

# Summary of the 2014 Director of Health's Task Force Regional Meetings

## Introduction

The Director of Health's 2014 Task Force on Oral Health and Access to Dental Care (DTF) met for the first time on April 4, 2014. They provided guidance to Ohio Department of Health (ODH) staff and facilitator Chris Kloth regarding 10 regional meetings to be conducted in five locations around Ohio.

The meetings were conducted in April and May. They engaged consumers, providers and others in dialogue regarding what, from their perspectives, is and is not working with respect to oral health and dental care access in Ohio, attributes of an ideal oral health system, and several questions targeted specifically at consumers or providers.

Meeting sites were selected that were easily accessible to consumers. Advocacy groups were contacted and asked to recruit consumers to attend the sessions. Unfortunately, only a few consumers directly experiencing the barriers this plan will address attended the meetings. They included some mothers of children with developmental disabilities and some adults facing barriers. Their comments are embedded in this summary,

Most of the "consumer" perspectives presented in this summary reflect interpretation of the experiences of advocates and providers with consumers. Much of what they described was consistent with views expressed by consumers. Two of the consumers captured these feelings with special clarity in statements triggered by the comments of other participants. These comments are included in Attachment A. Attachment B provides additional verbatim responses, offered by both consumers and providers, to additional questions posed by the facilitator.

Some dentists at every meeting indicated privately or publically that having too few private practice dentists on the DTF is a barrier to effective planning because they are the most critical resource for increasing oral health and access to dental care. They also indicated any future task force should include private practice general dentists.

The purpose of this summary from the regional meetings is to assist the DTF in refining its focus and priorities during the process. It is based on more than 50 pages of notes, which will be posted in an unedited format on the ODH DTF website.

A number of familiar themes emerged from the dialogues. The summary is organized by theme. For each theme the summary refers to barriers and challenges, what is working and elements or attributes of an ideal system. In addition, the summary distinguishes consumer and provider perspectives, as well as common ground. Further, it should be noted that there were divergent perspectives within each group.

## **Oral Health is Part of Overall Health**

**Barriers & Challenges:** Continuing the concern expressed during the last DTF planning process, oral health (as well as behavioral health/mental health, eyes and ears) are treated by patients and policy makers as separate from and less important than "medical" health. The net effect of this perception is that public policy and funding decisions make oral health and access to dental care lower priorities. This lower public priority (combined with other individual factors identified in this summary) influences individual and family decision making. Consumers and providers agree that this perceived lower priority makes every other effort to improve the system more difficult.

## Summary of the 2014 Director of Health's Task Force Regional Meetings

**What's Working:** Nationally, in Ohio and locally there are examples of a more holistic approach to health care. While not yet a norm, these examples will help provide insight into what conditions foster success. Consumers identified local health departments and Federally-Qualified Health Centers (FQHCs) as examples of settings in which there is a growing focus on the whole body and the whole person. Dentists and other providers saw the small but growing number of pediatricians who are assessing the oral health of their patients, applying fluoride varnish, providing some education and making referrals as an example of a more integrated approach.

**Ideal System:** Consumers and providers felt strongly that oral health must be a high priority in an ideal system. They suggested health policy should always address the whole person and that impact on health ought to be an element of every public policy deliberation. They also suggested that there ought to be one standard of care for everyone that is available, affordable and accessible. Some felt the policy of paying dentists for procedures undermines whole body health.

Both groups supported patient-centered care and suggested that all medical training ought to include an emphasis on the whole person. They also agreed that a dental exam ought to be mandatory every time a medical exam is required (e.g., Head Start, school, camp, etc.). Some providers prefer one stop health care facilities and suggest that dental might be added to Urgent Care centers. Most providers promoted increased collaboration among the medical disciplines, with cross-training and cross-referrals. They also wanted hospitals to become more effective in assuring dental disease is addressed when people arrive in the emergency room (ER), whether onsite or by referral. Providers value a strong team of dental professionals with clear roles and responsibilities.

What is new in the conversation for both groups is the role of metrics and standards in the ideal system. Ideas included review of identified claims data, linking payment of Medicaid/Medicare to quality assurance outcomes and, in general, more attention to outcomes and system impact.

### **Oral Health Knowledge**

**Barriers & Challenges:** Consumers and providers agreed oral health knowledge is a challenge that must be addressed. An extension of the overall lack of focus on oral health in the larger culture is the fact that it fosters misinformation, fears and anxiety. Both groups noted that many people across every age group and economic status have nonspecific fears related to dentistry. Others have internalized specific unpleasant experiences and, often, pass them on to family members and others. There are also beliefs that seem to be rooted in the lore and behavior patterns of some families and some populations. The resulting norms and habits continue to have a negative effect on individual, family and community choices - especially in early childhood. Participants also observed that most underlying media messages seem to offset any positive messaging in educational strategies or public service announcements (PSAs).

Both groups also observed that good nutrition is one key to good health. Poor nutrition contributes significantly to oral disease. Healthy food choices have been a national health concern at every economic level and across the life span. Throughout this summary document there are references to the interplay between personal choice, socio-economic factors and public policy. For example, the same schools we hope educate children about good health enter into sponsorships and "pour agreements" with soda companies in exchange for other

## Summary of the 2014 Director of Health's Task Force Regional Meetings

considerations. Also, "food stamps" pay for unhealthy food but do not pay for toothbrushes or toothpaste.

**What's Working:** Neither consumers nor providers identified any systematic examples of strategies for increasing oral health knowledge. However, a topic worth noting in one of the sessions was a perception that "clinic" care and dentists are of less quality than private practice dental practices. The term "center" was described as slightly better. In this context an FQHC might be seen as preferable to a free clinic. The extent to which the underlying assumption about quality is isolated or pervasive is not known. Finally, while nutrition was seen as an important concern, and both WIC and Head Start were favorably mentioned during both the challenges and ideal system dialogues, no examples of nutrition awareness were provided.

**Ideal System:** Consumers and providers agreed oral health knowledge needs to be an important part of an ideal system. They agree that public awareness about the connections between oral health and nutrition across an entire life span needs to increase. Consumers valued messages supporting consumer choice and engagement. As is noted in Attachment C, providers suggested that hygienists and non-dental professionals (e.g., school nurses, social workers, teachers, child care providers, etc.) could help to increase the impact of oral health messaging and education. WIC and Head Start were identified as potential partners. Making oral health assessments part of other mandatory health assessments would also provide an opportunity to begin oral health education. They also suggested that mentoring and outreach to young people in underrepresented populations to encourage them to pursue dental education might also help increase awareness in those communities.

### **The Number & Location of Dentists & Dental Specialists**

**Barriers & Challenges:** Another continuing concern is the perception that there are too few providers within a reasonable distance who are able and willing to serve the poor and the most vulnerable among us. However, this issue is more complex than numbers and location. Further, while consumers and providers attending the regional meetings agreed that distribution of care providers is a significant problem, they explain their concerns very differently.

Consumers expressed having a hard time finding providers who will take their coverage, work out payment plans or provide free coverage. They often can't see providers within a period of time such that both prevention and treatment can be addressed before oral disease worsens. The result often is a preventable trip to the ER. Wait lists and other delays were significant concerns. Consumers also have difficulty finding providers who are able and willing to provide specialized care for very young children, the elderly, people with disabilities, especially developmental disabilities, and others. They also need care that is available at times that reduce the impact of other barriers such as employment and child care. The lack of culturally competent providers was also noted.

Many providers explained the challenge in terms of money. Private practice dentists indicated that the current system reimburses them at rates below their cost, an unsustainable business model for any small business. They also noted a lack of incentives to locate in underserved areas. Public health dentists explained that funding of subsidized care (e.g., FQHCs, health departments, etc.) is also insufficient, with too few programs and too few staff.

While providers seemed to agree that these challenges have a workforce component, this continues to be a contentious conversation. When the topic came up at one of the meetings a

## Summary of the 2014 Director of Health's Task Force Regional Meetings

representative of one managed care plan (MCP) expressed discomfort, indicating that the divisiveness of "this issue" (which she later identified as dental therapists) has made her relationship with some providers uncomfortable and she is unwilling to express her own opinion.

Several consumers and advocates, and at least one dentist, indicated that expanding the roles of hygienists, as well as allowing dental therapists and community dental health workers to practice in Ohio are important options to consider. Of the dentists who commented on this topic, many expressed strong opposition to allowing dental therapists in Ohio, indicating it would significantly undermine the quality of care. They also pointed out that the Ohio Dental Association (ODA) supported changes that expanded the roles of hygienists since the last plan. They are also supporting new legislation that would allow further expansion of their roles.

Consistent with the last planning process, transportation was identified as a significant consumer barrier that is associated with the number and location of dentists. It was mentioned so often it has been listed here and as an element of other concerns.

**What's Working:** From a consumer perspective there were four threads. First, in some cases when a dentist provides reasonable care at a reasonable price it is appreciated, even if the consumer is not the payer. Another is that there are private practice dentists volunteering on and off the books to provide care to some of those in need, although it is hard to determine how much and to what end. They noted an increase in FQHCs and their growing capacity to serve. Finally, they also noted examples of providers taking care to people in need where they congregate naturally (e.g., schools, faith communities, senior and community centers, etc.).

From a provider perspective there were three threads. They reported that the ODA, often in partnership with others, supports and promotes such programs as Dental OPTIONS, Give Kids a Smile, dental volunteerism and some mobile dentistry. ODA and others have also been actively involved in advocacy for maintaining Medicaid dental coverage in Ohio and debt relief for dentists willing to serve in Dental Health Professional Shortage Areas. Medicaid Managed Care Plans (MCPs) pointed out that they provide transportation to patients, although this is not always known by consumers.

**Ideal System:** Consumers suggested increasing the number of providers, especially safety nets and especially in rural areas. They wanted providers to increase their flexibility in terms of when, where and who provides various types of services. They envisioned a system that recognizes and understands the complexities of the barriers they face and finds ways to either eliminate the barriers or work around them. Appropriate transportation for people across the life span and with special needs was important to them. Like providers, they support incentives to encourage people to serve the underserved, more FQHCs and public health mobile units.

Some providers stated that money is the key to an ideal system. General practice dentists indicated the ideal system should have increased, indexed reimbursements, incentives for those who serve the most vulnerable, loan forgiveness and lower tuition. They also indicated a preference for system interventions created or endorsed by the American Dental Association (ADA). Public health dentists and people working in local health departments believe there needs to be more stable and increased funding of their programs.

### **Ability to Pay/Coverage Issues**

**Challenges & Concerns:** Consumers and providers both expressed major concerns about insurance coverage and other factors that limit consumers' ability to pay for services. They

## Summary of the 2014 Director of Health's Task Force Regional Meetings

noted that coverage varies widely in what services are paid for and that coverage changes over the course of one's lifetime. Variations also occur with respect to special populations, such as people with developmental disabilities, behavioral and mental health challenges, veterans, migrants and others.

Continuity of care was also a concern. Some policies limit the number or types of procedures covered in a particular period of time for a particular patient, leading to expensive complications. Concerns were expressed about who is qualified for what type of coverage, costs and portability. There was also a concern about whether or not the consumer's preferred provider is included in their plan or willing to accept their plan. These inconsistencies increase confusion among consumers and undermine getting either preventive care or treatment.

Complexity of coverage policies and practices, as well as frequent changes, was a concern shared by all. In addition, consumers and providers identified dealing with MCPs as a challenge. For providers, the administrative burden related to these complexities increases their overhead costs.

The use of the ER as a source of all health care by the poor is well documented elsewhere in research and the media. However, with respect to oral health and access to dental care the problem is a little more complicated. ER doctors can prescribe antibiotics and pain medication to treat the presenting problem and be reimbursed without treating the underlying disease. Whether or not the patient finally gets to a dentist for treatment, the cost of the entire episode becomes unnecessarily high. Another challenge for the ERs is the growing number of drug abusers using dental complaints to get drugs for abuse.

**What's Working:** Neither consumers nor providers identified much they thought was working to improve their ability to get or keep adequate coverage. MCPs noted they are beginning to use incentives to promote more effective use of patients' coverage. Providers identified adult dental Medicaid coverage, safety nets and some ER diversion programs as helpful.

**Ideal System:** Consumers envisioned a system that covers whatever health care whenever they need it. They also wanted to have an authentic choice of providers and plans, as well as procedures they understand. Affordable coverage, co-pays and deductibles were important. Finally, consumers wanted ERs to make sure that the underlying disease is addressed.

Providers' suggestions often aligned with consumer suggestions, but with a slightly different focus. They envisioned a system in which dental coverage is permanently covered by Medicaid and Medicare at all age levels. Private and publically-funded insurance would cover the whole person and be affordable. Simplification of every aspect of the insurance system was important, with reduced red tape, easier authorizations and the ability to talk to "real people" when they have difficulties. Suggestions included the same forms and requirements for all insurance coverage and MCP partners, as well as reducing the number of plans available in Ohio or having one system and one plan for the entire state.

### **Life Span: Womb to Tomb**

**Challenges & Barriers:** One way of looking at oral health and dental care challenges is in terms of age. Most comments focused on the two ends of the age span. Comments gathered during these meetings are consistent with those from the last planning process. The most notable difference is the strong emphasis on the rapidly growing concern related to seniors.

## Summary of the 2014 Director of Health's Task Force Regional Meetings

Consumers and providers agreed that both prevention and treatment for seniors are problematic. Both groups were especially concerned about seniors in nursing homes and similar residential settings. A common concern was that oral health is a low priority in such settings. In addition, low wage, high turnover workers who could/should be providing preventive care lack sufficient training to do so and, even if they are trained, are uncomfortable doing so. Providers expressed concern that many seniors require specialized treatment they may not be able to provide.

They expressed mixed thoughts on the extent to which they can serve seniors in residential settings. For example, some dentists said it is too difficult to take the tools they need to nursing homes and similar facilities. Others said there isn't appropriate space for doing good work. Others indicated they are able to find appropriate space, such as the facility beauty salon, and are able to do good work.

From an early childhood perspective there was broad agreement that starting to work with families and very young children is extremely important and affects one's oral health for a lifetime. WIC, Head Start and similar programs have experienced cuts that limit their ability to serve children and families. Consumers, especially in rural areas, have difficulty finding dentists who are able and willing to work with very young children. Some providers indicated that very young children require special skills and methods they may not be trained in or comfortable with. Both groups report that pediatricians and OB/Gyns do little to address oral health. Dentists are not uniform in their understanding about when a child should first visit a dentist.

Starting with early childhood, and throughout school years, consumers and providers agreed that family habits, as well as school policies and practices often undermine good oral health. Consumers expressed lack of knowledge, the reduced number of school nurses and other educational priorities, cultural competence, language and fear as barriers.

Providers indicated that there is a shortage of pediatric dentists and that treating young children is relatively time consuming. Finally, another ongoing concern is that some entrepreneurial mobile dental programs go to schools and other places, provide exams and cleaning, but do not coordinate with local dentists for follow up, especially with respect to sharing clinical information of what was done. Workforce issues related to the use of non-dentists also arose here.

**What's Working:** Despite the growing concern for the needs of seniors, neither consumers nor providers identified much that helps seniors. Some dentists are able and willing to find a place to work at nursing homes and others provide care using portable equipment or mobile dental vans. By contrast, both groups identified several effective early childhood and school age initiatives. They agree that dental sealant, fluoride varnish and some other school-based programs are valuable. Consumers, and some providers, expressed an affinity for school nurses, WIC and Head Start.

**Ideal System:** In principle, consumers and providers envisioned appropriate, affordable care across the entire life span. This is especially important for advocates and family members of persons with developmental disabilities and other complicating health factors. Both groups identified the need to emphasize prenatal and early childhood prevention, education and care beginning with pregnancy. They suggested programs such as WIC and Head Start as examples of how to work with and engage young families. School-based programs seemed very valuable to both groups. Providers suggested better regulations for monitoring nursing homes and other residential care settings. They suggested addressing issues related to release authorizations when a parent or family member is unavailable.

# Summary of the 2014 Director of Health's Task Force Regional Meetings

## Special Populations

**Barriers & Challenges:** Another way of looking at oral health and access is by looking at the unique needs of some particular populations. Concerns related to people with developmental disabilities were expressed with clarity and urgency, especially by the mothers at the sessions. Challenges related to behavioral/mental health and drug abuse seemed to have increased significantly. Sedation and other medications are of particular concern to advocates. In addition, the needs of veterans, especially homeless veterans, were noted. These concerns are both enmeshed in and distinct from life span and coverage concerns.

Consumers were concerned about finding someone able and willing to provide covered or affordable services. Providers were concerned that the knowledge, skills and temperament needed for some of this work is highly specialized and may require methods or tools they are not trained to use. In addition, for those able and willing to do the work, the time and other resources required is exceptional and not reflected in reimbursement.

The growing number of refugees, immigrants and migrant workers are a concern for both groups. Consumers indicated a shortage of culturally competent providers able and willing to serve these groups. Providers concede that they face additional challenges in meeting these needs.

**What's Working:** Very few helpful initiatives were identified for Special Populations. For families and non-dental advocates from Toledo to Cincinnati, the Nisonger Center seems to be the gold standard for serving people with developmental disabilities. Consumers and advocates in northwestern Ohio indicated there has been some success working with migrant workers that might apply in other settings. In particular, they said aggressive outreach and public health mobile units were valuable. Providers appreciated cross-discipline training and specialists doing this work. Both groups mentioned annual events to help veterans.

**Ideal System:** The underlying theme here is that consumers and providers want to make sure that people with special needs have access to competent, sensitive, affordable and convenient prevention and treatment that is consistent with the unique needs of each patient. Both groups noted the need to address issues related to release authorizations when a parent or family member is unavailable. They suggested that dental and medical educators do a better job recruiting people who are willing and able to work with special populations and a better job of training them to do so.

## Culture of Poverty

**Barriers & Challenges:** Poverty is clearly one of the key variables linked to poor oral health outcomes and limited access to dental care. It was discussed in the meetings by both consumers and providers. Many concerns identified earlier in this summary are explicitly or implicitly rooted in poverty.

The term "culture of poverty" was used by consumers, advocates and providers to describe a concern in and of itself. There is not a shared understanding of what the term means. Some uses seem to reflect an attempt to synthesize the cumulative impact of a complex range of factors that create or complicate needs and barriers for the poor. Other uses seem to reflect a sense of futility in addressing the needs of poor or high risk patients. Among some there is a tendency to criticize patients with lower incomes for bad choices.

## Summary of the 2014 Director of Health's Task Force Regional Meetings

Consumers and some advocates identified a wide range of challenges they face in their daily lives that complicate everything they do, including getting oral health services. Some also indicated they feel caught in no-win situations. (e.g., they may get on a waiting list for an appointment with someone who will accept their coverage and before the appointment arrives the condition worsens and they end up in an ER; or by the time the appointment date arrives they have a job opportunity or child care challenge).

Consumers and providers agreed on some of the behavior that occurs in their relationships with one another. For example, both agreed that consumers in poverty frequently miss appointments. However, consumers, some advocates and some providers describe the failure to get to appointments in terms of complicated tradeoffs between jobs, child care, transportation, and more. Others repeatedly used terms and phrases like “no shows,” “don’t follow up,” “noncompliant” and “they don’t care.” According to some consumers the judgmental tone of these terms is reflected in how they feel treated by some providers. Consumers also expressed frustration with feeling disrespected by some providers and with the lack of cultural competence of some providers. Some providers who attended consumer meetings expressed dismay at how some consumers are treated.

**What’s Working:** Neither group cited any effective systematic initiatives to address the culture of poverty. Consumers had little hopeful to note related to addressing conditions of poverty.

**Ideal System:** Consumers indicated they want to be treated with respect and cultural competence in a setting that feels safe. They don’t want to be blamed for being in challenging circumstances. They suggested increasing the number of strategies that bring services to settings where people already congregate. Some providers suggested increasing workforce diversity, care coordination, reducing the previously identified barriers and more flexible hours.

### **Coordination of Services**

**Challenges & Barriers:** Consumers and providers agreed that the complexity and ever changing requirements of the system are barriers. They also indicated a lack of coordination and collaboration among private and public dentists, MCPs, Medicaid and other human service agencies. Consumers and advocates may not know what resources are available. If they know about potential resources, gaining access is challenging. Advocates and providers indicated they find it difficult to keep up to date with the criteria and requirements for accessing resources and may inadvertently share misinformation.

**What’s Working:** The level of focus on coordination has increased considerably since the last planning process. This seems to be, in part, the result of an increase in efforts by funders to promote coordination, cooperation and collaboration. MCPs reminded participants that coordination is one of their primary roles in the system. Some consumers and providers identified local examples of coordination emerging among agencies and within schools. ODA and Universal Health Care Action Network (UHCAN) Ohio both identified service coordination strategies developed at the national level.

**Ideal System:** Given the complexity of the system, consumers and providers both felt strongly that service coordination is an essential part of enhancing the system, especially in the short run while other strategies take time to implement. There are a number of approaches already being tried and others have been proposed.

# Summary of the 2014 Director of Health's Task Force Regional Meetings

Attachment A

## Notes from Two Consumers

As noted earlier, two consumers were especially forceful and clear in articulating their feelings as consumers affected by the barriers and challenges of the system as it exists today. The following notes document their statements.

### **One Patient: Challenges from a particular patient who has her own challenges and a brother with even more challenges**

- Dentists may think they treat all patients the same, or that we can't tell what they think, but we know.
  - It's easy for you to assign motivation.
  - We don't feel valued.
  - We do feel labelled.
- Monitor interaction with dentists and you may notice the following common exchanges:
  - "It's only \$600."
    - The attitude when this was said was not appreciated.
    - \$600.00 is a lot for me.
  - "Take out a loan"
    - As if affordable credit is easy for me to get!
  - "Go to the dentist down the street"
    - Yes, I can walk, and...
    - I may even prefer to go to another, but...
    - They are not covered in my plan and you are.

### **Another Patient: Challenges from a particular patient who is also an advocate for migrant workers**

- It's a battle:
  - I don't know where to turn.
  - I know the system and it's hard for me to manage.
  - People are in a crisis mode always.
  - Transportation is a barrier, not a solution.
- Other barriers:
  - Car
  - Job
  - Teeth
  - Fear
    - Will I get a real dentist or substandard care?
    - Does it hurt or am I immune to pain?
- Wait, I forgot
  - They (dentists) don't care about me.
  - I tried to get their help and they said no.
- They judged me by their middle class values and standards.
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# Summary of the 2014 Director of Health's Task Force Regional Meetings

## Attachment B

### Additional Consumer Questions

The DTF provided ODH staff and facilitator with several questions to ask consumers and providers. What follows are the notes from the consumer questions.

**Who provides your care?** Almost everyone who attended the sessions said they see a private dentist. A few like to go their local dental colleges. At least one goes to an FQHC.

#### Who refers you to the dentist?

- One dentist talked with pediatricians in his area and pediatric referrals increased
- DDS who knew the local resources referred a patient to the ER, which referred the patient to a care center, where the
  - Visit was scheduled promptly
  - Care was covered
- Some mobile dentists make referrals to area dentists
- One ER noticed problem, but made no referral
- OB/GYN/Midwife prenatal
- Pediatrician
- Dermatologist
- Kindergarten screenings
- Head Start screenings
- School based hygienists
- School nurses

#### Where does oral health fit in range of needs for consumers?

- It depends on the day!
- Many (most?) at risk and low income patients are well-intentioned regarding oral health.
- They are often faced with multiple personal and family barriers and challenges
- As one consumer said at one of the regional meetings, "If you don't live the life, you don't get it."
- Costs increase but not income
- Oral health is often at the bottom of lists after many other life challenges or not on the list at all.

# Summary of the 2014 Director of Health's Task Force Regional Meetings

Attachment C

## Additional Provider Questions

The DTF provided ODH staff and facilitator with several questions to ask consumers and providers. What follows are the notes from the provider questions.

### How do you educate your patients?

- What is ODH doing to educate people?
- Dental professionals
  - Every first appointment I turn to parent
    - Parent looks in mouth
    - Talk about brushing
    - Discuss water, sugar, beverages
    - This exam is for you also
    - Review plan with patient or care giver
    - Provide pamphlets
    - Ask them why they are here
  - Assistants talk about hygiene, care
  - Dentist: discuss gum disease, tobacco
  - Dentists
    - Talk one on one
    - Talk to patients when they do come in
  - See parents
    - Talk, explain oral health
    - Invite family member to be in room
  - Building relationships helps
  - Share training opportunities with primary care physicians, pediatrics, etc., elderly
  - Educate physicians
    - Explain the reason for being seen by age 1
    - Increase awareness
    - Do their part
  - Provide mock dental office to help prepare patients
  - Free clinic: tell them about links
- Educate teachers / role model
- Head Start
  - Provide materials
  - Offer training to families
  - Child Development Centers of Franklin County (a Columbus Head Start program) has a train the trainer
  - Work with pregnant women already involved in HS programs
- WIC
  - Promote healthy eating
  - Nutrition
  - Dental
  - Work with pregnant moms — prenatal

## **Summary of the 2014 Director of Health's Task Force Regional Meetings**

- Prenatal classes: opportunity to educate parents
- Health Department/Columbus Public Health
  - We speak at city council to inform public officials
  - We fund education programs for parents of young children/families
- ADA prevention program
- Midlevel practitioners provide education in community
- Community dental health coordinators
- Go to where do people congregate in community
  - Churches
  - Clubs
  - Places open during "off hours"
  - May or may not follow up
- Barbershop /salons are a good location for education of some groups

### **What is the role of publically funded programs in oral health and dentistry?**

- Should focus on prevention
  - Should provide mandatory education to families as a requirement to get assistance
  - Publically funded programs
- To be safety net
  - Health center — another dental home or stop gap
  - Clinics would improve overall health impact
  - Some providers want to make sure safety nets are monitored for churning
- Public funded programs good for:
  - Safety net
  - Shortage areas
- Cleveland Metro:
  - Hospital setting
  - 75% Medicaid
  - Write off
  - Residents learn procedures
- Quality of public is as good as private
- Private practice: looks down on public programs and public health
- Private practice: We could meet all the needs if barriers were removed, especially if raise fees
- Private Practice: Public funded patients scare typical patients in our offices
- Reimbursement models differ
  - procedure
  - encounter
- Look at different reimbursement models
- Include overhead
- Explain business model
  - They operate by different standards
  - Reimbursement
  - No shows

## Summary of the 2014 Director of Health's Task Force Regional Meetings

### What is/are the appropriate role(s) for non-dental professionals?

- Non-dental work
  - Provide reminders
- Education
- Education in schools
- Early Childhood Education (ECE) programs
- Anyone who works with children
- Head Start helps with families & young children
- WIC helps with families & young children
- Recognize potential problems and refer
  - Schools
  - Nursing homes
  - Make referrals
- Outreach
  - Social worker can go to visit
  - Social services teams
  - Groups that reach out work together
- Relationship building
- Collaboration across organizations + disciplines
- They can make sure people know
  - What is available
  - Where to go
- Care coordinator/ADA community Dental Health Coordinator (various approaches cited)
  - Follow up calls
  - Reminders
  - Transport
- Engage
  - Other medical professionals (all health)
  - Insurance providers (all health)
  - Those who provide tech tools
  - Business investments/investors
- Should require dental exam for many public social benefit programs to assure first visit
- ODH should tap profits of dental suppliers

### What do you mean by diverse workforce?

- According to one MCP representative, "It's complicated."
  - Don't want to take sides
  - Heard at FQHC, "Go see a real dentist."
  - Dental Therapist: perceptions vary widely and bitterly
- Having an adequate number of trained people from various disciplines
- What does the dental team look like
  - People who come from underserved areas
  - Diverse mindsets — approaches to problem solving
  - Touched by someone with disability

## Summary of the 2014 Director of Health's Task Force Regional Meetings

- Diverse work force
  - Student diversity in dental school works better if academic programs and faculty reflect diversity
  - Go to junior high to start recruiting young people as dentists
  - Do they look like my patients?
  - Language diversity
- Person working on me can deal with whatever my oral health issues may be
- Health interventions
- Diverse members on team
  - Mid-level providers
  - Expose young children to career early
  - Someone who is able + willing to serve people w/ challenges
  - Can meet a variety of needs
- Hygienists
  - Full/part time
  - Go to underserved areas — general supervision
  - Give more responsibilities
  - Multiple classifications in office
- Oral Health Access Program
  - Hygienists can serve
  - Dentist must see
- Having “local” people
  - We need to get home grown people to return to practice
- Several agencies work together
  - Have care coordinators with community connection
- Dentist/oral health team as change agents
- Cultural barriers addressed
  - When people can relate to diverse patients in changing world
  - Choose Ohio First — only medicine
- A culturally diverse workforce
- Cultural competency
  - Helps recruit dental students and patients
  - Success in certificate program
  - Return for more education
- Intercultural competence
  - Language / communication barriers
  - Changing demographics of dental students
- Diversity & inclusion
  - Ethnic diversity
  - Gender
  - LGBTQ
  - Code word... negative for some
- Guarantee an interview if you volunteer in indigent area MUA (medically underserved area)
- San Antonio — high school students can get experience

## Summary of the 2014 Director of Health's Task Force Regional Meetings

### Where/How/From whom do you get your patient referrals?

- Some pediatricians doing oral health education and refer for fluoride varnish
- Health fairs for high school (but I have no time) (comment by 2 dentists)
- First toothbrush at fair
- Dentists have Facebook page: "Tell the Story"
- School nurses make referrals
- Not a lot from other medical professionals

**Two additional provider conversations arose:** Two spontaneous conversations arose in Bowling Green that seemed worth noting.

- Patient trust
  - Intergenerational changes in expectations
    - In baseline care
    - In baseline costs
  - Demographics
    - Age shift
    - Geographic distribution
  - Providers: The public pictures the "successful" dentists of old, not today's reality
- Corporate dentistry
  - Lots of students start there
  - Valiant goal — reach out
  - Answer to private equity firm
    - Efficiency
    - Buying power
    - Share staff
    - Overhead
    - Double books
    - Calling all the time
    - Add work