WISCONSIN
Oral Health
COALITION
Children's Health
Alliance of Wisconsin

WOHC Regional Meeting Activity worksheets

Activity 1

STRATEGIC AREA 1: What are the assets and gaps/barriers that currently exist in oral health care relating to INFRASTRUCTURE?

Goal 1.1: Increase funding to provide Wisconsin residents with needed preventative and restorative services.	
Assets: Medicaid pilot project Delta Dental- Foundational supports fellowship to Marquette University School of Dentistry (Tri-County) Northeast Wisconsin Technical College Oral Health Partnership N.E.W Community Clinic Partnership Clinic in Calumet County Ministry Door Clinic Fond du Lac Save a Smile Seal-A-Smile	**Barriers:** Low Medicaid reimbursement Low income/uninsured population Lack of Medicaid providers If you are a Medicaid provider, you expose yourself to the public (publishing of phone number, too many calls) Medicaid prior approval process Medicaid coverage of services is limited

Analyze claims data with dental/health records to identify positive return on investment for medical insurance providers to cover preventative oral health/dental care
Convene the groups/stakeholders
Increase Medicaid reimbursement to private practice

Goal 1.2: Expand the role of communities and local health departments in the education, prevention and treatment of dental disease.	
Assets: Prenatal Care Coordination- Outagamie and Calumet linking oral health Fond du Lac County has dental hygienist on staff Oral Health Partnership has linkage with school system School-based focus- tri-county and Partnership Health Center Fluoride varnish Head Start/Early Head Start linkages Women, Infant and Children program linkages Newborn information packets include oral health (use of home educators)	**Barriers:** Local health department has limited capacity for staffing Transportation to clinic

State supplied education to public health departments
Regional oral health consultants (Carrie Stempski has background information)
Increase public health funding so that instead of cutting programs, they can add and maintain programs such as oral health

Goal 1.3: Expand the use of proven technology to facilitate oral health education and delivery of services.	
Assets: Electronic record linked to system to track and do performance management (Oral Health Partnership) Teledentistry has potential	**Barriers:** Software not sophisticated enough Medical and dental records do not connect well Lack of technology in public health sector Uncertain about teledentistry (scope of practice, time constraints, billing) Health Insurance Portability and Accountability Act/privacy regulations

Develop something to allow for regional/statewide reporting - model after immunization/vaccine registry (Lori Mueller – resource)
Cloud based program to link clinics and public health to refer and track patients (example MPOWR program)
Use social media for "fun/catchy" oral health facts and figures.

Goal 1.4: Increase the number of providers and clinics providing oral health care to the underserved.	
Assets: Marquette University School of Dentistry serves large population St. Mary's Hospital – operating room cases Federally qualified health centers Safety Net Clinics – non federally qualified health centers Hi-Life Program (nursing home oral health care)	**Barriers:** Practices are all over the board on "age one dental visit" Medicaid billing (paperwork burden) Student loan debt Health professional shortage area map outdated/inaccurate Developmentally disabled population not captured by current system Dental hygienist scope of practice not allowing nursing home care

Goal 1.5: Maintain and improve the oral health surveillance system to provide comprehensive and timely reporting of oral health needs, outcomes and disparities.	
Assets: Elderly, Head Start, 3rd grade surveys DentaSeal software	**Barriers:** Population is transient Electronic health records do not link together Data is old (need timely data)

Goal 1.6: Develop systems to support the evaluation of oral health programs and policies across the state.	
Assets: Hospital emergency room use for dental a problem Oral Health Coalition	**Barriers:** Software lacks connectivity functionality Inconsistent coding by providers Nursing home evaluation is not accurate Need handbook of "best practices" (i.e. mobile dentistry, especially targeting local health departments)

Consultants for public health and programming (i.e. Instruct programs on how to set up a Seal-A-Smile program) (Conduct screenings)
Mentor other programs starting up
Define standard criteria to evaluate oral health outcomes, to compare and allow for studying best practices
Best practice manual
Develop quality of care dashboard/software that can work with different electronic dental software applications (structured data) (Marshfield)

Goal 1.7: Promote and support oral health research.	
Assets: Marquette University School of Dentistry has capacity Marshfield Research Foundation Manitoba Oral- General Health Curriculum Access to research online	**Barriers:** Need funding Return on investment needs attention (i.e. demonstrate cost savings of prevention and the link between systemic health and oral health)

Open data for research
Develop data warehouse and allow programs to provide information

Goal 1.8: Maintain, expand and support the Wisconsin Department of Health Services' Oral Health Program.	
Assets:	**Barriers:**

Goal 1.9: Maintain, expand and support the Wisconsin Oral Health Coalition.	
Assets: Nonprofit hospitals participate in community needs assessment and community health improvement Annual meeting	**Barriers:** Multiple priorities competing for attention Another meeting

Form coalition in northeast WI (in Green Bay tri-county area)
Maintain strong Wisconsin Oral Health Coalition staff (maintain strong support and varied expertise, marketing and strategic planning)

STRATEGIC AREA 2: What are the assets and gaps/barriers that currently exist in oral health care relating to PREVENTION AND HEALTH PROMOTION?

Goal 2.1: Maintain and expand fluoridation in community water systems.	
Assets: Fluoridation advocate Education Support from health departments Long history of fluoridation Supporting statistics (e.g., decrease in decay) www.tapintohealthyteeth.org	**Barriers:** Anti-fluoridation advocates in area Cost Perceived health risks Decision makers (lack of health education) Decisions being made in closed meetings

Statewide pro-fluoridation campaign (expand TAP)
Consistent, easy to understand facts provided at regular intervals to decision makers (decision makers change positions often, this would help always catching the new ones as well as reminding the old)
Educate about the positives of fluoridated water and community water fluoridation

Goal 2.2: Increase the number of children receiving sealants.	
Assets: Seal-A-Smile WISIPP- incentive sealant program	**Barriers:** Consent forms School time and space

Hire social workers to come in and have patients sign form
Consent forms to be given with the start of school paper work or at Boys and Girls clubs
Go into high risk schools as well as other schools
Connecting with the schools to establish a date that occurs every year and doesn't change so the school can schedule/somewhat be prepared about SAS program
Be an advocate for children to get school nurse on board
Discuss this with local providers first

Goal 2.3: Increase the use of evidence-based preventative measures, such as oral cancer screenings, sealants, tobacco cessation education and fluoride.	
Assets: OHP Community partners Health department Tobacco cessation Pro healthcare clinics for cancer screenings/tobacco cessation NEW (adult)/OHP (children) clinics	**Barriers:** Access to care Cancer screening, Tobacco cessation locations (how to reach vulnerable adult populations) Knowledge of scope of practice List of available clinics in North Eastern region

Cerate local health/dental fairs with local providers (dentists, hygienists, RNs, medical providers, resp. care providers)
Screen for oral cancers, tobacco cessation and sealant needs

Goal 2.4: Educate the public on evidence-based oral health prevention measures.	
Assets: Wisconsin Oral Health Coalition toolkits Health Departments Wisconsin Dental Association Marketing methods (social media, billboards)	**Barriers:** Dispersal of information Cost Health literacy

Get other health insurance companies to put money towards oral health (not just Delta Dental)
Oral Health education in every Boys and Girls Club in WI

Goal 2.5: Develop culturally-sensitive/competent patient education materials.	
Assets: Bi-lingual provider Managed Health Services providing translators	**Barriers:** Language barriers Oral health literacy Some patients do not read native language (still need to assure understanding) Be more aware of the practice for covering translators

Hire diversity staff within program
Speaker bureau for multi-cultures
Educate staff regarding culture
Reach out to people who are from the target group to find the best approach for presenting information/ offering services
Work with multicultural agencies to help education and provide educational materials (ex. Casa Alba Hmong Center)

Goal 2.6: Increase engagement of the general public in oral health-related initiatives.	
Assets: Marketing	**Barriers:** Marketing Access/follow-up care Socioeconomic status and oral health Lack of data/knowledge of ways to market/promote

Consistent segment with radio station
Introduce the topic of an activity already happening. Fair or annual events (large employer health fairs)

Goal 2.7: Develop and share evidence-based and consistent oral health messages with community- based organizations, policymakers, health professionals and educators.	
Assets: Marquette Dental School Marshfield Clinic Institute for Oral Systemic Health (has data)	**Barriers:** Self-research Scope of practice Consistency for public health models in education (hygiene) Need better software/technology

Goal 2.8: Increase awareness of the connection between oral health and overall health.	
Assets: Increase awareness of the connection between oral health and overall health Evidence based information	**Barriers:** Medical consults without delay Insurance and what is covered vs. recommended

Building models of integrated care – promoting the relationship between public health and private practice
Home dental and medical community board created (to discuss gaps, needs, they can consult/bridge and create relationships)

Goal 2.9: Improve oral health literacy	
Assets: Tool kits/materials in multiple languages Classroom education WI Health Literacy Organization	**Barriers:** Appropriate material at reading level Messaging by companies (promoting white teeth vs. healthy teeth)

Create template/education materials at about 5th grade level in common state languages that any practice can customize as their own

Goal 2.10: Promote the impact of personal behavior and self-care on the prevention of oral disease.	
Assets: School based toothbrush programs Telling stories that people can relate to Marketing/ exposure	**Barriers:** Team based care between public health, dental health and medical Additional funding

Parent engagement presentations at local after school programs
Buy/sell on Facebook pages

STRATEGIC AREA 3: What are the assets and gaps/barriers that currently exist in oral health care relating to ACCESS?

Goal 3.1: Expand access to early oral health interventions	
Assets: Brown County Oral Health Partnership (low income children, 3 facilities) Partnership CHC (goes to Head Start Outagamie and Winnebago) WIC has oral health component and refers women/kids Door County Ministry Dental Clinic serves children as soon as they have teeth	**Barriers:** Rural areas have transportation issues/ transportation issue in cities Cost of oral health products is high Not a high value placed on the service Local dentists not taking MA; or not in rural areas Staff is limited- can't reach outside Brown Co. (OHP) Decay before child gets the school based clinic – expand Early Head Start program Perceived need is low Lack of translation services

Medical providers to discuss oral health at yearly exams/appointments
More school-based restorative programs

Goal 3.2: Improve the accessibility to oral health care services for individuals from vulnerable populations.	
Assets: Program that reach children in schools (OHP) Head Start board includes parents Community clinic serves adults Partnership CHC has Spanish and Hmong language lines Partnership CHC have a connection to refugee population to get screening right away Hospital systems in Brown. Co are supportive of oral health NWTC has adult dental program	**Barriers:** DDS not seen as important as medical professionals Patients aren't engaged to identify their barriers (don't know enough about their barriers) Patients aren't currently engaged in the coalition Too many failed attempts Poor transportation and busy work schedules Language barriers Lack of long range funding MA benefits (restricted by what MA will pay for) Culture (following system for appointments)

Need Dentist(s) that take MA in Calumet County (Access to care)
Expand RDH scope of practice to include same services as school-based to nursing home/assisted living
Expanded practice ability/licensing for dental hygienists similar to MN to be able to increase the number of patients seen without having to increase number of dentists. Also would increase number of billable services without having to increase hours
Free transportation for people in rural areas
MA transportation change to allow parent to take all children with them to appointments (medical would agree with this change)
Models to reduce no-show rates (book out only 2 weeks in advance) (emergency Fridays, 2 strikes out, reminder calls, etc)

Goal 3.3: Promote available and affordable options for dental care for all Wisconsin residents.	
Assets: FQHC's local initiatives for Brown Co Give Kids a Smile Day Mission of Mercy Money get to pay for people who can't pay at all Non-federally qualified community clinics see a lot of patients Utilize community organizations (Rotary, Lions club) for funding to fill gaps for kids who don't have MA but still can't pay (Waupaca Co.)	**Barriers:** GKAS and MOM are not enough. More need to be getting treatment completed Business planning (don't know what payment system will be) to get money to pay for people who can't pay at all Animosity between private practice FQHC and community clinics

Expansion of FQHC methodology statewide

Goal 3.4: Increase the availability of dental services for underserved populations.	
Assets: FQHC's local initiatives like Brown Co. OHP RDH can do more in public settings Non-fed qualified clinics Tribal clinics Partner with private dentist to see if payment can be negotiated (payment plans for patients) Having clinics in community where populations are (reduce travel burden)	**Barriers:** Barrier is finding model that will maintain efficiently

Goal 3.5: Promote adequate and sustainable funding for publicly-financed dental coverage.	
Assets: WOHC mini grants add funding opportunities for groups (soda tax) SAS FV is a MA reimbursed service for children and can be put on in medical offices MA covers adult and children in WI	**Barriers:** Utilizing MA so can't apply for state/federal funding (can't grow program) PH funding keeps getting cut No new resources (always the same) MA reimbursement rates are too low. ACA – OH is not an essential benefit Educating the public (using stories so population will understand the problem, need to spend money)

Add OH to become an essential benefit (ACA)
Make and increase in MA reimbursement rates a priority
MA Covering 2 cleanings per year
Legislation for soda tax (similar to tobacco tax, would be sustainable source of funding)
Support expanded MA dental pilot project

Goal 3.6: Support and expand school and community-based oral health programs.	
Assets: School districts (Menasha)) has an RDH to serve students Smiles for life –in public schools only Technical schools with dental hygiene have clinics to see students GB public schools support Brown Co OHP for high risk students (share data to determine high risk/need)	**Barriers:** Schools have a lot on their plate (hard to add another program with three months off a year)

More school districts to have RDH and county health departments
Dental hygienists on staff at schools

Goal 3.7: Reduce oral health-related emergency department visits	
Assets: FQHC take ER patients and become their dental home Brown Co ER do not give our narcotics (policy) –OH initiative (hospitals, HD, NEW Community Clinic (adults) helped to do this Fond du Lac- referral with ER, contact person to get "Save a Smile" (NWTC uses same referral process) See very few children in ER See few pregnant women in ER Hospitals involved with referral process ER can schedule in NEW community clinic through the HER community clinic software	**Barriers:** People visiting ER for dental also utilize for medical (don't know how to utilize health care) FQHC: if you "no show" then you can't come back for set time (so then they go to the ER) Clinic: do emergency care if miss appointment, but not if aggressive or not cooperative

Look at possible barriers

STRATEGIC AREA 4: What are the assets and gaps/barriers that currently exist in oral health care relating to WORKFORCE?

Goal 4.1: Identify gaps in the oral health workforce and develop strategies to address them.	
Assets: Strong partnerships (BCOHP) Loan repayments (DHPSA, FQHCs, others) FDL – save a smile (increase MA money) Ability for RDH's to practice without supervision in some settings	**Barriers:** Lack of good data to show gaps/needs (stories) Lack of DDS (MA) Expanded capacity for RDH/DA/other (settings and scope) Lack of specialists (MA) Burnout of providers in high risk clinics Lack of ethnic minority providers

Focus on quality data and risk prevention in all levels of oral health educations (DDS, RDH, DA)
Promote acceptance of MA Pilot Program with more dentists enrolled so that the state can expand into other counties and eventually statewide
Show the legislators the education that an RDH has and abilities so they may use their full potential to help access to care- to change the scope of practice and practice setting
DDS and RDH groups need to work together

Goal 4.2: Increase interdisciplinary clinical and professional collaboration.	
Assets: Integrated clinics/systems Existing CE opportunities Community health needs assessments (if they identify OH as a need) (FDL HD, possibly others?)	**Barriers:** Lack of OH education for medical providers Time constraint of medical providers Silos/Mouth separate from body Non-integration of patient records EB outcomes not utilized

Increase education in medical schools and nursing schools

Goal 4.3: Promote lifelong learning related to oral health disciplines.	
Assets: Smiles 4 Life curriculum for medical providers WDA dental home training Existing PH champions	**Barriers:** PR is lacking to promote the importance of OH (could recruit workforce)

Medical model promote oral health more with flyers and educational materials in the office
Expand more oral health co-op programs (like WCTC dental assistant programs) for high school students to do during their junior/senior year

Goal 4.4: Improve and increase recruitment and educational support for students interested in oral health professions.	
Assets: Internships (Marshfield)/fellowships (tri-county)/field experiences Community based field experiences	**Barriers:** Geography (providers/locations) Lack of exposure (internships)

Paid internship certification in pediatric dentistry
Have RDH/DDS students do more public health rotations or internships either school or public health clinic or FQHC
Develop residency programs in hospital based dentistry to allow generalists to treat special needs patients

Goal 4.5: Promote the education and utilization of public health principles within the oral health community.	
Assets: Local public health departments Oral health is in state health plan	**Barriers:** Not all DDS/RDH grads have strong understanding of PH principles Lack of funding Lack of understanding of mobile/portable equipment/program

Barrier- not all DDS/RDH have strong understanding of public health principles | Solution- require a few credits of CE in public health with licensure renewal
Best practices in other states for dental school rotations/externships
National/state oral health summit
Most RDHs are not aware that they can work unsupervised in some settings
Expand RDH care in different practice settings