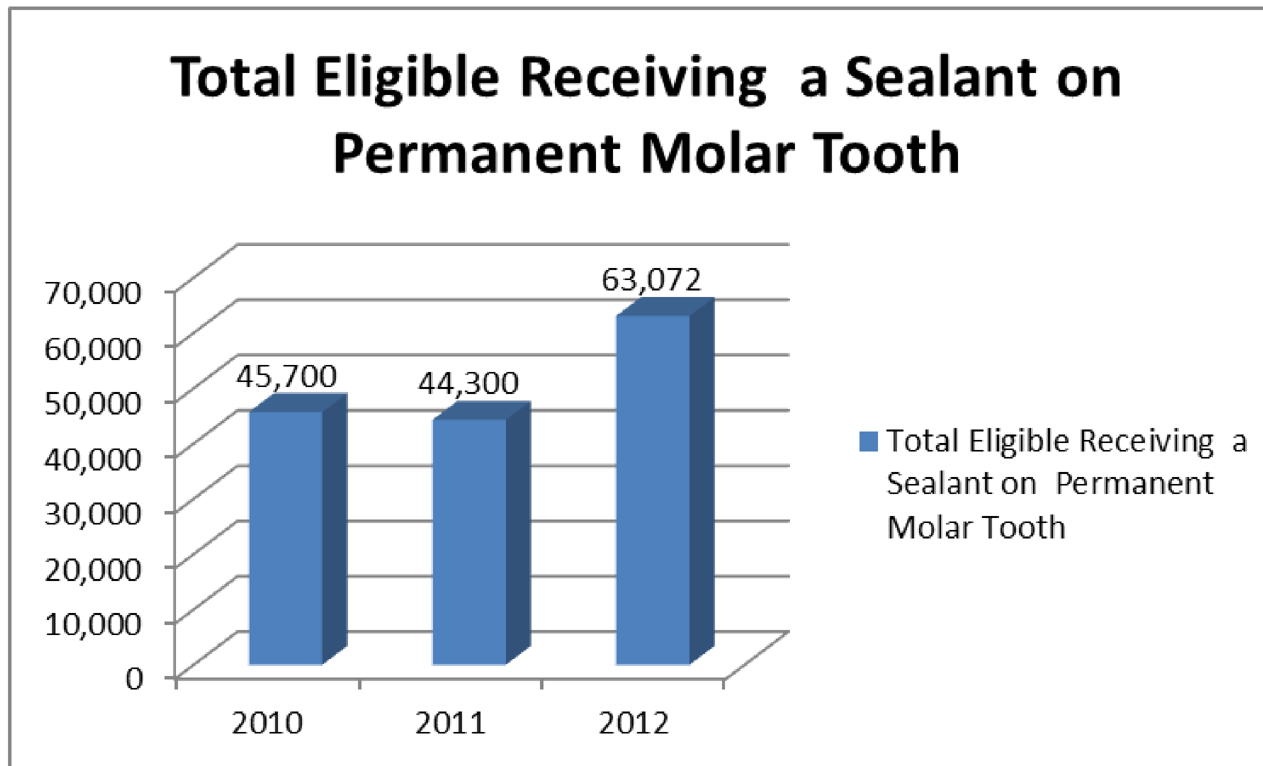




Focus Area: Improved access to and utilization of quality oral health care

Indicator #2: Total Medicaid/SCHIP eligible receiving a sealant on permanent molar tooth

CMS 416/ EPDST Report Dental – FY 2010-2012



Stories behind the baseline (data)
Focus Area: Improved access to and utilization of quality oral health care
Indicator 1.3a: Percentage of Florida schools with school-based sealant programs
Indicator 1.3b: Total Medicaid/SCHIP eligible receiving a sealant on permanent molar tooth

Factors that have contributed to improving the data:

- There is increased awareness of the importance of sealants
- Oral Health Florida supports the work of their Sealant Action Team to improve access to care
- The Sealant Action Team contributes to member mentorship, validates importance of individual sealant programs, provides expert advice on the nuts and bolts and best practices of implementing and managing a sealant program
- Law was passed to allow dental hygienists to work in a public health access setting under the authorization of a dentist.
- There is a growing awareness of oral health and sealant data gaps
- Prior examination by dentists are not required prior to application of sealants by dental hygienists

Factors that restrict the data:

- There is a lack of cohesive support from partners and stakeholders to develop, maintain and increase sealant programs
- There is a lack of continuity of data collected from all sealant programs. (i.e. SEALS)
- No agency collects sealant data (SEALS) on a statewide basis.
- Low oral health literacy leads to a low value being placed on sealants
- Some parents do not understand that their child's sealants are not going to take away from their coverage/"savings account." *AHCA has been implementing outreach to dispel misinformation*
- There is low parent participation and low consent form return
- Unknown status around health equity

Potential Partnerships:

Incomplete list of critical partnerships identified to address underlying factors and garner support:

- PTA
- School administration
- School district boards of education
- Florida Department of Health
- Florida Department of Education
- Agency for Healthcare Administration (AHCA)
- Florida Department of Children and Families
- Florida Association of Community Health Centers
- Schools of Dentistry and Dental Hygiene
- Florida Dental Hygiene Association
- Nonprofit and faith-based organizations (especially those providing sealants)
- United Way Florida
- Tribal Councils
- National Dental Association
- National Hispanic Association
- Urban League

Prioritized factors:

Prioritized factors are the factors that we have chosen to address for greatest impact.

- Lack of awareness and support of school sealant programs
- Low oral health literacy
- Lack of statewide adoption for standardizing sealant data (SEALS)

What Works: Our best ideas

- Implement oral health education and advocacy campaigns aimed at Florida Department of Education, the State Board of Education, local Boards of Education, the state Legislature, and the general public about the importance of oral health and the potential of school based sealant programs in preventing dental caries in school age children
- Improve funding sources for development and maintenance of school based sealant programs through advocacy and education of such organizations as United Way and other statewide and local philanthropic agencies
- Continue to explore best practices used in other states to develop and implement school based sealant programs and monitor data more effectively about implementation in Florida through use of the SEALS program for data collection and evaluation

Recommended statewide strategies and action steps:

Prioritized factors	Strategies	Action Steps
Lack of statewide adoption for standardizing sealant data (SEALS)	• Encourage the use of SEALS data collection tool	
Low oral health literacy		
Lack of awareness and support of school sealant programs	• Increase school-based sealant programs in Florida • Increase Medicaid reimbursement for sealants • Advocate for client Medicaid reimbursement for sealants provided in health access settings	• Adopt standardized definition of “school-based sealant program” and “school-based preventive program” • Develop a recommended consent form • Create 1 page “white paper” on sealants for Florida (using current data) • Adopt and promote best practice for sealant protocol • Obtain CDC funding for the state of Florida to support the Department of Health’s oral disease prevention program

Focus Area: Increased access to community water fluoridation

Indicator 2.1: Percentage of population on community water systems receiving fluoridated water

Past generations have solved many problems of infectious disease for our people. Problems like small pox and measles are a thing of the past. Today, we have the tools to prevent the most common infectious diseases affecting children and families, including tooth decay. Preventing this disease will avoid expensive treatments, missed work, school and missed opportunities later in life.

Why is this important?

Background and rationale for focusing on the indicator.

According to the Centers for Disease Control and Prevention (CDC), studies show that water fluoridation reduces tooth decay by about 25 percent over a person's lifetime. Community water fluoridation is safe, effective, economical and available to all consumers of a fluoridated community water supply regardless of age, income, education, or socioeconomic status. Income and the ability to access regular dental care are not barriers to receiving fluoride's protective benefits. In addition, the CDC reports that "every $1 invested in this preventive measure yields approximately $38 savings in dental treatment costs." The CDC has recognized water fluoridation as one of 10 great public health achievements of the 20th century.

The Centers for Disease Control and Prevention Community Water Fluoridation. (July 2013) Accessed from http://www.cdc.gov/fluoridation/index.htm on May 15, 2014.

How will we know this has been achieved?

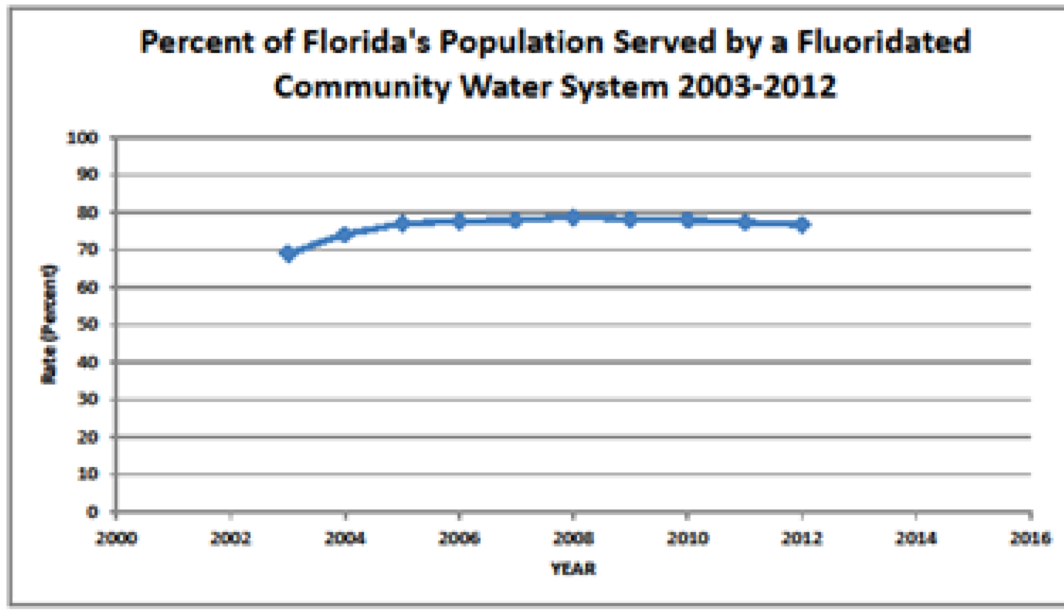
Percentage of population on community water systems receiving fluoridated water.

Data Development Agenda: Priorities for new or improved data

- County level data collection
- Present all data through the health equity lens

Focus Area: Increased access to community water fluoridation

Indicator 2.1: Percentage of population on community water systems receiving fluoridated water by 79.6%



Source: Florida Department of Health, Florida CHARTS
http://www.floridacharts.com/charts/SearchResult.aspx

Fluoridation data points

Year	Rate (%)	Year	Rate (%)
2003	68.9	2008	78.7
2004	74.1	2009	78.1
2005	76.9	2010	77.9
2006	77.6	2011	77.3
2007	77.8	2012	76.6

Stories behind the baseline (data)
Focus Area: Community Water Fluoridation:

Factors that have contributed to improving the data:

- Team approach of stakeholders (FDHA, OHF, FDOH, UFCD, local coalitions)
- State and local legislative policies: Surgeon General, Local budgets for fluoridation systems (resources)
- Advocacy/PR/media: Public hearings, articles, speakers, education materials
- Research to offset anti-fluoridation (CDC, ADA)

Factors that restrict the data:

- Anti-fluoridationists are communicating false information about fluoride chemical
    - Generates confusion/fear/doubt/lack of trust
    - Lack of information, common language and health literacy
    - Providing resources to maximize search engine optimization (SEO-Google)
- Lack of consumer engagement at community level
- Economics
    - Municipal budgets decree
    - Easy to cut fluoride budget – belief that removing fluoride will cut costs
    - Optional service - not a high priority
    - Don't understand Return on Investment
- Politics
- Arguments regarding small government interfering in person life
- Belief that removing fluoride will cut costs
- Unknown status of health equity

Potential Partnerships:

Incomplete list of critical partnerships identified to address underlying factors and garner support:

- Florida Association of Counties
- Consumers
- Water operators
- Engineers
- Local dental groups
- Dental insurance companies
- Florida Department of Health
- Florida Dental Hygiene Association
- University of Florida School of Dentistry
- Nova Southeastern University College of Dentistry
- Florida League of Cities
- Oral Health Florida
- Local Coalitions
- County Health Departments
- American Dental Association
- Centers for Disease Control and Prevention (CDC)
- American Academy of Pediatrics Campaign for Dental Health (ILikeMyTeeth.org)
- Pew's Children's Dental Campaign Project
- Children's Dental Health Project
- Association of State and Territorial Dental Directors
- Tribal Councils
- National Dental Association
- National Hispanic Association
- Urban League

Prioritized factors:

Prioritized factors are the factors that we have chosen to address for greatest impact.

- Insufficient funds in state and local budgets to support fluoridation
- Lack of proactive educational campaigns and community mobilization
- Lack of a clear understanding of health inequity in oral health

What Works: Our best ideas

- Increase information distribution
- Advocacy and political involvement (support a fluoridation candidate)
- Word of mouth, a no cost idea
- Support state funding for community water fluoridation
- Focus on large water systems
- Increase consumer and stakeholder involvement
  - Mobilize grass roots community advocates
- Provide continued education on the benefits of water fluoridation in your community
- Search engine optimization on pro-fluoride information

Recommended statewide strategies and action steps:

Prioritized factors	Strategies	Action steps
Insufficient funds in state and local budgets to support fluoridation	• Maintain and secure funding for Community Water Fluoridation (CWF) (block grant decreased from 150,000 in 2008 to 35,000 this year)	• OHF support continued funding via public testimony and science • Increase OHF fluoridation action team participation • Recruit OHF and LC members to participate on the Preventive Health and Health Services Block grant Ad Council
Lack of proactive educational campaigns and community mobilization	• Build and mobilize local coalitions to advocate for CWF (This has been very successful)	• Increase # of members in OHF Fluoridation work group • Link FPHI's coalition-building with fluoridation effort • Prioritize largest water systems not fluoridated • Show return on investment for CWF • Advocate for recurring statewide funding

Recommended statewide strategies and action steps:

Prioritized factors	Strategies	Action steps
Lack of proactive educational campaigns and community mobilization	• Reward best practice examples in CWF in state using ASTDD awards, OHF, FDOH awards by end of 2014	• Work with FDA and FDHA and OHF partners to recognize communities that are optimally providing fluoride officially by presenting their awards to city councils
Lack of proactive educational campaigns and community mobilization	• Maximize search engines for pro-fluoridation facts	• Encourage CDC/HHS and other entities to allocate resources to refute anti-fluoridation on search engines

Existing and Potential Partners

Identified through Brainstorming – List is Incomplete

- American Academy of Pediatrics Campaign for Dental Health (ILikeMyTeeth.org)
- American Dental Association
- Area Agencies on Aging
- Association of State and Territorial Dental Directors
- Center for Medicare and Medicaid Services (CMS)
- Centers for Disease Control and Prevention (CDC)
- Children's Dental Health Project
- Colleges of Dentistry and Schools of Dental Hygiene
- Community Catalyst
- Community Health Workers
- Consumer advocates
- Consumers
- County Health Departments
- Dental insurance companies
- Dentists and dental societies
- Early childhood coalitions
- Engineers
- Florida Agency for Health Care Administration (AHCA)
- Florida Association of Community Health Centers
- Florida Association of Counties
- Florida CHAIN
- Florida Chapter of the AAP
- Florida Dental Hygiene Association
- Florida Department of Children and Families
- Florida Department of Education
- Florida Department of Health
- Florida Head Start State Collaboration Office
- Florida League of Cities
- Florida Legal Services
- Group dental practices
- Health Resource Administration (HRSA)
- Hospitals
- Hospitals (including administrators, providers, social workers/case managers)"
- Human Services Organizations
- Insurance groups/managed care
- Legislators
- Lobbyists
- Local Coalitions
- Local dental groups
- Managed care plans
- National Dental Association
- National Hispanic Association
- Nonprofit and faith-based organizations
- Nova Southeastern University College of Dentistry
- Office of the Governor
- Oral Health Florida
- Pew's Children's Dental Campaign Project
- Primary care professionals
- PTA
- Rural health
- Safety net providers
- School administration
- School district boards of education
- School districts
- Social Workers
- Special Olympics Florida
- State Legislature
- Tribal Councils
- United Way Florida
- University of Florida School of Dentistry
- Urban League
- US. Health and Human Services (HHS)
- Water Operators

The difference between population indicators and performance measures:

This strategic plan was created based upon population indicators only. Once an implementation plan is developed and state partners commit to implementation actions, including strategies and action steps, each program will design its own performance measures to ensure accountability.

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

Performance measures relate specific program efforts to outcomes

	Quantity	**Quality**
Input Effort	How much did we do?	How well did we do it?
	Is anyone better off?	
Output Effect	How much change/effect did we produce? #	What quality of change/effect did we produce? %

Retrieved February 7, 2014, from http://www.raguide.org/RA/3_3.htm

Appendix: Associated Indicator Data

In addition to the five indicators included in the plan, the appendix includes additional reliable data by which progress can be measured. This includes:

- Percentage of children ages 5-42 months receiving preventive services from physicians slide 36
  - Source: University of Florida, Gator Kids Healthy Smiles Report

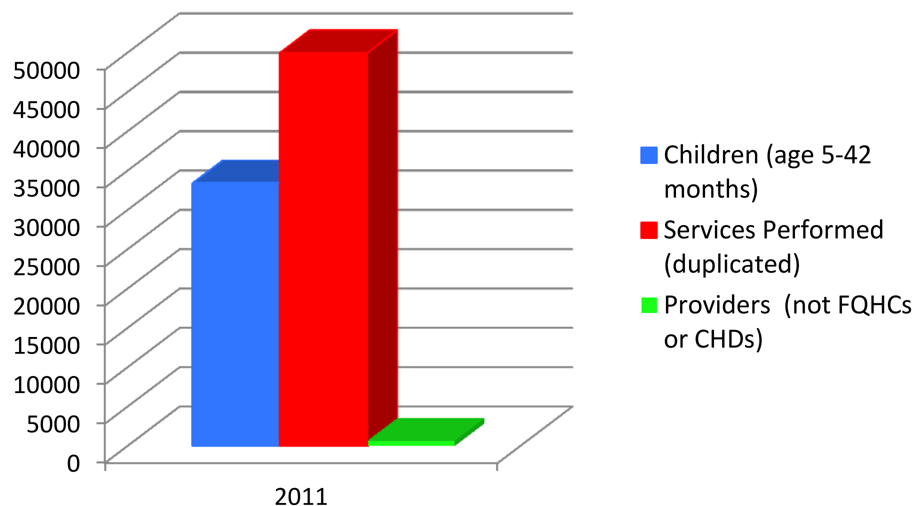
- Number of dental providers providing Medicaid dental services slide 37
  - Source: Source: Division of Medical Quality Assurance (MQA) Annual Report, Florida Department of Health (DOH)
  - Source: AHCA, Florida and Florida Medicaid Department of Social Services (DSS)

Selected headline indicators that lack reliable data are not included in this data appendix. The Data Development Agenda (DDA) and sources and methods for collecting such data are being pursued.

Because this plan remains at the population level, performance of individual programs (with the exception of Florida Medicaid) have not been included.

Focus Indicator: Improved access to and utilization of quality oral health care

- **Additional Supporting Data:** Percent of children ages 5-42 months receiving preventive services from physicians



University of Florida, Gator Kids Healthy Smiles Report

Estimated 33K additional children received services in FQHCs and CHDs - only 10% of eligible children

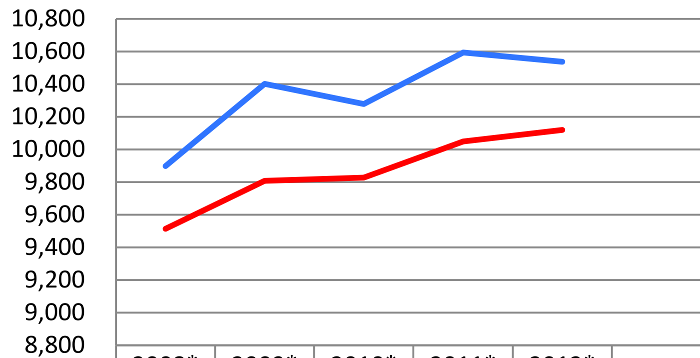
Source: University of Florida

	2011
Children (age 5-42 months)	33,436
Services Performed (duplicated)	50,000
Providers (not FQHCs or CHDs)	672

Indicator: Improved access to and utilization of quality oral health care

Additional Supporting Data: Number of dental providers providing Medicaid dental services

Number of Dental Providers

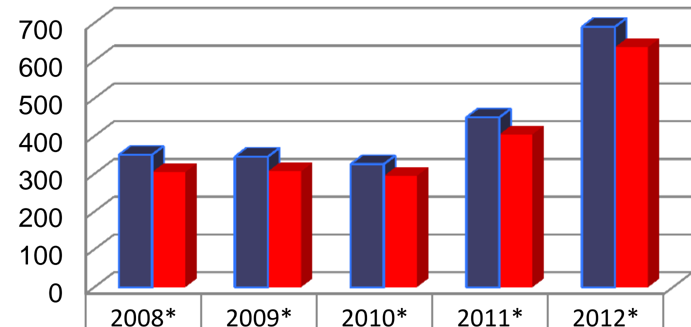


	2008*	2009*	2010*	2011*	2012*
FL Dentists	9,512	9,807	9,827	10,048	10,118
FL Dental Hygienists	9,897	10,402	10,278	10,593	10,536

Source: Division of Medical Quality Assurance (MQA) Annual Report, Florida Department of Health (DOH)

Source: AHCA, Florida and Florida Medicaid Department of Social Services (DSS)

Number of Medicaid Billing Dentists



	2008*	2009*	2010*	2011*	2012*
Number of Billing Dentists Who Saw 50 or More Beneficiaries Under Age 21 Years	351	346	326	450	690
Number of Billing Dentists Who Saw 100 or More Beneficiaries Under Age 21 Years	305	307	295	405	636