

POTENTIAL STRATEGIES FOR CONSIDERATION

Dentistry is a part of the wide spectrum of health services that act to improve the health of the public. Dentistry is one of the traditional professions (e.g. medicine, law, and religion) that involve public confidences and trusts. As such, society allows the profession a large degree of self-determination and self-regulation. Thus, dentistry has a social responsibility to improve the profession. The overriding challenge to the profession of dentistry is to make access to quality oral health care available to all members of the public who seek care. The goals of the profession are to promote oral health, improve the quality of life for all persons, and to eliminate health disparities in dental disease burdens and access to care.

Recognizing this challenge, the State Oral Health Improvement Plan for Disadvantaged Persons has identified that there are inequities in the quality and the delivery of oral health care for certain populations in Florida. These inequities are evident even though the oral health of the State has improved over the past few decades. Demographic changes, economic realities, improvements in science and technology, advances in understanding the process of diseases, changes in social awareness, and the globalization of health care issues have all contributed to the general improvements seen in oral health throughout the State. However, at the same time, these factors also contribute to the oral health disparities found among certain disadvantaged populations.

The State Oral Health Improvement Plan for Disadvantaged Persons has determined that the following are the most relevant issues that affect the disparities in oral health status of disadvantaged persons in the state of Florida: 1) inadequate awareness of the importance of oral health; 2) inadequate integration and coordination of State agencies and organizations; 3) inadequate access to oral health services; 4) inadequate Statewide data that describes the disease burden and needs of Florida's population; 5) inadequate utilization of available resources; 6) inadequate statewide implementation of prevention programs; 7) inadequate funding; and 8) inadequate State infrastructure. This list is not all encompassing and most of these issues do not stand-alone. Many of these issues overlap and require that policymakers address these issues collectively instead of separately. For example, in order to improve access to oral health care services, policymakers must address the issues of improving the workforce and providing adequate funding as well.

1) Inadequate awareness of the importance of oral health. Historically, policymakers, the public, and even health care providers have considered oral health and the need for care to be less important than other health needs. Policymakers and medical providers have viewed dental health as secondary to or separate from systemic health. Oral health is not a top priority or core public health function in the State in an environment of limited funding and other pressing public needs. Additionally, most of the public believes dental disease is an eventuality, rather than being preventable. Moreover, the public may be unaware of what dental programs are available throughout the State. Education and awareness programs that improve the dental literacy of policymakers, the public, and health care providers will lead to more informed and better decisions on oral health issues.



2) Inadequate integration and coordination of efforts to improve oral health throughout the State of Florida. Various state agencies, academic institutions, and public and private organizations in different areas of the state fund different medical and dental programs. However, there are little integration and coordination efforts. Thus, there is a patchwork approach among the various oral health programs. This lack of integration and coordination tends to cause some overlap in care and advocacy, but more importantly many gaps in care and advocacy throughout the State.

3) Inadequate access to oral health services for all Floridians. Throughout the State of Florida there are: a limited amount of available dental and medical health insurance coverage (both employment provided and safety net programs) that Floridians can rely upon to effectively and efficiently cover their oral health care needs; a limited number and availability of specialists (pediatric, geriatric, and public health dentists) distributed throughout the state; a limited availability of specialty centers for special needs patients; a disproportionate geographic distribution of oral health providers, especially in rural counties; inadequate transportation for many low-income or special needs dental consumers; a lack of expanded hours of operation among dental providers to accommodate low-income, working, or special needs dental consumers; insufficient provider willingness to treat disadvantaged populations - many oral health care providers are unwilling to treat disadvantaged patients because of a lack of incentives, administrative headaches, and inadequate education resulting in fear of treating special needs patients; and a lack of diversity in the dental provider workforce.

4) Inadequate statewide data that describes the dental disease burdens and needs of various disadvantaged groups among Florida's population. There is an inadequate statewide, oral health, outcome-based surveillance system in place in the state of Florida. Without adequate data, policymakers are unable to identify and evaluate the State's oral health needs and subsequently, target, promote, and develop data driven oral health policies and initiatives.

5) Inadequate utilization of available resources. Federal and State laws, regulations, policies, and academic training (or lacks thereof) limit the oral health workforce. Medicaid policies relating to reimbursement rates and administrative bureaucracy deter dental provider participation in Medicaid; State licensure regulations restrict the numbers of providers; State scope of practice laws restrict the types and amount of oral health services that the dental workforce can provide; and inadequate dental and medical training limit the numbers of health care providers who are able to provide oral health care to the State's disadvantaged populations. Moreover, some existing oral health care service facilities are underutilized due to an inability to attract oral health care providers.

6) Inadequate statewide implementation of prevention programs. Certain oral health prevention programs have been proven to reduce the burden of dental disease. Implementation of these programs needs to become a priority for the State.



7) Inadequate funding. Most every potential solution to any problem involves money. Funding is necessary for not only direct dental care service programs, but also for improvements in the State oral health safety net infrastructure; for implementation of dental public health initiatives; for advocacy; and for the undertaking of oral health awareness and education programs. New funding sources or new ways of acquiring funding are necessary in order to improve the oral health of disadvantaged persons in the State of Florida.

8) Inadequate State infrastructure. The State of Florida does not have an adequate number of programs, facilities, or providers to provide safety net dental services to all disadvantaged populations.

Subsequently, the State Oral Health Improvement Plan for Disadvantaged Persons has identified and discussed the following strategies that could address these issues and which could, ultimately, improve the oral health of disadvantaged persons in the state of Florida. Ideas for individual strategies were derived from various individuals, organizations, previous recommendations in certain national reports, and existing programs in other states. This report notes any examples where other states or organizations have implemented an individual strategy. Many of these examples come from the Association of State and Territorial Dental Director's "State Dental Public Health Activities" website and the National Health Law Program's "State Initiatives to Improve Access to Dental Care".

Moreover, where possible, this report indicates support for each individual strategy. Support was categorized as either: 1) Scientific studies support strategy; 2) Generally supported as effective in reports, articles, or organizational guidelines; 3) Scientific validation on-going; or 4) Support is mainly subjective or anecdotal.

Scientific studies refer to published, peer-reviewed studies. Reports refer to recommendations listed in the "2000 Surgeon General's Report on Oral Health in America", "A Call to Action to Promote Oral Health", "Healthy People 2010", "Oral Health in America: The Oral Health America National Grading Project 2003", "Oral Health U.S., 2002", the "Association of State and Territorial Dental Director's (ASTDD) Guidelines for State and Territorial Oral Health Programs", the American Dental Association's (ADA) "Future of Dentistry", various Centers for Disease Control and Prevention (CDC) reports, various private organizational reports (e.g. American Cancer Society, Developmental Disabilities Council, Children's Dental Health Project), and other reports from respected public and private organizations. Organizational support refers to published support from organizations including, but not limited to: the ADA, the American Student Dental Association (ASDA), the American Dental Education Association (ADEA), the ASTDD, the CDC, the American Medical Association (AMA), the American Academy of Pediatric Dentistry (AAPD), and the American Academy of Pediatrics (AAP).

From 25 to 30 team members scored each strategy on a 1 – 5 scale, with "1" indicating the lowest possible Impact or Feasibility and "5" indicating the highest possible Impact or Feasibility. Mean scores for each strategy for Impact and Feasibility are noted. Moreover, the percent distribution of votes indicating "low" Impact or Feasibility (scores of "1" or "2") and the percent of votes indicating "high" Impact or Feasibility (scores of "4" or "5") are also noted.





I. Inadequate awareness of the importance of oral health.

Strategies

1. Provide targeted oral health promotion programs that improve public awareness as to the importance of good oral health, the association between oral health and general health, the systemic impact of oral health, and the benefits of oral health prevention.
 - a. Explanation – Target programs toward specific target areas (e.g. tobacco, fluoride, oral hygiene, nutrition); specific disadvantaged populations and dental diseases (e.g. oral cancer and Black males, periodontal disease and pregnant women); or specific cultural factors of disadvantaged populations (e.g. Spanish language or Creole language educational materials and media campaigns). Utilize social marketing and focus groups.
 - b. Benefits – Targeted materials address specific disparities that disadvantaged populations face; this would increase awareness and increase the demand for preventive oral health services; Integrates oral health into systemic health.
 - c. Barriers – Budgetary constraints.
 - d. Examples – Washington -Watch Your Mouth campaign <http://www.kidsoralhealthwatch.org/>; Connecticut - <http://www.ctoralhealth.org/about.htm>; <http://www.oralhealthamerica.org/>; and New Jersey’s Oral Health/Nutrition Resource Guide and “Miles of Smiles” newsletter; New Hampshire’s “Access to Care” Project.
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section III (Poor knowledge of the importance of oral health); Section III (Personal/Behavioral factors); Section IV (Oral health disparities among disadvantaged populations); Section VI (Integration of oral health in general health).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.73; Feasibility: 3.33.
 - h. Percent Distribution – Impact: High – 60.00%, Low 20.00%- ; Feasibility: High – 33.33%, Low – 13.33%.

2. Provide school-based oral health education.
 - a. Explanation – 1) Work with the school systems to ensure that appropriate grade-level oral health education programs in both public and private schools. Review current school oral health education programs; 2) Send oral health education information home with child; and 3) Combine oral health education with kindergarten registration, PTO meetings.
 - b. Benefits – The youth in our state will be educated on important oral health issues.
 - c. Barriers – Budgetary constraints; Legal and legislative issues; Training; Language and Cultural issues; Still must address dental IQ of parents.
 - d. Examples – New Hampshire; New Jersey (“Cavity-free Kids” preschool program); Maine (School Oral Health Program).



- e. State Oral Health Plan Section Links – Section III (Personal/Behavioral factors); Section VI (School-based education programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.75; Feasibility: 3.39.
 - h. Percent Distribution – Impact: High – 64.29%, Low – 17.86%; Feasibility: High – 46.43%, Low – 14.29%.
3. Provide community-based oral health education.
- a. Explanation – Include oral health education at community or school health fairs and festivals, senior centers, community events, community centers, nursing homes and ALF's, and faith-based centers and programs.
 - b. Benefits – Free; Able to speak to parents/guardians (interactive); Opportunity to give out educational/awareness materials; Introduction and engagement tool.
 - c. Barriers – Training; Staffing; Language and Cultural issues.
 - d. Examples – Arkansas (Prevent Abuse and Neglect through Dental Awareness – P.A.N.D.A); Connecticut (Open Wide); Nevada (Healthy Smile – Happy Child Program); New Jersey (Franny Flossisaurus & Mr. Gross Mouth Oral Health Teaching Kits); Oregon (Project: PREVENTION); Utah (The Smile Factory).
 - e. State Oral Health Plan Section Links – Section III (Personal/Behavioral factors); Section VI (Community and School-based education programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 2.79; Feasibility: 3.96.
 - h. Percent Distribution – Impact: High – 42.86%, Low – 50.00%; Feasibility: High – 75.00%, Low – 10.71%.
4. Educate lawmakers and policymakers.
- a. Explanation – 1) Provide lawmakers and policymakers with: appropriate information regarding the importance of oral health; appropriate data on State oral health needs; and appropriate estimates of effectiveness and costs of programs; and 2) Recruit/Educate lawmakers and policymakers to champion oral health issues
 - b. Benefits – Lawmakers and policymakers that support dental health are more likely to push for increased dental services and funding. With proper knowledge lawmakers and policymakers can make more informed decisions.
 - c. Barriers – Funding; Organized advocates are probably needed to be effective; Cooperation between all organized dental health care providers – must show a unified front.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section V (Lack of knowledge among policymakers that oral health is important)
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.48; Feasibility: 3.33.



- h. Percent Distribution – Impact: High – 55.56%, Low – 22.22%; Feasibility: High – 55.56%, Low – 25.93%.
5. Educate other health care providers as to the importance of oral health.
- a. Explanation – The public may seek health care services from other health care providers (such as physicians, nurses, and nurse practitioners) before and many times more often than they see an oral health provider. Other health care providers need to be aware of dental diseases and conditions so that they can properly treat or refer patients in need.
 - b. Benefits – Expands access to oral health care services.
 - c. Barriers – Training; Possible insurance issues; Cooperation between various health care providers.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section III (Lack of access to professional care); Section V (Workforce issues).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.19; Feasibility: 3.23.
 - h. Percent Distribution – Impact: High – 34.63%, Low – 23.08%; Feasibility: High – 30.77%, Low – 23.08%.

II. Inadequate integration and coordination of State agencies and organizations.

Strategies

6. Co-locate dental services with other health care services or link medical services with dental services.
- a. Explanation – 1) Partner with WIC / Immunization Clinics/ Health Care Provider / Dentist Office / Kid Care / etc.; 2) Oral Health Resource Directory; 3) Education and information dissemination and sharing; 4) Referral services; and 5) Coordination of care.
 - b. Benefits - Avoids missed opportunities.
 - c. Barriers – Cooperation; Physical space; Funding.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section III (Lack of access to professional care); Section V (Training and utilization of medical personnel); Section V (Integration of oral health in general health); Section VI (Improving health through coalitions); Section VII (Safety net programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.60; Feasibility: 2.10.
 - h. Percent Distribution – Impact: High – 50.00%, Low – 6.67%; Feasibility: High – 13.33%, Low – 66.67%.





7. Expand or create community clinics and affiliate with local hospitals.
 - a. Explanation – Include or establish oral health services in community health care clinics or other existing health care facilities; or link dental services to existing health care facilities.
 - b. Benefits - Coordinated care results in better overall health; Greater opportunities for individual and parent education regarding the need for good oral health care and importance of making and keeping appointments; Greater opportunities for education regarding home care; Not as many start-up costs; Population already in place.
 - c. Barriers- Funding; Staffing; Training existing staff; Turf wars.
 - d. Examples – Tacachale and UF; Rhode Island’s “Providence Smiles” project.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section VI (Community-based prevention programs); Section VI (Integration of oral health in general health); Section VI (Improving health through coalitions); Section VII (Community Health Centers); Section VII (Safety net programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 4.10; Feasibility: 2.0.
 - h. Percent Distribution – Impact: High – 76.67%, Low – 10.00%; Feasibility: High – 6.90%, Low – 75.86%.

8. Use the existing community network to identify the most vulnerable (e.g. those with diabetes & cardiovascular diseases).
 - a. Explanation – Target vulnerable populations using existing community networks such as the aging senior network.
 - b. Benefits – Population already identified.
 - c. Barriers – Training; Turf wars.
 - d. Examples – Alabama (ECC prevention in WIC children);
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section IV (Elderly); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.21; Feasibility: 3.41.
 - h. Percent Distribution – Impact: High – 44.83%, Low – 20.69%; Feasibility: High – 48.28%, Low – 17.24%.

9. Establish or identify existing coalitions to promote oral health care.
 - a. Explanation – The dental profession needs to partner with 1) professional marketing/public relation firms in order to produce effective educational programs; 2) professional advocates to more effectively influence legislators; 3) other health care settings or facilities to link disadvantaged populations that present in those facilities with dental care within 60 days of initial contact; 4) Establish a State task force or dental advisory committee (establish a unified voice that speaks for the entire dental (and medical) profession that can identify needs,



- establish standards of care, identify emerging trends, and recommend solutions);
5) Develop a statewide non-profit coalition.
- b. Benefits – Efficiency and effectiveness.
 - c. Barriers – Funding; Training; Expertise Cooperation.
 - d. Examples – Washington’s Watch Your Mouth campaign; Illinois IFLOSS coalition; Massachusetts; Missouri; and New Jersey.
 - e. State Oral Health Plan Section Links – Section III (Personal/Behavioral factors); Section IV (Oral health disparities among disadvantaged populations); Section V (Lack of knowledge among policymakers that oral health is important); Section V (Training and utilization of medical personnel); Section VI (Integration of oral health in general health); Section VI (Improving health through coalitions).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.43; Feasibility: 2.70.
 - h. Percent Distribution – Impact: High – 56.67%, Low – 23.33%; Feasibility: High – 30.00%, Low – 43.33%.
10. Conduct separate work groups, forums, or summits to develop strategies, objectives and action steps for specific disadvantaged populations, as needed.
- a. Explanation - Based on the current strategies submitted, additional efforts appear to be needed to develop action steps for specific disadvantaged groups.
 - b. Benefits - Will ensure that specific groups are not overlooked and facilitate progress and integration.
 - c. Barriers - Resources and time constraints.
 - d. Examples - Head Start Summits supported by HRSA through grant applications to ASTDD; Georgia Oral Health Summit; Colorado Commission on Children’s Dental Health; Delaware Health Care Commission’s Dental Care Access Improvement Committee; Massachusetts Special Legislative Commission on Oral Health; Ohio Director of Health’s Task Force on Access to Dental Care; and the Montana Dental Summit.
 - e. State Oral Health Plan Section Links - Section IV (Oral health disparities among disadvantaged populations); Section VI (Improving health through coalitions); Section VI (Integration of oral health in general health).
 - f. Support for this Strategy - Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.00; Feasibility: 3.69.
 - h. Percent Distribution – Impact: High – 31.03%, Low – 34.48%; Feasibility: High – 62.07%, Low – 17.24%.

III. Inadequate access to oral health services for all Floridians.

Strategies

11. Increase and assure appropriate types of available oral health care providers and increase diversity in the field of oral health.



- a. Explanation – 1) Increase efforts to encourage prospective students from underserved areas and/or from disadvantaged groups to choose a career in the dental field; 2) Implement no payment, no interest loan program, loan forgiveness programs, or other incentive programs at the State level or expand federal loan forgiveness programs in exchange for dental providers serving in designated dentally underserved areas of Florida; 3) Increase Number of Pediatric Dentists (Increase the number of programs or number of residents that programs enroll); 4) Increase the number of dental hygienists and dental assistants – more schools, larger class sizes, recruiting/incentive programs; and 5) Promote diversity in the oral health workforce by utilizing Affirmative Action (schools must enroll “x” amount of certain minority students to reflect population demographics), Minority Loan Programs, and Recruiting of Minority Dental Students.
 - b. Benefits - Increase the number of dental providers serving disadvantaged populations.
 - c. Barriers – Funding issues; Does not guarantee that dental providers will treat or continue to treat underserved populations; Finding qualified applicants.
 - d. Examples – Colorado, Kansas; Maine; Minnesota, and Illinois (loan forgiveness programs in exchange for practice in dentally underserved areas). Nebraska (incentives for students to consider rural practices). North Dakota (Mentorship program in partnership with the National Health Services Corps SEARCH program to address workforce issues in underserved areas). Most of these programs already exist – just need to expand.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce).
 - f. Support for this Strategy - Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.86; Feasibility: 2.00.
 - h. Percent Distribution – Impact: High – 65.52%, Low – 6.90%; Feasibility: High – 3.45%, Low – 72.41%.
12. Improve the Medicaid program to stimulate greater health care provider participation.
- a. Explanation – 1) Increase Medicaid dental reimbursement rates; 2) Tax Credit/Non-Taxable Income Status for oral health providers that accept Medicaid Income; 3) Streamline administrative processes to reduce the administrative burden and requirements for oral health providers that accept Medicaid; 4) Promote outreach activities to recruit dentists into the Medicaid program; and 5) Simplify the Medicaid system for providers and Medicaid-eligible Floridians alike
 - b. Benefits – Increase oral health provider participation; Increase access; Increase Medicaid eligible participation.
 - c. Barriers – Budgetary and legislative constraints; Tax credits/Non-taxable income must be legislated on federal level; Does not necessarily translate to increasing numbers of Medicaid patients utilizing dental services.
 - d. Examples – “Smile Alabama”; Tennessee – TennCare program; Delaware; Georgia; Indiana; Michigan; and South Carolina.



- e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Barriers to care – provider issues); Section V (Shortage of dental providers); Section VII (Medicaid),
 - f. Support for this Strategy – Scientific studies support strategy.
 - g. Mean Score – Impact: 4.48; Feasibility: 1.69.
 - h. Percent Distribution – Impact: High – 86.21%, Low – 0.00%; Feasibility: High – 3.45%, Low – 72.41%.
13. Promote continuity of care through case management and patient education.
- a. Explanation – 1) Educate parents and patients about importance of regular oral health care, proper office protocol, and the importance of making appointments and compliance; 2) Case managers for providers to ease administrative process 3) Outreach programs targeted towards specific disadvantaged populations (HIV/AIDS, etc.); 4) Identify special populations and link care and follow-up to appropriate services.
 - b. Benefits – Improved client compliance; Increased provider willingness to accept Medicaid, Improved access to care; Establishes dental home.
 - c. Barriers – Budgetary constraints; Lack of awareness by the Medicaid program; Legislative constraints and mandates that discourage such programs; Funding; Staffing; HIPAA – confidentiality issues; Certain populations may be wary of government intrusion into their lives – scared of deportation, etc.
 - d. Examples – “Smile Alabama”; Washington’s Access to Baby and Child Dentistry Program; Migrant Tracking System; New Hampshire’s “Access to Care” Project; New Mexico’s “Patient Management Assistance” Program; North Dakota’s “Project Will Show”.
 - e. State Oral Health Plan Section Links – Section III (Poor knowledge of the importance of oral health); Section IV (Oral health disparities among disadvantaged populations); Section VI (Integration of oral health in general health); Section V (Barriers to care – provider issues); Section V (Shortage of Dental providers); Section VII (Medicaid).
 - f. Support for this Strategy – Scientific studies support strategy.
 - g. Mean Score – Impact: 3.90; Feasibility: 2.48.
 - h. Percent Distribution – Impact: High – 68.97%, Low – 6.90%; Feasibility: High – 17.24%, Low – 55.17%.
14. Reduce economic barriers to dental care.
- a. Explanation: 1) Provide funding to safety net dental programs to treat uninsured clients; 2) Expand Medicaid and SCHIP eligibility for dental services; 3) Advocate for the addition of dental care services to Medicare; and 4) Advocate for the addition of dental care services to medical insurance; 5) Adult dental coverage in Medicaid.
 - b. Benefits – Increase access to oral health care.
 - c. Barriers – Funding; Legislative and social issues; Opposition from the insurance industry.



- d. Examples – New Hampshire (adult dental benefits in Medicaid); Colorado (Old Age Pension Dental Program)
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care; Section VI (Integration of oral health in general health); Section VII (Safety net programs); Section VII (Medicare, Medicaid).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 4.24; Feasibility: 1.53.
 - h. Percent Distribution – Impact: High – 76.47%, Low – 5.88%; Feasibility: High – 0.00%, Low – 100.00%.
15. Expand training regarding special needs populations into core dental, dental hygiene, and dental assisting school curriculums and establish a dental care services web that includes satellite, regional, and designated centers of excellence.
- a. Explanation - 1) Establish two Centers of Excellence at the dental schools and develop a statewide treatment and referral program; 2) Establish 5 regional centers for special needs patients; and 3) Dental schools need to provide adequate training for students to provide care for the disabled, elderly, and other individuals with certain health conditions.
 - b. Benefits – Improves infrastructure; Increases workforce able to treat special needs patients; Establish a dental home for clients that cannot find a dentist practicing in a private practice setting.
 - c. Barriers – Budgetary constraints; Lack of resources and trained professionals.
 - d. Examples – UF and NOVA have established Centers of Excellence.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section IV (Oral health disparities among disadvantaged populations); Section V (Workforce issues); Section VII (Academic programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 4.10; Feasibility: 2.31.
 - h. Percent Distribution – Impact: High – 86.21%, Low – 10.43%; Feasibility: High – 13.79%, Low – 68.97%.
16. Assure access and availability of dental services in a variety of settings that meet the needs of all underserved populations.
- a. Explanation - 1) Develop satellite centers in rural areas; 2) Establish school-based screening and sealant oral health programs; 3) Incorporate all elderly services into local health department clinics; 4) Increase the utilization of mobile dental vans; 5) Provide transportation services and child care in public access health centers; 6) Increase the number of State and Federal safety net programs (e.g. dental units in CHDs); 7) Expand CHD dental services hours of operation; 8) Increase the number of school-based dental clinics or referral programs; and 9) Increase the number of nursing home or ALF-based dental clinics or referral systems.
 - b. Benefit – Increase access to care for patients with complex needs; Establishes a referral program for clients needing specialized care; Provide specialized training



- for dental health care providers; Reduces barriers to care such as transportation, time off work, and child care issues.
- c. Barriers – Funding issues; Legislative constraints (mobile vans); Regulatory issues (informed consent and scope of practice if utilizing dental hygienists); Lack of resources and trained professionals.
 - d. Examples – Michigan “Healthy Kids” Program; Existing dental mobile vans.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to sealants); Section III (Lack of access to professional care); Section IV (Oral health disparities among disadvantaged populations); Section V (Barriers to care – patient issues); Section V (Workforce issues); Section VI (Community and school-based prevention programs); Section VII (Safety net programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 4.39; Feasibility: 1.59.
 - h. Percent Distribution – Impact: High – 87.10%, Low – 3.23%; Feasibility: High – 6.90%, Low – 82.76%.
17. Create incentives for volunteer programs providing dental care for disadvantaged clients.
- a. Explanation – Encourage the development of incentives to increase volunteerism in providing dental care to disadvantaged clients.
 - b. Benefits – Increase access to oral health care for disadvantaged clients; Training.
 - c. Barriers – Budgetary constraints; Lack of resources and participating dentists; Liability issues for volunteers.
 - d. Examples – Project: Dentists Care; Continuing Education credits for volunteerism; Reduced dental licensure fees for volunteerism.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section IV (Oral health disparities among disadvantaged populations); Section V (Workforce issues); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.06; Feasibility: 2.59.
 - h. Percent Distribution – Impact: High – 29.41%, Low – 17.65%; Feasibility: High – 17.65%, Low – 52.94%.
18. Examine modification of the Informed Consent Doctrine.
- a. Explanation - The informed consent law as it exists may create a barrier to care for certain persons who the law deems “incompetent” to make personal decisions regarding their health and well-being (e.g. minors and the mentally disabled) – thus, health care providers may not provide care to such legally incompetent persons without first giving and gaining informed consent from a parent or legal guardian except in emergency situations that are life threatening. Modifying the informed consent doctrine to allow for health care providers to either act as guardians or to provide necessary care in certain special emergency circumstances (e.g. pain or infection, not just life threatening situations) would improve access for these incapacitated persons.



- b. Benefits – Allows for immediate care of persons in need; Solves possible parent (guardian) scheduling and transportation problems that may prevent parent (guardian) from getting care.
- c. Barriers – Need to change the law. Possible opposition from parents; Potential for provider abuse.
- d. Example – Supreme Court Case law (Estelle v. Gamble, Youngberg v. Romero, Deshaney v. Winnebago): “when the state takes someone into custody and holds them against their will (deprivation of liberty), the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being” (this mainly applies to inmates and mentally committed patients, but courts have looked at schools); State Parens Patriae doctrine – state assumes the role of parent in instances where parental supervision is absent or deemed deficient.
- e. State Oral Health Plan Section Links – Section V (Barriers to care – provider issues).
- f. Support for this Strategy – Support is mainly subjective or anecdotal.
- g. Mean Score – Impact: 3.28; Feasibility: 1.76.
- h. Percent Distribution – Impact: High – 44.83%, Low – 24.14%; Feasibility: High – 10.34%, Low – 82.76%.

IV. Inadequate Statewide data that describes the disease burden and needs of Florida’s population.

Strategies

19. Implement a high quality, on-going, representative oral health surveillance system to establish baseline values for oral disease and to measure effectiveness of oral health programs. Data is a prime driver of national and state issues. Current data is inadequate. Whenever possible, information should be county-specific.
 - a. Explanation – 1) The oral health surveillance system should include information on oral diseases, utilization patterns, and oral health needs; 2) Incorporate dental surveillance in all DOH dental clinics - Design or acquire software that can utilize dental treatment information into usable epidemiological study data; 3) Apply for Federal Loans to Initiate Surveillance/Studies of Special Needs Patients; and 4) Advocate for more Dental Questions on Federal and State BRFSS.
 - b. Benefits – Data is important in making policy decisions; Improved data on dental needs and burdens; Can measure the benefits of oral health interventions and programs.
 - c. Barriers – Funding constraints; Lack of resources; Implementing – need plan and coordination; Coordination; Resistance from health care practitioners to take part; Arriving at consensus on types of information to be collected; Possible HIPAA issues.
 - d. Examples – Arkansas; Delaware; Illinois; Maine; Maryland; Missouri; New Hampshire; New Mexico; Oregon; Pennsylvania; Utah; Vermont; Washington; and Wisconsin. CDC state cooperative agreement funding (currently, 12 states are involved)



- e. State Oral Health Plan Section Links – Section V (Barriers to care – State issues); Section VI (Oral health surveillance systems).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.33; Feasibility: 2.85.
 - h. Percent Distribution – Impact: High – 51.85%, Low – 25.93%; Feasibility: High – 25.93%, Low – 40.74%.
20. Survey dental health practitioners – both students and actively practicing dental health care providers - on issues related to treating the underserved.
- a. Explanation – 1) Survey active dental providers to determine what incentives would get them to treat special needs or disadvantaged individuals; 2) Survey dental, dental hygiene, and dental assisting students to determine what factors they consider in location decisions; and 3) Survey dental, dental hygiene, and dental assisting students to determine what incentives will entice them to locate in underserved areas.
 - b. Benefits – Will provide data regarding problems that can be used for policy development.
 - c. Barriers – Funding.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section V (Barriers to care – State issues); Section V (Workforce); Section VI (Oral health surveillance systems).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.07; Feasibility: 3.52.
 - h. Percent Distribution – Impact: High – 51.85%, Low – 33.33%; Feasibility: High – 55.56%, Low – 22.22%.
21. Advocate for a statewide research agenda.
- a. Explanation – Advocate designing national studies that utilize state-specific information vs. regional information; 2) Evaluate the effect managed care dental plans have on access to care for disadvantaged populations in Medicaid and SCHIP; 3) Utilize social marketing programs; 4) More training in research and public health education in dental education programs; 5) Utilize schools of public health and schools of social work, etc. in designing studies and gathering data; and 6) Coordination with other health care organizations (e.g. AHEC) and DOH departments that may have data or grant funding that can be tied to dental information.
 - b. Benefits – More knowledgeable workforce; Improved data; Less resistance to participation in State surveillance initiatives; Determine the most cost effective means to deliver quality dental health care.
 - c. Barriers – Funding constraints; Difficult to design studies to report state-specific data; State studies are complex and resource intensive; Coordination; Cooperation.
 - d. Examples –



- e. State Oral Health Plan Section Links – Section V (Barriers to care – State issues); Section VI (Oral health surveillance systems).
- f. Support for this Strategy – Support is mainly subjective or anecdotal.
- g. Mean Score – Impact: 2.85; Feasibility: 3.44.
- h. Percent Distribution – Impact: High – 33.33%, Low – 33.33%; Feasibility: High – 48.15%, Low – 11.11%.



V. Inadequate utilization of available resources.

Strategies

22. Advocate for programs to train non-dental health professions to provide oral assessments and use of fluorides.
- Explanation – Train medical personnel (e.g. physicians and nurses) to perform oral health screening assessments on children for referral to dentists. Additionally, medical personnel could be trained in the application of fluoride varnish.
 - Benefit – Medical personnel often see children at a younger age than dental providers. Earlier intervention; Improved access; Earlier and more preventative and oral health education for the public.
 - Barriers – Legal issues; Lack of reimbursements for services; Legislative issues; Lack of awareness on the benefits of such interventions; Dental Practice Act issues.
 - Examples – Minnesota - <http://www.mchoralhealth.org/PediatricOH/index.htm>; Missouri (physicians administer appropriate fluoride treatments during immunization visits)
 - State Oral Health Plan Section Links – Section I (Relationship of oral diseases to systemic health); Section III (Lack of access to fluoride); Section III (Lack of access to professional care); Section V (Workforce issues).
 - Support for this Strategy – Scientific validation on-going.
 - Mean Score – Impact: 3.96; Feasibility: 2.86.
 - Percent Distribution – Impact: High – 64.29%, Low – 3.57%; Feasibility: High – 21.43%, Low – 39.29%.
23. Advocate for statutory and regulatory reform to the State Dental Practice Act to eliminate or reduce the supervision requirements for Dental Hygienists practicing in community health and school based settings.
- Explanation – 1) Allow for dental hygienists that are part of county health departments and other safety net programs to provide minimal oral disease preventive services such as dental sealants in schools without direct supervision of a dentist; 2) Allow dental hygienists to be supervised by health professionals who are other than dentists (e.g. physicians).
 - Benefit – Dental hygienists could provide care on-site to individuals instead of the patients being transported to an office, clinic or facility off-site; Increased access; Reduce the cost of school-based programs.
 - Barriers – Legislative and regulatory issues – change must come from the Legislature or Florida Board of Dentistry; Opposition from the dental community; Insurance issues – screening versus exam – how to get reimbursement for both dental hygienist exam and dentist exam if need treatment?; Medicaid provider numbers; Training issues – Expand training.
 - Examples – 1) Allowing dental hygienists to perform screenings (vs. exams?) without dental supervision in 35 other states has increased Medicaid utilization. 2)



Allowing dental hygienists to perform preventive care in public health facilities, nursing homes, and school settings has increased access in many states, such as California, Connecticut, Washington, Maine, Colorado, Minnesota, and Missouri. 3) Center for Health Workforce Studies, University at Albany (6/03) evaluated regulatory, supervision, tasks and reimbursement category for dental hygienists. Florida scored 33/100 – Limiting Category – Only 13 other states scored lower than Florida.

- e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.45; Feasibility: 2.45.
 - h. Percent Distribution – Impact: High – 44.83%, Low – 24.14%; Feasibility: High – 17.24%, Low – 55.17%.
24. Advocate for or design incentives for improved training of all dental health care providers in the area of treating special needs patients.
- a. Explanation – 1) Expand dental health for special needs patients curricula in dental, dental hygiene, and dental assisting schools; 2) Residency programs; 3) Rotations in special needs clinics; 4) Continuing education classes; 5) Continuing education credits for volunteerism; 6) Cultural Competency and Foreign Language Courses or Instruction; and 7) Mentoring programs
 - b. Benefit – Increase access; More providers competent and willing to treat special needs patients.
 - c. Barriers – Funding; Lack of resources to provide training; Staffing; Time – overburdened curricula; Inadequate training for providers; Reluctance by providers to treat these populations.
 - d. Examples – Tacachale and UF; Special Needs clinic and NOVA; Iowa (Pediatric Dental Education Program); New Jersey.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section III (Psychosocial factors); Section V (Barriers to care - provider issues); Section V (Workforce issues).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.79; Feasibility: 3.21.
 - h. Percent Distribution – Impact: High – 60.71%, Low – 10.71%; Feasibility: High – 46.43%, Low – 21.43%.
25. Examine alternate methods of licensing of dentists – Option of 1 year of public service or residency vs. Exam.
- a. Explanation - Give graduating senior dental students or recent graduates from other states (less than 5 years experience) the option of working for 1 year in a public service dental setting (CHD, residency program, Indian Health Service, Public Health Service, etc.) or taking the clinical board exam. Medical school model of need for residency training before licensing.



- b. Benefits - Increases workforce in designated dentally underserved areas; Experience for new dentists; Eliminates some of the controversies surrounding dental clinical boards.
 - c. Barriers - Funding residencies (need adequate salary).
 - d. Example – New York has implemented this strategy and two states (Minnesota and Connecticut) are currently considering similar proposals
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 1.81; Feasibility: 1.22.
 - h. Percent Distribution – Impact: High – 11.11%, Low – 74.07%; Feasibility: High – 3.70%, Low – 92.59%.
26. Advocate for licensure by credentials.
- a. Explanation - Allow experienced out-of-state dentists and dental hygienists with good records to gain a Florida dental license by credentialing.
 - b. Benefits - Increases the dental workforce.
 - c. Barriers – Controversial within the dental community; Need to properly review incoming dentists’ and dental hygienists’ records; Need change in Dental Practice Act.
 - d. Examples – Florida is one of only four states that do not offer licensure by credentials (Delaware, Hawaii, and Virginia are the others); The ADA supports freedom of movement for dentists.
 - e. State Oral Health Plan Section Links – Section II (Lack of access to professional care); Section IV (Workforce issues).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 1.85; Feasibility: 1.30.
 - h. Percent Distribution – Impact: High – 11.11%, Low – 74.07%; Feasibility: High – 3.70%, Low – 92.9%.
27. Advocate for oral health education in medical schools or inclusion of oral health training in medical continuing education requirements.
- a. Explanation - The Surgeon General’s Report put the medical community on notice in 2000 that oral health is a part of systemic health, but the medical community has failed to act. (e.g. medical and dental school partnerships; threat of malpractice lawsuits against medical professionals for failure to diagnose dental disease); Oral health and dental diseases are a part of systemic health; Physicians need to be trained to identify and refer patients for treatment of dental disease or needs.
 - b. Benefits - Expands the workforce; Educates health care providers as to the importance of dental health; Educates the public about the importance of dental health.
 - c. Barriers - Medical school resistance to teaching such courses; Overburdened curricula.



- d. Examples – Minnesota (web-based continuing education-
<http://www.mchoralhealth.org/PediatricOH/index.htm>.)
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section III (Lack of access to professional care); Section V (Workforce issues).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.92; Feasibility: 2.96.
 - h. Percent Distribution – Impact: High – 69.23%, Low – 19.23%; Feasibility: High – 46.15%, Low – 46.15%.
28. Advocate for oral health screenings becoming a “standard of care” in medical examinations.
- a. Explanation – The medical profession needs to establish that oral health screenings are the standard of care in a physical examination.
 - b. Benefits - Educates health care professionals about the importance of oral health; Expands workforce.
 - c. Barriers - Resistance from medical profession.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section II (Relationship of oral diseases to systemic health); Section III (Lack of access to professional care); Section V (Workforce issues).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.85; Feasibility: 2.50.
 - h. Percent Distribution – Impact: High – 69.23%, Low – 7.69%; Feasibility: High – 19.23%, Low – 50.00%.

VI. Inadequate Statewide implementation of preventative programs.

Strategies

29. Increase access to fluoridation.
- a. Explanation – 1) Encourage community leaders to initiate community water fluoridation in their communities; 2) Statewide or countywide community fluoridation mandate.
 - b. Benefits – Decrease the burden of dental decay; Reduce oral health disparities seen in disadvantaged populations; Cost effective; Supported by courts of law.
 - c. Barriers – Anti-fluoridation campaigns; Budgetary constraints; Convincing legislators that oral health is important and that fluoridation is safe and effective; Legislators are afraid of controversial legislation (want to get reelected); If the measure failed, it would give ammunition to anti-fluoridation groups.
 - d. Examples – Statewide mandate - Ohio.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to fluoride); Section VI (Community and school-based prevention programs).
 - f. Support for this Strategy – Scientific studies support strategy.



- g. Mean Score – Impact: 4.39; Feasibility: 2.82.
 - h. Percent Distribution – Impact: High – 82.14%, Low – 3.57%; Feasibility: High – 21.43%, Low – 42.86%.
30. Expand school-based and school-linked dental sealant programs for children.
- a. Explanation – Delivery of sealants funded through Medicaid and Healthy Kids; Recommended in NGA Action Plan; 4) Local demonstration projects recommended in SWDCC strategic plan; Benefits – Most effective way to increase utilization of sealants; Allows greater access to oral health services and education for school children.
 - b. Barriers – Budgetary constraints; Funding for coordinator; Equipment start-up; Lack of willingness or awareness on the part of the school decision makers; Low parent participation.
 - c. Examples – Arizona (Dental Sealant Program); Idaho (Seal Idaho 2000); Illinois (Dental Sealant Grant Program); Kentucky (KIDS SMILE program); New Jersey (Community and School-Linked Sealant Project); New Mexico (School Based Dental Sealant Program); Ohio (School-Based Sealant Program); Wisconsin (“GuardCare” Program); Wyoming (Dental Sealant Program).
 - d. State Oral Health Plan Section Links – Section III (Lack of access to sealants); Section VI (Community and school-based prevention programs).
 - e. Support for this Strategy – Scientific studies support strategy.
 - f. Mean Score – Impact: 4.18; Feasibility: 2.53.
 - g. Percent Distribution – Impact: High – 82.35%, Low – 0.00%; Feasibility: High – 23.53%, Low – 58.82%.
31. Increase the availability and use of school-based fluoride mouthrinse programs.
- a. Explanation – Increase utilization of fluoride mouthrinse programs for children and evaluate their effectiveness; Increase utilization of school-based fluoride mouthrinse programs in communities without community water fluoridation
 - b. Benefits – Fluoride mouthrinses are a practical means to deliver targeted high doses of fluoride to children, especially in areas without community fluoridation of the water supply; Fluoride is cost effective.
 - c. Barriers – Budgetary constraints; Lack of awareness about the use of fluoride mouthrinses, Training; Staffing; Opposition from teachers; Opposition from dental community.
 - d. Examples – Idaho (School Fluoride Mouthrinse Program); New Jersey (“Save Our Smiles” Fluoride Mouthrinse Program); New York (School-based Supplemental Fluoride Program); Oregon (King Fluoride School-Based Rinse/Tablet Program); Vermont (Fluoride Mouthrinse Program); Virginia (School Fluoride Mouthrinse Program).
 - e. State Oral Health Plan Section Links – Section III (Lack of access to fluoride); Section VI (Community and school-based prevention programs).
 - f. Support for this Strategy – Scientific studies support strategy.
 - g. Mean Score – Impact: 3.65; Feasibility: 3.18.



- h. Percent Distribution – Impact: High – 47.06%, Low – 5.88%; Feasibility: High – 35.29%, Low – 17.65%
32. Increase use of fluoride varnish programs in school and medical office settings.
- Explanation – Increase utilization of fluoride varnish programs for children and evaluate their effectiveness; Increase utilization of fluoride varnish programs in communities without community water fluoridation
 - Benefits – Fluoride varnishes are a practical means to deliver targeted high doses of fluoride to children, especially in areas without community fluoridation of the water supply; Fluoride is cost effective.
 - Barriers – Budgetary constraints; Lack of awareness about the use of fluoride varnishes, Training; Staffing; Opposition from teachers; Opposition from dental community.
 - Examples –Iowa (Fluoride Varnish Application Program); New York (School-based Supplemental Fluoride Program).
 - State Oral Health Plan Section Links – Section III (Lack of access to fluoride); Section VI (Community and school-based prevention programs).
 - Support for this Strategy – Scientific validation on-going.
 - Mean Score – Impact: 3.65; Feasibility: 2.59.
 - Percent Distribution – Impact: High – 47.06%, Low – 5.88%; Feasibility: High – 17.65%, Low – 47.06%.
33. Advocate for school-based general health promotion.
- Explanation – 1) Quality school lunch programs; 2) Remove candy and soda machines from schools.
 - Benefits – Improved diet and nutrition; Improved awareness of oral health and general health.
 - Barriers – Schools may oppose (funding issues – schools may receive revenue from food and beverage companies to make their products available).
 - Examples –
 - State Oral Health Plan Links – Section II (Relationship of oral diseases to systemic health); Section VI (Community and school-based prevention programs); Section VI (The integration of oral health in general health).
 - Support for the Strategy - Generally supported as effective in reports, articles, or organizational guidelines.
 - Mean Score – Impact: 3.47; Feasibility: 3.29.
 - Percent Distribution – Impact: High – 64.71%, Low – 25.53%; Feasibility: High – 41.18%, Low – 29.41%.
34. Annual (or more regular) oral health screenings of school-aged children, prior to school year enrollment.
- Explanation - Currently, Florida requires a health exam (but no dental exam requirement) only upon initially entering the Florida school system. Need to expand the requirement to every year or at least to multiple years (e.g. Initial entry, 3rd grade, 6th grade, 9th grade).



- b. Benefits - Educates public about importance of dental health; Decreases school days lost due to dental disease; Improves access and utilization; No infrastructure or start-up costs.
- c. Barriers - Many patients will be on Medicaid – thus, need more funding; Compliance issues; Coordination between DOH and DOE; Coordination with Medicaid and SCHIP.
- d. Examples - Pennsylvania, New York, Illinois, Connecticut, Massachusetts.
- e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section VI (Community and school-based prevention programs).
- f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
- g. Mean Score – Impact: 4.24; Feasibility: 3.04.
- h. Percent Distribution – Impact: High – 72.41%, Low – 6.90%; Feasibility: High – 39.29%, Low – 35.71%.

VII. Inadequate funding.

Strategies

- 35. Advocate for the legislature to reallocate tobacco settlement monies for tobacco control programs.
 - a. Explanation – The Legislature has cut monies going to tobacco control programs.
 - b. Benefits – Funding from tobacco settlement already exists; tobacco control programs work.
 - c. Barriers – Competition for settlement monies.
 - d. Examples – Illinois (Utilizing Tobacco Master Settlement Agreement Funds to Support Oral Health Programs).
 - e. State Oral Health Plan Section Links – Section II (Personal/Behavioral factors).
 - f. Support for this Strategy – Scientific studies support strategy.
 - g. Mean Score – Impact: 3.69; Feasibility: 2.00.
 - h. Percent Distribution – Impact: High – 55.17%, Low – 13.79%; Feasibility: High – 13.79%, Low – 72.41%.

- 36. Explore and expand leveraging/matching systems to draw down federal support - Apply for federal or organizational grant monies to support oral health programs.
 - a. Explanation – The Federal government and private organizations provide grant and seed money for research, pilot programs, and infrastructure that the State does not fully utilize.
 - b. Benefits - Alternative funding sources that do not cost the State money.
 - c. Barriers - Awareness of grants; Grant-writing; Staffing projects; Coordination and integration.
 - d. Examples – Vermont (Dental Access Grants); North Carolina’s “Access Dental Care” project.



- e. State Oral Health Plan Section Links – Section V (Barriers to care – State issues); Section VI (The integration of oral health in general health); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.55; Feasibility: 2.90.
 - h. Percent Distribution – Impact: High – 51.72%, Low – 20.69%; Feasibility: High – 31.03%, Low – 37.93%.
37. Research the concept of mandatory pro-bono for licensure.
- a. Explanation – Advocate for a mandatory pro-bono requirement in order to maintain a Florida dental license. All Florida-licensed dentists must provide a certain amount of hours every two years of volunteer services to disadvantaged populations or pay a set fee if they choose not to provide services (e.g. 32 hours/2 years or \$3,200). Can provide services to nursing homes/ALF's, schools, Project: Dentists Care; Give Kids a Smile, etc. May also receive continuing education requirement for such service.
 - b. Benefits - Expands workforce available to disadvantaged populations; Educates dentists to the need and burdens of disadvantaged populations; Monies generated from those dentist opting to pay fee instead of providing services can go to dental programs for the disadvantaged; Dentists can expand their patient pool.
 - c. Barriers - Resistance from organized dentistry; Compliance issues.
 - d. Example - Many states have this requirement for lawyers.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Barriers to care - state issues); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 2.59; Feasibility: 1.21.
 - h. Percent Distribution – Impact: High – 27.59%, Low – 48.28%; Feasibility: High – 0.00%, Low – 93.10%.

VIII. Inadequate State Infrastructure.

Strategies

38. Advocate or encourage a public health dentist to be on the Florida Board of Dentistry.
- a. Explanation – The Florida Board of Dentistry is made up of 11 members - seven members of the board must be licensed dentists actively engaged in the practice of dentistry in this state. Two members must be licensed dental hygienists actively engaged in the practice of dental hygiene in this state. The remaining two members must be laypersons who are not, and have never been, dentists, dental hygienists, or members of any closely related profession or occupation. The majority of dental professionals on the board come from clinical backgrounds. Thus, the overwhelming influence of the Board is to implement procedures relating to individualized patient-based care, not population-based or prevention-based programs.

- b. Benefits – Public Health Dentistry will have a voice in dental decisions that regulate the profession in the State.
 - c. Barriers – Turf war; Possible opposition from clinical dentists.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section III (Poor knowledge of the importance of oral health); Section V (Barriers to care – Government/Policy issues).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 2.57; Feasibility: 2.81.
 - h. Percent Distribution – Impact: High – 28.57%, Low – 46.43%; Feasibility: High – 48.15%, Low – 44.44%.
39. Establish a State grant writing office.
- a. Explanation - Full time position that researches and applies for federal or private organizational funding that will support dental services, research, and infrastructure in the state.
 - b. Benefits - Coordinated effort; Maximizes funding sources and opportunities.
 - c. Barrier - Funding to staff position.
 - d. Examples –
 - e. State Oral Health Plan Section Links – Section V (Barriers to care – State issues); Section VI (The integration of oral health in general health); Section VI (Oral health surveillance systems).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 2.88; Feasibility: 2.53.
 - h. Percent Distribution – Impact: High – 29.41%, Low – 29.41%; Feasibility: High – 5.88%, Low – 41.18%.
40. Create additional dental school(s) (USF or FSU), dental hygiene schools, and dental assisting schools.
- a. Explanation – Most reports indicate that there is currently a shortage of all dental health care providers. Moreover, these reports expect the shortages to grow in the next two decades
 - b. Benefits - Expand the dental workforce
 - c. Barriers - Funding; Staffing; Opposition from existing dental professionals (more dentists means more competition)
 - d. Examples – Arizona School of Dentistry and Oral Health (2003)
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues)
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.00; Feasibility: 1.12.
 - h. Percent Distribution – Impact: High – 35.29%, Low – 29.41%; Feasibility: High – 0.00%, Low – 100.00%.
41. Establish a Statewide, coordinated volunteer dental workforce utilizing retired dentists and part-time dentists.



- a. Explanation – Create a volunteer referral network utilizing the trained dental professions that are not practicing full-time in the state.
 - b. Benefits - Expands access for disadvantaged groups.
 - c. Barriers - Liability issues for volunteers; Some providers do not want to be placed on certain volunteer lists due to fear of stigma attached to treating disadvantaged patients.
 - d. Example - Project: Dentists Care, Inc.; Nebraska; Pennsylvania.
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues); Section VII (Safety net programs).
 - f. Support for this Strategy – Generally supported as effective in reports, articles, or organizational guidelines.
 - g. Mean Score – Impact: 3.31; Feasibility: 2.55.
 - h. Percent Distribution – Impact: High – 44.83%, Low – 20.69%; Feasibility: High – 17.24%, Low – 41.38%.
42. Establish a Statewide directory of dental providers who are willing to treat disadvantaged populations.
- a. Explanation – Establishing a directory would give provide a network of providers that the public or other health care organizations can access easily.
 - b. Benefits – Increased access; Expands dental provider’s patient pool; Possible continuing education credits or licensure fee waivers; Good will.
 - c. Barriers – Provider unwillingness to be listed due to stigma; Possible HIPAA/confidentiality issues.
 - d. Example – Maine Telephone Referral Service; New Jersey Dental Clinic Directory; Ohio OPTIONS (links disadvantaged with volunteer dentists who agree to provide donated or discounted services in their offices)
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 2.59; Feasibility: 3.53.
 - h. Percent Distribution – Impact: High – 29.41%, Low – 58.82%; Feasibility: High – 52.94%, Low – 23.53%.
43. Advocate for increases in compensation for State public health dental providers.
- a. Explanation – State public health providers are paid less than their private counterparts, work more hours, and are overwhelmed with patients in need.
 - b. Benefits – Increased provider willingness to become a State provider; Increases access; Staff retention.
 - c. Barriers – Funding.
 - d. Example –
 - e. State Oral Health Plan Section Links – Section III (Lack of access to professional care); Section V (Workforce issues); Section VII (Safety net programs).
 - f. Support for this Strategy – Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.47; Feasibility: 2.12.



- h. Percent Distribution – Impact: High – 47.06%, Low – 11.76%; Feasibility: High – 5.88%, Low – 58.82%.
44. As a requirement of acceptance into a state-supported dental or dental hygiene school, dental and dental hygiene students must commit to a year of practice in rural, underserved areas of Florida.
- a. Explanation - The State subsidizes dental educations at state-supported schools. Thus, as a condition of acceptance in a state-supported school (and the subsequent financial benefits of receiving their education at a State school), dental and dental hygiene students would be contractually required to provide a year of dental service in rural, underserved areas of the State.
 - b. Benefits - Increase workforce in rural, underserved areas; Extra year of mentoring for new graduates; Offsets the State's investment in educating dental providers.
 - c. Barriers - Opposition from dental community; Legal and Statutory issues.
 - d. Examples - FSU requires this policy of incoming medical students; Delaware requires a 1-year General Practice residency or a similar hospital-based program to meet the requirements for state licensure.
 - e. State Oral Health Plan Links - Section III (Lack of access to professional care); Section V (Workforce issues); Section VII (Safety net programs).
 - f. Support for this Strategy - Support is mainly subjective or anecdotal.
 - g. Mean Score – Impact: 3.94; Feasibility: 2.00.
 - h. Percent Distribution – Impact: High – 64.71%, Low – 11.76%; Feasibility: High – 11.76%, Low – 76.47%.

