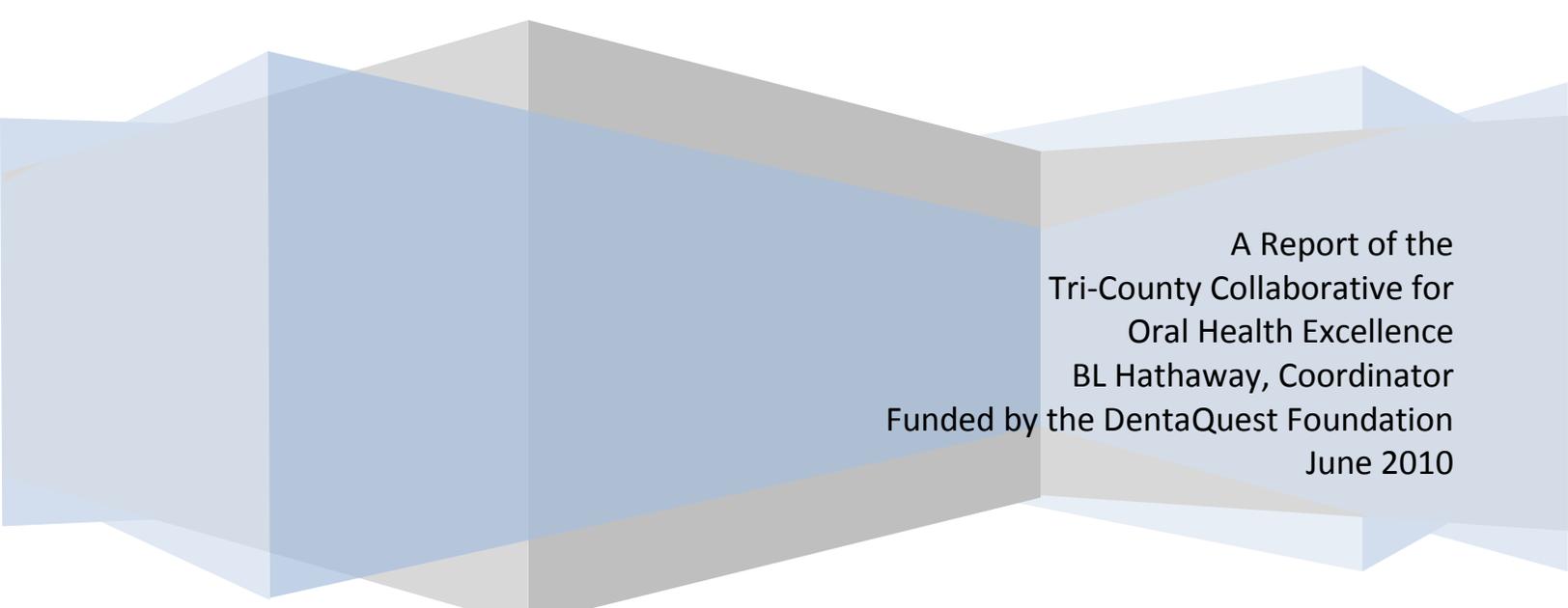


Tri-County Collaborative for Oral Health Excellence
Tri-CCOHE

Oral Health 2013

A Strategic Plan for Oral Health in Barnstable,
Dukes and Nantucket Counties



A Report of the
Tri-County Collaborative for
Oral Health Excellence
BL Hathaway, Coordinator
Funded by the DentaQuest Foundation
June 2010

About Tri-CCOHE

Tri-County Collaborative for Oral Health Excellence (Tri-CCOHE)

For the past twelve years, oral health professionals, program providers, educators and advocates have been meeting as a task force to address the most common chronic disease of childhood—dental disease. Beginning in the fall of 2007, a planning effort got underway to formalize the relationships and intentions of the task force and develop the Tri-County Collaborative for Oral Health Excellence (Tri-CCOHE). Representatives from the counties of Barnstable, Dukes and Nantucket identified resources, needs and opportunities to improve oral health for the most vulnerable residents of our region. Our wealth of community resources, history of collaboration and commitment to our mission led to the vision of a tri-county region where everyone has access to oral health care regardless of their ability to pay.

We recognize that it is time to move beyond a patchwork of programs and services to a regional system that expands on and integrates our diverse initiatives. Many of the relationships and resources critical to the construction of a service system already exist. Our intent, in partnership with supportive funding partners, is to create the system described within our *Oral Health 2013* plan to prevent dental disease, to increase access for the uninsured and underinsured, to enhance services to serve special populations and to expand, integrate and sustain oral health programs and services.

Membership to Tri-CCOHE is open to any individual or organization that supports the Collaborative's mission. The Cape Cod Foundation is the fiscal sponsor for Tri-CCOHE and provides fiscal management and accountability to funding sources.

Tri-CCOHE Collaborators

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Liz DiCarlo
Michael Buckley, DMD
Ellen Gould
Sarah Kuh

Steering Committee

In addition to the representatives of the Collaborating Organizations, the Steering Committee participants have included:

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Karen Bissonnette, Community Health Center of Cape Cod
Kristin Carboni, Community Coalition of Cape Cod
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Also,

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Dental Assisting Students, Cape Cod Regional Technical High School

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Edward Bangs Kelley and Elza Kelley Foundation, Inc.

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We thank the five original funders who provided local resources to launch Tri-CCOHE. These five organizations demonstrated through their support that they understand that broad-based collaboration can most effectively provide the multiple strategies necessary for systems change.

The Bilezikian Family Foundation

The Cape Cod Foundation

Community Benefits, Cape Cod Healthcare

Cape and Islands United Way

Edward Bangs Kelley and Elza Kelley Foundation, Inc.

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Strategic Planning

In 2006, members of Tri-CCOHE, then called the Oral Health Task Force, came together to assess oral health needs and resources and develop *Oral Health 2010*, a strategic plan to improve access to oral health programs and services on Cape Cod, particularly for the low-income uninsured and those insured by MassHealth. The strategies were organized around four priorities: prevention, access to treatment, special populations and coordination. In 2008, oral health efforts across the Cape and on Nantucket and Martha's Vineyard coalesced into the Tri-County Collaborative for Oral Health Excellence, Tri-CCOHE. *Oral Health 2010* was amended to include the Islands and adopted by the Collaborative as its roadmap for improving oral health.

Between 2006 and 2010, many of the strategies, though not all, were implemented and resulted in positive change. These accomplishments are documented within this report. An extensive resource and needs assessment, *Making Headway: Easing the Burden of Dental Disease*, was released. Taking into account these findings, data collected semi-annually and the evaluation of progress toward the goals and objectives that had been targeted for completion by 2010 became the basis for the development of this updated Strategic Plan, *Oral Health 2013*. Tri-CCOHE also was assisted by the 2009 report by the Massachusetts Office of Oral Health, *The Status of Oral Disease in Massachusetts: A Great Unmet Need*, the issue of the Massachusetts Dental Society's *Call to Action*, and the completion of the *Oral Health Plan for Massachusetts*, the statewide strategic plan for oral health.

This strategic plan reflects our circumstances and intentions as of June 2010. As with the previous plan, it is arranged around the four priorities: prevention, access, special populations and collaboration. Each section describes progress on the earlier plan, the current status in that priority area and the workplan for

2010-2013. Needs and conditions inevitably will change and the specifics of the plan will need to be adjusted accordingly.

Many people contributed to the development of this plan; others provided financial support to carry out the strategies, but; even more will be needed to implement it. New and diverse partners need to be recruited and new and diverse resources need to be secured. With hard work, persistence and a get-it-done attitude this ambitious plan can become a reality. We can fulfill our mission to create an oral health system with 100% access to emergency, preventive, restorative and specialty care and move closer to our vision of optimal oral health for everyone living in Barnstable, Nantucket and Dukes Counties.

PREVENTION

Report of Progress on 2010 Goals

Current Status

Work Plan for 2010-2013

**Oral Health Work Plan
RESULTS 2006-2010
Prevention**

Global Goal I. Reduce the incidence of dental disease in children.

Goal	Steps	By When	Who's Responsible?	Progress
A. Expand pre-school and school based oral health programs	1. Brainstorm/map existing programs.	Q1 2006	Core Team-Jackie Long, Nandina Collins, Ellen Gould, Elaine Madden, Lee Sullivan	Completed
	2. Adopt tracking system used by Forsyth to monitor individuals and report Tooth Tutoring program outcomes.	Q3 2006		Completed 9/07
	3. Institute new public health model using glass ionomers.	Q 4 2006	Forsyth Institute	Completed 1/08 Fall 2009 – reinstated use of glass ionomers
	4. Develop capacity to bill MassHealth for services provided in school settings and a mechanism to enroll children who are MassHealth-eligible	Q1 2007		Completed 10/09 Children without insurance directed to CHCs or CACCI
	5. Expand clinical service delivery to all Cape and Island. pre-school & school-aged children in public elementary schools.	Cape- Q2 2008 MV- Q2 2008 Nantucket- Q3 2008		6/09 All towns except Falmouth and Bourne
	6. Expand clinical service delivery to middle and high schools.	Q3 2010		Middle school and high school on Nantucket
	7. Adopt/adapt standardize curricula in oral hygiene for use in schools	Q4 2008		No progress
	8. Provide age-appropriate instruction in oral hygiene to school-aged children in all Cape and Islands public elementary schools.	+ 8 2009 + 8 2010 + 8 2011		Students partici- pating in Forsyth- Kids receive instruction from hygienists Cavity Free Kids curriculum at Head Start tied into nutrition program. Daily instruction in oral health. Family workers do home- based curriculum.

Prevention

Global Goal I. Reduce the incidence of dental disease in children.

Goal	Steps	By When	Who's Responsible?	Progress
B. Create awareness of the importance of oral health and the need for access to care.	1. Link with <u>Watch Your Mouth</u> campaign.	Q2 2006	Jackie Zibrat-Long, Kate Vaughn	Completed
	2. Define parameters of awareness campaign (what awareness to create with whom)	Q4 2006	Core Team: Jackie Zibrat-Long, Kate Vaughn, Kathy Eklund	Unfunded. No awareness campaign conducted
	3. Conduct pre-test	Q4 2006	BL Hathaway & Warren Smith	As of '09, patient care coordinator conducts outreach at health fairs, mall etc.
	4. Refine public awareness campaign	Q4 2006	Core Team	
	5. Implement local awareness campaign	Q1 2007	BL Hathaway	
	6. Evaluate impact of plan.	Q2 2007	BL Hathaway & Warren Smith	
	7. If positive result, institutionalize campaign		Core Team	
	8. Advocate at local, state and federal level for access to affordable oral health care.	Ongoing	All	On-going
C. Increase use of fluoride to prevent cavities.	1. Determine elementary schools participating in Swish program.	Q3 2005		Completed SY 08-09 4,633 children participating in elem. schools except Chatham, MV and Nantucket
	2. Include message about fluoride use in awareness campaign	Q4 2006	Core team	
	3. Engage MDs to: a) encourage parents to maintain fluoride use with young children b) apply fluoride varnishes at well baby visits once teeth erupt. c) examine children's teeth and refer for treatment, if needed.	2009	BL Hathaway Dr. Hugh Silk Dr. Guisipina Romano-Clarke Dr. Amos Deinard	UMass curriculum, <i>Smiles for Life</i> , MV 08 Training at Bass River Pediatrics, CC Hospital and CHCs in 09 Nantucket in the works 1/'10
	4. Advocate for and support initiatives to add fluoride to municipal water supplies	Yarmouth 2008	Harris Contos, Shiela Gagnon, Health Care For All, MDS	Defeated in Yarmouth

Prevention

Global Goal I. Reduce the incidence of dental disease in children.

Goal	Steps	By When	Who's Responsible?	Progress
D. Expand prevention education and activities in other programs serving children, youth and families.	1. Identify effective models for educating young children and parents of young children about oral hygiene. 2. Select a model for replication. 3. Identify service providers through the Barnstable County Council for Children, Youth and Families and engage partners. 4. Train professionals and paraprofessionals working with children and families to convey information/instruction regarding oral hygiene.	2008	Core Team	5/09 Linked with the BEST <i>Open Wide</i> Program to serve preschool children and parents Building linkages. Patient care coordinator attends BCCCYF and annual youth conference '10 focus on preschool educators

Process Objective: By 2008, methods will be standardized for securing parental permission, collecting data, delivering clinical care, billing for services, and providing oral hygiene instruction. **Accomplished**

Behavioral Objective: By completion of the 2007-8 school year, observable decay in children screened in Lower/Outer Cape pre-school and elementary schools will be <15%. **Accomplished**

Community Outcome Objective:

Baseline: Currently, children in 12 towns have access to some school-based dental services.

By 2008, public preschools and elementary school children in all 15 towns on the Cape and the towns on Martha's Vineyard and Nantucket will have access to comprehensive primary dental disease prevention services within the public schools.

As of 1/10, access available in public schools in 19 of 22 towns

Funding Sources: Billing for reimbursable services
 Foundation grants
 County grants
 State funds

PREVENTION

Background

Dental disease (also referred to as cavities, caries and tooth decay) is the most common chronic disease in both children and adults on Cape Cod and the Islands, as well as across the country. Oral health is an essential and integral component of overall health throughout life. No one can be truly healthy unless he or she is free from the burden of dental disease.

As pointed out in the 2009 report issued by the state's Office of Oral Health, *The Status of Oral Disease in Massachusetts*, "...dental caries is almost completely preventable given a child's access to prevention measures such as dental sealants, regular cleanings/exams, topical fluoride, and fluoridated drinking water." Despite the fact that safe and effective disease prevention measures exist and dentistry is organized to manage disease, limited application of these prevention practices and lack of access to appropriate and timely care, as well as other risk factors, result in a spate of untreated dental caries. Dental disease, a significant public health problem, continues to have a negative impact on the quality of life of millions of Americans and thousands of people in Barnstable, Dukes and Nantucket Counties.

Current Status

Regular visits to a dentist for an examination and cleaning are important prevention measures. Private practitioners have been and continue to be the backbone of preventive services for the majority of Cape and Islands residents, providing cleanings and examinations twice a year beginning at a young age. However, for approximately 33% of households, access to affordable preventive and restorative care presents a challenge. Children in these families often have gone without routine checkups, cleanings, fluoride, sealants and restorative care. Cape Cod Community College led the way in bringing prevention services to the schools. Supervised dental hygiene externs provided care for children identified by school nurses. Over the past six years, the Cape and Islands have experienced

significant and commendable growth in school-based prevention programs with the introduction of ForsythKids, a program of the Forsyth Institute. ForsythKids provides approximately 2,500 school children on the Cape and Nantucket with semi-annual screening, cleaning, fluoride varnish and sealants. Most of the participating schools are public elementary schools. Where preschools are part of the school, this age group is offered the prevention services as well. Middle and high schools participate on Nantucket and a few other Cape towns. Commonwealth Mobile Oral Health Services (CMOHS) provides school-based preventive and restorative dental care to preschool, elementary, middle and high school students participating in the Vineyard Smiles program on Martha's Vineyard. To sustain services beyond the original three year grant funding from the DentaQuest Foundation, CMOHS billed MassHealth and the Children's Medical Security Plan and established a fee schedule for uninsured and privately insured Vineyard Smiles participants.

Fluoride in its various forms, tablets, mouth rinse, fluoride varnish and community water fluoridation, all serve to prevent dental disease. Primary care physicians prescribe vitamins with fluoride for young children. Massachusetts recently added MassHealth coverage for oral health screening and fluoride varnish applied in medical settings. A concerted effort to engage and train providers is underway. All elementary schools on the Cape, except Chatham, participate in the state-sponsored fluoride SWISH program. Martha's Vineyard and Nantucket schools do not avail themselves of the fluoride mouth rinse program.

The addition of fluoride to drinking water has been listed as one of "the ten great public health achievements" of the twentieth century by the Centers for Disease Control. It has been demonstrated repeatedly over 60 years of experience and research that it is safe, effective, and practical in reducing tooth decay on the order of 30-50%, and highly cost-efficient, second only to the polio vaccine in public health cost-benefit analysis. Of the fifteen towns on the Cape, none derive the benefits of community water fluoridation. Eleven are served entirely or almost

entirely by a municipal water supply (Barnstable, Bourne, Brewster, Chatham, Dennis, Falmouth, Harwich, Orleans, Provincetown, Sandwich and Yarmouth), and thus could benefit most efficiently from this public health practice; four have limited or no public water supply, instead relying on private well water (Eastham, Mashpee, Truro and Wellfleet), and thus would need to be addressed by other fluoridation means. Two towns on Martha's Vineyard and none on Nantucket have fluoridated water. The addition of fluoride to our drinking water turns more on politics than public health. A 2008 effort to introduce fluoride to the public water supply in Yarmouth was defeated, ironically, as a result of the political maneuverings, rather than scientific understanding.

According to the MA Office of Oral Health, "school dental sealants programs have been shown to be highly cost-effective in preventing caries experience among the school-aged population." We are extremely fortunate to be among the 8% of Massachusetts schools that have sealant programs. Sealants are offered to children participating in the ForsythKids program on the Cape and Nantucket and the Vineyard Smiles program on Martha's Vineyard. Between January 1 and June 30, 2009, 1,064 of the 2,061 children served in school-based programs received 3,175 sealants.

Head Start programs across the country and here on Cape Cod and the Islands continue to be leaders in education about oral health for young children and their families. Children receive assistance and instruction in brushing techniques and other aspects of oral health as part of the daily program. Head Start also provides fluoride tablets to about 220 preschoolers through participation in the fluoride administration program of Massachusetts Department of Public Health.

Head Start programs also understand and value the role of the parent as a partner in disease prevention and provide educational materials and home-based instruction on the importance of oral health, its link to general health, nutrition and oral hygiene.

Summary

Dental disease is preventable, though the burden of disease much greater for those who have limited access to prevention strategies including fluoride, sealants and regular dental visits. Access to effective evidence-based prevention strategies targeting the individual and the community are necessary for preventing oral disease throughout the life cycle. Tri-CCOHE will advocate for, promote and support public health programs to increase access to preventive care and reduce dental disease.

**Oral Health Work Plan
Goals and Objectives 2010-2013
Prevention**

Committee on Prevention: Kerry Bickford/Barnstable County Extension Services, Amos Dienard/MD, Estelle Fritzingler/Community Action Committee (CAC), Beth Gaffney/CAC, Janice Healey/MA DPH—Office of Oral Health, Ricki Lacy/Cape Cod Child Development, Kristen Lind/CAC, Aira Mynttinen/RDH, Jackie Zibrat-Long/ForsythKids, DDS

Global Goal I. Reduce the incidence of dental disease

Goal	Objectives	By When	Who's Responsible	Progress
A. Build partnerships for prevention with public and private entities and individuals throughout the Cape and Islands	1. Maintain current members and engage new stakeholders in planning Cape and Islands prevention initiatives	2010-15 on-going	Staff	Added representatives from Barnstable Schools, CMOHS, Dept. of Developmental Services, Latham Centers, Elder Services 2/10
	2. Engage natural allies as oral health educators (dental professionals, school nurses, phys ed teachers, nursing home staff, medical providers, Boards of Health)	2011	Tri-CCOHE Steering Committee	
	3. Develop plan to link medical providers to dental providers and other community partners	2011		
B. Expand evidence-based prevention programs in schools and preschools	1. Support toothbrushing for preschoolers by providing oral health education, brushing techniques and supplies to preschool providers	2010 on-going	Committee	
	2. Facilitate evidence-based preventive services for children in center-based and home-based preschool settings	2010 on-going	Committee	
	3. Continue to assist families in securing a dental home for themselves and their children	2010 on-going	Care coordinators	
	4. Increase the % of school-aged children at moderate to high risk for disease who participate in	On-going		

<p>C. Provide oral health education in various settings</p>	<p>evidence-based school prevention programs</p> <p>1. Include evidence-based information on fluoride and sealants in oral health education and public awareness messages</p>	2011		
	<p>2. Facilitate access to the new MA oral health curriculum for community health outreach workers, school nurses and other interested parties</p>	2011	Staff	
	<p>3. Provide evidence-based information to health professionals on anticipatory guidance and early intervention for pregnant women at high risk of dental caries</p>	2011	Staff Dr. Deinard	
	<p>4. Collaborate with nurse leaders to determine: a) School efforts to reduce dental disease and injury b) oral health education currently provided in schools</p>	2012	Staff Dental students	
	<p>5. Offer integrated age-appropriate oral health curriculum to schools and preschools</p>	2013	Staff to identify existing resources	
	<p>6. Train professionals and paraprofessionals working with children and families to provide evidence-based oral health education for children and parents in community settings</p>	2013	Staff to facilitate	
<p>D. Offer affordable, accessible preventive services and supplies for adults</p>	<p>1. Tri-CCOHE care coordinator will assist clients in securing preventive care at least 1X/yr</p>	2010	Staff	
	<p>2. Have tooth-brushing/ flossing supplies available through food pantries</p>	2011	Committee	
	<p>3. Locate evidence-based preventive care clinics at non-</p>	2011	Committee	

<p>E. Increase the use of fluoride and sealants for caries prevention</p>	<p>traditional sites and hours</p> <ol style="list-style-type: none"> 1. Increase the % of elementary school children receiving fluoride and sealants in school-based programs and dental offices 2. Engage and support primary care physicians to: <ol style="list-style-type: none"> a) encourage parents to maintain fluoride use with young children b) apply fluoride varnish at well child visits c) examine children's teeth and refer for treatment, if needed 3. Join with DPH, local Boards of Health, Better Oral Health for MA, MDS, Health Care for All and others in advocating for legislation to require water fluoridation in towns and cities with a public water supply 	<p>2010 on-going</p> <p>On-going Nantucket-2010 Cape Cod-2010/2011 MV--</p> <p>2011 on-going</p>	<p>Providers of school-based services Private practitioners</p> <p>Staff Maryanne Worth Sarah Kuh Dr. Amos Deinard Deidre Callanan</p> <p>Committee Harris Contos, lead</p>	
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ACCESS to CARE

Report of Progress on 2010 Goals

Current Status

Work Plan for 2010-2013

**Oral Health Work Plan
RESULTS 2006-2010**

Access to Treatment

Global Goal II: Increase access to dental care for low-income uninsured and underinsured

Goal	Steps	By When	Who's Responsible?	Progress
A.. Maximize the capacity of the community dental centers.	1. Investigate capacity at existing facilities.	Q2 2006	Core Team Dave Reidy, Dr. John Mancini, BL Hathaway, Liz DiCarlo,	Completed
	2. Staff all operatories at all times with fully qualified dental practitioners.	ongoing		Recruitment has been a CHC priority
	3. Develop a plan with timelines to maximize use of existing operatories that may include efforts to: a)reestablish services at Duffy b) expand hours at the M-UCCHC c) expand hours at EJCDC d) prepare for and engage private practice dentists as volunteers or staff e) incorporate dental students, hygiene students, and dental assisting students f) other	Q4 2007	d) Core Team and Dr. Borgia e) Dr. Mancini, CCCC, CCRTHS	
	4. Implement plan	2008		
	5. Establish centralized enrollment, triage and referral to most appropriate service.	2008		
B. Increase the number of operatories that offer access to affordable care, with attention to the Outer Cape, Upper Cape, Martha's Vineyard and Nantucket.	1. Investigate and map out options to add operatories for Mid and Lower Cape.	2007		Ellen Jones Community Dental Center in Harwich added 3 chairs in summer 2009
	2. Add operatories for the Mid and Lower Cape.	2008		Marion Jordan Dental Center at CHC of Cape Cod opened in 9.09
	3. Develop operatories on the Upper Cape at the Community Health Center of Cape Cod	2008		MV Hospital Dental Center opened 3.09
	4. Re-establish capacity on Martha's Vineyard	2008	Core team + Karen Gardner	OCH using office of private practitioner to provide service
	5. Establish capacity on the Outer Cape with fed, state or grant funds	2008		3 DDS accept Mass-Health. Private practitioners treat children identified by ForsythKids as in need of treatment
	6. Establish capacity on Nantucket	2009	Core team + Henry Tuttle, David Hale	

Access to Treatment

Global Goal II: Increase capacity to provide dental care for the low-income uninsured.

Goal	Steps	By When	Who's Responsible?	Progress
C. Expand community capacity to provide dental care for the low-income, uninsured beyond the community health centers (CCDC, MassHealth, CCCC)	C1. Increase the number of CCDDS members participating in Cape Cod Dentists Care.	Ongoing	Core Team – Gail Quinn, Elaine Madden, Dr. Tom Borgia, Dr. Tim Martinez, TPA rep.	77 DDSs participating as of 4/08
	2. Work with CCCC to determine potential to move CCDC hygiene capacity to college.	Q4 2007		
	3. Collaborate with local dentists and Third Party Administrator (TPA) to increase access to care for low-income residents on MassHealth	Q4 2007 and beyond		Dr. Fortenberry, CC District Dental Society has actively and successfully recruited dentists. As of 3.10, 35 dentists accepting MassHealth
D. Make local access to specialty care available for low-income adults	D1. Investigate ways to modify CCDC to focus on specialty care	Q1 2008		Completed
	2. Assess current specialty care referral patterns for patients of safety net providers	Q2 2008		Completed assessment and report
	3. Determine specialty care capacity to meet the needs of the underserved among private practitioners	Q3 2008		Completed
	4. Coordinate specialty clinics and specialty care network of providers	Q4 2008		Specialists agreed to see CHC patients through CCDC

Process Objective:

By December, 2007, the Core Team will present a proposal for expanded hours at the community dental centers

Hours extended to some evenings and weekends

By September, 2008, a plan will be developed to maximize care provided to low-income MassHealth and uninsured adults by dentists in private practice.

In December 2008, the MDS *Call to Action* set a goal to have 65% member participation by 2013. Cape Cod District is recruiting.

By June 2009, there will be 10 additional operatories at the Cape health/dental centers and at other sites on Martha's Vineyard and Nantucket.

By September 2009, there were 10 additional operatories.

Community Outcome Objective:

Baseline: EJCDC, M-UCCHC, CCDC and MassHealth providers currently have an annual capacity of ~ 6200 people.

By 2010, annual capacity to serve MassHealth patients will increase by 100%.

Annual capacity has increased by 300%!

ACCESS TO ORAL HEALTH CARE

Background

The 2006 Oral Health Report: Mapping Access to Oral Health Care in Massachusetts sheds light on the ways in which provider availability barriers such as the number and types of dentists, their geographic distribution and their participation in public health insurance programs impact access to dental care. The 2009 study of *The Human Condition* in Barnstable County documents clearly that affordability, the cost of dental procedures, is also a significant barrier to care. Acceptability, which is the responsiveness of the system to the cultural, ethnic and physical differences, can be the most difficult barrier for some groups to overcome.

Current Status

The Cape Cod District Dental Society has approximately 190 members—150 general practitioners and 40 specialists. Thanks to the concerted efforts of the District Dental Society and the Massachusetts Dental Society, the availability of dentists accepting MassHealth in this region has increased significantly from four dentists in general practice in 2006, to 54 of the 190 members. In FY 2009, these 54 private practitioners served approximately 7,809 MassHealth patients.

Cape Cod Dentists Care was created in 2003 to provide a vehicle for local dentists in private practice to volunteer their services to serve the low-income uninsured. Since that time, 80 dentists have participated and served close to a thousand people. This program, established to meet the needs of the low-income uninsured who fall into the eligibility-affordability gap, was originally funded by Delta Dental's foundation and then the MA Department of Public Health. This year, the program is without funding.

On Martha's Vineyard, there are eight dentists in private practice, one pedodontist and seven general practitioners. Currently, none of these accepts MassHealth. An orthodontist who practices in New Bedford comes to the Vineyard twice a month.

There is one oral surgeon and there are no periodontists on the Vineyard to serve the population of about 15,000. A dental clinic located at the Martha's Vineyard Hospital reopened in April 2008 to target the low income uninsured and underinsured. Availability of dental care for children on Martha's Vineyard has increased during the past four years primarily through the implementation of the Vineyard Smiles, a school-based oral health program offering education, prevention and disease management services.

On the island county of Nantucket, there are seven dentists in private practice. Three of these dentists are MassHealth providers. There are no specialty practices on Nantucket. Expansion of availability of services for children has been by way of ForsythKids, the school-based program providing screening, cleaning, fluoride varnish and sealants. The ForsythKids care coordinator has engaged Nantucket dentists to provide restorative treatment for children, as needed.

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and the shortages may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). As of January 2009, all of the Cape and Islands were considered Dental Health Professional Shortage Areas. The MA Office of Oral Health reported that the tri-county region had dental HPSA designations based on the following criteria:

- Lower/Outer Cape as a low income population
- Mid-Cape as a geographic area
- Upper-Cape as a geographic area
- Dukes County as a single county
- Nantucket as a geographic area

Since 1998, the Barnstable County Department of Human Services has conducted a regular assessment of *The Human Condition* in the County. Over the years, as high

as 83% of key informants have identified dental care as a serious unmet service need. In the 2009 update, *Monitoring the Human Condition*, two oral health affordability issues were among the top five issues and service barriers faced by Cape Cod households.

- 25% reported problems “paying for or getting dental care”
- 24% of respondents reported “not having enough money to pay the doctor, dentist or to buy prescription medications”

If the focus is shifted to the neediest households (the approximately 26% of households encountering the highest levels of problems and experiencing some of the most serious barriers in accessing help):

- A staggering 64% of respondents reported “not having enough money to pay for the doctor, dentist or to buy prescription medications” and
- 60% reported problems “paying for or getting dental care.”

Virtually the same study of the human environment was undertaken in Nantucket County in 2006. Based on the findings of *the Nantucket Health & Human Services Needs Assessment Study*, the number one and two health and healthcare related issues on Nantucket were:

- “Paying for or getting dental insurance,” reported by 27% of Nantucket households
- “Not having enough money to pay the doctor, the dentist or to buy prescription medication,” reported as an issue by 25% of households

Again, if the focus is shifted to the most needy households:

- An astounding 83% of households reported “not having enough money to pay the doctor, the dentist or to buy prescription medication”
- 79% reported problems “paying for or getting dental insurance.”

In Dukes County (Martha’s Vineyard), affordability as a barrier to care emerged as a major finding of the 2005-6 *Vineyard Smiles Oral Health Community Assessment*. The cost of dental care was reported to be out of reach for most children from lower income families on Martha’s Vineyard, as well as adults.

- 39% of those completing the Questionnaire for Adults reported that someone in their household who needed dental care in the past 12 months was unable to obtain care.

- Thirteen percent (13%) reported that someone in their household went to the hospital emergency room because of problems with teeth, mouth or dentures.

Community health centers are the critical safety net of the oral health delivery system for many people as they offer affordable access to care. Health Centers alone do not have the capacity to meet current demand, according to Catalyst Institute's 2007 report, *Toward a Stronger Oral Health Safety Net*. Among the findings in their study to identify the challenges faced in community health center dental programs were the following:

- In 33% of community health centers in Massachusetts providing dental care, new patients waited three months or more to be seen for their first appointment.
- In 50% of community health center dental programs, existing patients waited five weeks or more to be seen for their next appointment
- In 80% of the centers, emergency visits represented 10% or more of total patient visits.
- 22 dental programs were recruiting for one or more positions.

The past five years have shown significant growth in the capacity to provide affordable care at community health centers on Cape Cod. At the time that the original oral health strategic plan was developed in 2006, there were two sites with a total of nine operatories; the Ellen Jones Community Dental Center had three and the Mid-Upper Cape Community Health Center had six operatories. These two community dental centers were serving about 5,400 people. Since then, sites and operatories have been added: the Martha's Vineyard Hospital Dental Clinic has two operatories; the Community Health Center of Cape Cod has three operatories, and; Outer Cape Health Services has one off-site operatory. The Ellen Jones Community Dental Center in Harwich added three. In 2009, community health centers' 9.8 FTE dentists served approximately 15,000 people, providing dental care in Barnstable and Dukes County targeting uninsured, Medicaid and other vulnerable patients.

The issue of acceptability, whether the services are equipped to respond to cultural, language and physical differences, also stands as a barrier to care. Currently, four of the five community health/dental centers have Portuguese language capacity to

respond to the needs of our largest immigrant group—Brazilians. Two private practices purport to have Portuguese and four have Spanish language capacity. Anecdotal reports by advocates for people with disabilities, including physical, developmental and mental impairments, describe little success in finding dental providers who are able to make appropriate accommodations. Access to care to address the oral health needs of impaired elders is also problematic.

Summary

While access to dental care for people with MassHealth coverage has improved significantly on the Cape and Islands, it is important to note that having dental insurance does not guarantee receiving dental care if there is no dentist available to provide it or if the available dentist does not accept an individual's insurance. Tri-CCOHE will work to foster a multi-pronged community response to remove this and other access barriers through the combined efforts of school-based programs, private practitioners, community health centers, mobile oral health providers and others to insure that services are available, affordable and acceptable to those in need.

**Oral Health Work Plan
Goals and Objectives 2010-2013
Access**

Committee on Access: Steve Bellorini/DMD, Miriam Erickson/Cape Cod Dentists Care, Sarah Kuh/Martha's Vineyard Health Care Access Program, Elaine Madden/Cape Cod Community College, Linda Mayers/Barnstable Schools, Aira Mynttinen/RDH, David Reidy/Mid-Upper Cape and Ellen Jones Community Dental Center, Maryanne Worth/Nantucket Human Service

Global Goal II. Increase access to dental care for low-income uninsured and underinsured

Goal	Objectives	By When	Who's Responsible	Progress
A. Maximize capacity of community dental centers	1. Recruit retired dentists as part time employees or volunteers	In progress	Providers	Th pm now at M-U T, W eves in future
	2. Add non-traditional days and hours	In progress (See Goal IV)	Providers	
	3. Maintain existing and secure additional funds		Tri-CCOHE	
	4. Link families of children identified in need of treatment through school-based programs with a CHC dental home	In progress	School-based providers and CHCs	
	5. Increase the number of operatories, with particular attention to the Outer Cape and MV	2012	CHCs and MV Hospital Dental Clinic	
B Sustain and expand community capacity to provide dental care for the low-income, uninsured through MassHealth, CCCC, CCDC etc.	1. Build on the evidence-based best practices to provide affordable care on Nantucket	2010	Staff to facilitate Nantucket Council for Human Services Dr. Deinard	
	2. Invite participation of public health dentists in District Dental Society	2010	Dr. Fortenberry Dr. Buckley	
	3. Maintain the Cape Cod Dentists Care network of providers	2010	Committee	
	4. Investigate what role CMOHS could play in meeting treatment needs	2011	Committee Lauren Marvel	
	5. Work with Doral, MDS and District Dental Society to increase number of people on MassHealth served by private	2011	Committee	

	<p>practitioners</p> <p>a) Recruit additional MassHealth providers</p> <p>b) Identify ways to decrease the MassHealth no-show rate</p> <p>c) Urge MassHealth providers to increase their panel size</p> <p>6. Engage private practitioners who are willing to serve as dental homes for children (and their families) who are participating in preschool & school-based programs</p> <p>7. Explore the feasibility of providing low cost clinics for underserved adults</p> <p>8. Connect children seen in ADA project, <i>Give Kids a Smile</i> (and other short term projects) to dental homes</p> <p>9. To maximize application and enrollment into insurance programs for low income patients</p>	<p>2011</p> <p>2012</p> <p>2013</p> <p>2010</p>	<p>Committee</p> <p>Committee</p> <p>Committee</p>	
C. Increase local access to affordable specialty care	<p>1. Care coordinators to maintain link with patient until completion of service</p> <p>2. Sustain CCDC arrangement with specialists</p> <p>3. Encourage oral surgeons in private practice to accept MassHealth</p>	<p>2010</p> <p>2010</p> <p>2011</p>	<p>Care coordinators linking with CHOWs</p>	
D. Explore alternative mechanisms for delivery of care in the event of the loss of MassHealth funding for adult dental care	<p>1. Bring together CCDDS Executive Committee and Tri-CCOHE Executive Committee to brainstorm possible responses</p>	<p>As needed</p>		

SPECIAL POPULATIONS

Report of Progress on 2010 Goals

Current Status

Work Plan for 2010-2013

**Oral Health Work Plan
RESULTS 2006-2010**

Access to Treatment

Global Goal II: Increase access to dental care for low-income uninsured and underinsured

Goal	Steps	By When	Who's Responsible?	Progress
A.. Maximize the capacity of the community dental centers.	1. Investigate capacity at existing facilities.	Q2 2006	Core Team Dave Reidy, Dr. John Mancini, BL Hathaway, Liz DiCarlo,	Completed
	2. Staff all operatories at all times with fully qualified dental practitioners.	ongoing		Recruitment has been a CHC priority
	3. Develop a plan with timelines to maximize use of existing operatories that may include efforts to: a)reestablish services at Duffy b) expand hours at the M-UCCHC c) expand hours at EJCDC d) prepare for and engage private practice dentists as volunteers or staff e) incorporate dental students, hygiene students, and dental assisting students f) other	Q4 2007	d) Core Team and Dr. Borgia e) Dr. Mancini, CCCC, CCRTHS	
	4. Implement plan	2008		
	5. Establish centralized enrollment, triage and referral to most appropriate service.	2008		
B. Increase the number of operatories that offer access to affordable care, with attention to the Outer Cape, Upper Cape, Martha's Vineyard and Nantucket.	1. Investigate and map out options to add operatories for Mid and Lower Cape.	2007		Ellen Jones Community Dental Center in Harwich added 3 chairs in summer 2009
	2. Add operatories for the Mid and Lower Cape.	2008		Marion Jordan Dental Center at CHC of Cape Cod opened in 9.09
	3. Develop operatories on the Upper Cape at the Community Health Center of Cape Cod	2008		MV Hospital Dental Center opened 3.09
	4. Re-establish capacity on Martha's Vineyard	2008	Core team + Karen Gardner	OCH using office of private practitioner to provide service
	5. Establish capacity on the Outer Cape with fed, state or grant funds	2008		3 DDS accept Mass-Health. Private practitioners treat children identified by ForsythKids as in need of treatment
	6. Establish capacity on Nantucket	2009	Core team + Henry Tuttle, David Hale	

Access to Treatment

Global Goal II: Increase capacity to provide dental care for the low-income uninsured.

Goal	Steps	By When	Who's Responsible?	Progress
C. Expand community capacity to provide dental care for the low-income, uninsured beyond the community health centers (CCDC, MassHealth, CCCC)	C1. Increase the number of CCDDS members participating in Cape Cod Dentists Care.	Ongoing	Core Team – Gail Quinn, Elaine Madden, Dr. Tom Borgia, Dr. Tim Martinez, TPA rep.	77 DDSs participating as of 4/08
	2. Work with CCCC to determine potential to move CCDC hygiene capacity to college.	Q4 2007		
	3. Collaborate with local dentists and Third Party Administrator (TPA) to increase access to care for low-income residents on MassHealth	Q4 2007 and beyond		Dr. Fortenberry, CC District Dental Society has actively and successfully recruited dentists. As of 3.10, 35 dentists accepting MassHealth
D. Make local access to specialty care available for low-income adults	D1. Investigate ways to modify CCDC to focus on specialty care	Q1 2008		Completed
	2. Assess current specialty care referral patterns for patients of safety net providers	Q2 2008		Completed assessment and report
	3. Determine specialty care capacity to meet the needs of the underserved among private practitioners	Q3 2008		Completed
	4. Coordinate specialty clinics and specialty care network of providers	Q4 2008		Specialists agreed to see CHC patients through CCDC

Process Objective:

By December, 2007, the Core Team will present a proposal for expanded hours at the community dental centers

Hours extended to some evenings and weekends

By September, 2008, a plan will be developed to maximize care provided to low-income MassHealth and uninsured adults by dentists in private practice.

In December 2008, the MDS *Call to Action* set a goal to have 65% member participation by 2013. Cape Cod District is recruiting.

By June 2009, there will be 10 additional operatories at the Cape health/dental centers and at other sites on Martha's Vineyard and Nantucket.

By September 2009, there were 10 additional operatories.

Community Outcome Objective:

Baseline: EJCDC, M-UCCHC, CCDC and MassHealth providers currently have an annual capacity of ~ 6200 people.

By 2010, annual capacity will to serve MassHealth patients will increase by 100%.

Annual capacity has increased by 300%!

ORAL HEALTH CARE FOR SPECIAL POPULATIONS

Background

Tri-CCOHE defines special populations as those groups of people whose physical or mental condition or circumstances render them vulnerable to oral disease and present significant barriers to accessing the care that they need to achieve and sustain oral health.

Vulnerable populations include children from low-income households, the homeless, linguistic minorities, people with developmental disabilities, HIV infection, physical disabilities and special health care needs, mental illness, substance abuse, people with medically compromising conditions, and the elderly, particularly those who are homebound or institutionalized. Access to dental care for these populations is limited while their numbers continue to grow.

Current Status

The burden of untreated dental disease falls heaviest on individuals from lower socioeconomic groups. Children in low-income families are particularly vulnerable to oral health problems. The 2008 study, *The Oral Health of Massachusetts' Children*, reported that 25% of all children and 41.5% of children from low-income families start kindergarten with dental decay. More than 40% of all third graders and 60.8% from low-income families were affected by dental caries. In the tri-county region:

- An average of 33% of kindergarten and elementary school students screened in Barnstable County had caries experience.
- An average of 50% of children from low to moderate income families screened in Dukes County had caries experience.
- 28.7% of children screened through prevention programs offered in the tri-county schools had untreated decay.

Cape Cod Community College externs have been providing school-based preventive care to children identified by school nurses since 1997. They also worked with Cape Cod Child Development's Head Start families to provide preventive care and link them with treatment provided by private practitioners. In 2004, The Forsyth Institute began to offer a comprehensive dental disease prevention program in public elementary schools, first on Cape Cod and then on Nantucket, targeting minorities and children from low-income families. Currently, about 2,500 children are receiving a dental exam, cleaning, fluoride varnish and sealants in school-based settings. Efforts to target high risk populations have been successful; 49% of children participating in the program are on MassHealth and 40% have no insurance.

Screening of low to moderate income children through the Vineyard Smiles program on Martha's Vineyard found that 31% of third graders had untreated caries. These children and many others have received and continue to receive treatment at school from the Commonwealth Mobile Oral Health Services.

According to the November 2009 report, *The Status of Oral Disease in Massachusetts: A Great Unmet Need*, issued by the Office of Oral Health, Massachusetts, 3% of the population is developmentally disabled." "For children and youth in Massachusetts, 15% under 17 years of age have special health care needs..." According to the Barnstable County *Monitoring the Human Condition Study*, among people at least five years old in 2007, 14% reported a disability. The likelihood of having a disability varied by age from 6% of people 5-15 years old, to 9% of people 16-64 years, and to 33% of those 65 and older.

Local providers of human services to people with disabilities note that it is difficult to secure dental care on the Cape and Islands. There are a very limited number of dentists who accept MassHealth who are experienced in working with people with disabilities. While services are available off-Cape, in Boston and Taunton,

transportation and the need for staff to accompany clients make it difficult to arrange and costly to access services.

Local and regional resources that are being brought to bear on dental care for special populations include a growing care management capacity for vulnerable populations with significant barriers to care. Patient care coordination is available for children identified in schools with urgent needs for care, linguistic minorities, people with medically compromising conditions and the uninsured and under-insured. Special Projects of National Significance (SPNS), a five year federal grant awarded to Harbor Health Services in 2007, is intended to insure oral health access for people with HIV infection on the Cape and Islands. This program has demonstrated the importance of case management in assisting people with multiple or complex barriers to get necessary oral health care.

In Massachusetts, 13% of the population is 65 years of age or older and the numbers are expected to grow. According to *The Status of Oral Disease in Massachusetts: A Great Unmet Need*, the elderly make up an increasing portion of the population who are at greater risk of oral disease. Not only do the elderly have increased risk of disease, many also lack access to oral health care. Individuals who are homebound, on fixed incomes, without dental insurance or have Medicare coverage (Medicare does not include dental care) may face serious financial barriers.

In 2009, a preliminary oral health assessment across the Commonwealth of seniors age 60 and older in long term care facilities showed overwhelming oral health needs. Thirty-five percent (35%) of the residents were edentulous; 59% of the seniors with teeth had untreated decay with 7% having urgent dental needs, impacting their nutritional and medical health.

Here on the Cape, the percentage of residents age 65 and older is 24%, as compared to the reported 13% statewide. The Executive Director of the Area

Agency on Aging, reports barriers to care for seniors include lack of access to dentists who accept MassHealth, difficulty securing or providing transportation to care, the complexity of arranging in-house care for those in long-term care settings, problems providing escorts to care for frail elders, and lack of providers to care for people with dementia. There also is a significant need for examining, fitting and adjusting dentures.

On Martha's Vineyard in 2006, 145 low to moderate income seniors were screened as part of a needs assessment. Ninety-eight percent (98%) had as history of dental disease as evidenced by fillings and/or missing teeth; 37% had untreated decay, 27% of seniors age 65 and older had complete tooth loss; 52% had not had a routine cleaning or checkup during the previous year; 33% had a visit because something was wrong or hurting and 43% of these adults went off-island for care. Local and regional resources that are being brought to bear on dental care for a small percentage of elders include screenings completed at long-term care facilities by Cape Cod Community College dental hygiene externs, screenings and cleanings being performed on Martha's Vineyard by the Forsyth Institute, and restorative care for some low income elders being provided by the Commonwealth Mobile Oral Health Services.

Summary

Programs providing services to special populations, whether they be children from low-income families, developmentally disabled, medically compromised or elderly, have extended their resources, and in many cases overextended them, in order for the people they serve to access oral health services. As we move forward, the oral health community intends to work with these providers and their clients to understand their needs and access barriers and develop local responses.

**Oral Health Work Plan
Goals and Objectives 2010-2013
Special Populations**

Committee on Special Populations: Liz DiCarlo/IDCS-Cape Cod Healthcare, Linda Fortenberry/Cape Cod District Dental Society, Sheila Gagnon/Advocate, Cheila Mageste/Tri-CCOHE, Alan Malatesta/MA Dept. of Developmental Services, Michael Marchese/Latham School, Anne McDonald/SPNS—Harbor Health Services, Leslie Scheer/Elder Services

Global Goal III: Enhance capacity, services and skills to serve special populations

Goal	Objectives	Priority/By When	Who's Responsible	Progress
A. Apply best practice preventive measures in settings serving elders and people with disabilities	1. Determine the oral health knowledge, skills and needs of people with disabilities, parents, caregivers in the family home, group home and other settings and offer training, as needed	2010	Staff	Submitted proposal to CCHC 5/12 Notified of funding 6/3
	2. Collect and make available appropriate instructional materials about oral health and hygiene	2011	Staff	
	3. Provide regular preventive care locally	2011	Committee	DDS clients retain MassHealth services
	4. Secure funding to offer preventive care on MV	2011	Staff	
	5. Develop a process that moves people screened and identified in need of treatment to care	2011		
B. Increase local capacity to provide oral health care for special populations including children and adults with disabilities	1. Bring together stakeholders to explore options for provision of services for people with disabilities on CC & I	2010	Staff to facilitate	Meeting with MA Dept. of Dev Servcs nurses 5/27/10
	2. Develop a service delivery plan to provide emergency, preventive, restorative, specialty and prosthetic care to children and adults with disabilities including: a) Capacity to educate patients and	2011	Committee	

<p>C. Increase local capacity to provide oral health care for elders</p>	<p>caregivers about preparing for dental appointments (video?) b) Training for dental professionals on serving people with behavioral problems. c) Support services including transportation, escort volunteers d) Maximized utilization of CCCC and community health center operatories for special populations including the homeless</p>	<p>2011</p>	<p>Staff, Sarah Kuh, Maryanne Worth</p>	
	<p>3. Secure funding to offer treatment on MV and Nantucket and implement service delivery plan</p>	<p>2011</p>	<p>Committee</p>	
	<p>1. Describe dental care needs of low-income, dental uninsured elders living in the community</p>	<p>2011</p>		
	<p>2. Assess current oral health needs and resources at long term care facilities on CC, MV and Nantucket</p>	<p>2011</p>		
	<p>3. Explore other service delivery models for caring for residents of long term care facilities Dental schools Externships On site clinics Mobile dentistry Virtual dental home Rehabilitation facility</p>	<p>2011</p>		
<p>4. Develop a service delivery plan to provide emergency, preventive, restorative, specialty</p>	<p>2012</p>			

<p>D. Provide Care Coordination for special populations with significant access barriers</p>	<p>and prosthetic care to elders including: a) capacity to make, repair and adjust dentures b) avenues to provide specialty care for people with dementia 5. Secure funding and implement plan</p>	2013		
	<p>1. Sustain care coordination capacity in CHCs and Tri-CCOHE to assist those with medically compromising conditions and individuals with limited English proficiency</p>	2010		
	<p>2. Maintain capacity to access specialty care services through the CC Dentists Care model</p>	2010		
	<p>3. Expand capacity of care coordination to assist elders and people with disabilities in the community and in residential care to secure dental care</p>	2011		

COLLABORATION

Report of Progress on 2010 Goals

Current Status

Work Plan for 2010-2013

**Oral Health Work Plan
RESULTS 2006-2010**

Program Coordination

Global Goal IV: Improve coordination among existing programs

Goal	Steps	By When	Who's Responsible?	Progress
A. Develop a regional system to expand, enhance, integrate and sustain oral health programs and services.	1. Convene monthly meetings of the Cape and Islands Oral Health Steering Committee.	Ongoing	BL Hathaway, John Mancini	On-going
	2. Link with Martha's Vineyard and Nantucket to consider a tri-County collaboration to develop economies of scale and to seek resources and expand services.	Q2 2007		Completed
	3. Investigate ways of creating an oral health coordinator or other means to coordinate programs and services, write collaborative grants, use volunteers, and conduct evaluation across the Cape and Islands.	Q3 2007		Completed
	4. Constitute and convene regular meetings of an executive committee to guide tri-county efforts	Q1 2008		Constituted 01/08
	5. Develop a business plan that identifies resources needed to build and sustain a regional oral health infrastructure	2008		Business plan completed 6/08
B. Establish a coordinated system of workforce development.	B1. Determine staffing needs of participants and develop a recruitment plan to benefit all	2010		Not completed

Process Objective: A county and/or tri-county coordination function will be described by October 2007 and funded by October 2008. **Accomplished 12/08**

Community Outcome Objective: By 2010, oral health programs and providers will function as a system. (Proxy data) **Decrease in ED services for dental care**

Funding Sources: ADA Counties
Oral Health Foundation United Way Private Foundation

COLLABORATION

Background

Given the finite resources available to offer subsidized or low-cost dental care, it is imperative that each resource be maximized. This can be accomplished if the service providers work together to insure that they each have a discrete and necessary role to play, that patients are directed to the most appropriate service, that funds are sought collaboratively rather than competitively and driven by the needs of the community.

As we connect with stakeholders such as dentists in private practice, schools, funders, and others to gain their a trust and involvement, we need to demonstrate a coordinated community-wide initiative rather than a patchwork of programs that are advocating for the life of their own programs and bumping into one another in pursuit of clinical staff, volunteers, patients and funds.

Current Status

As a vehicle to work toward a regional oral health system, the Tri-County Collaborative for Oral health Excellence (Tri-CCOHE) was established in 2008 with the vision of optimal oral health for everyone living Barnstable, Dukes and Nantucket Counties. There are currently 19 members of Tri-CCOHE who have completed Participation Agreements. Members come together every other month as a Steering Committee to problem solve, set priorities and develop and implement strategies to increase access and decrease dental disease. There are five members of the Executive Committee that include representatives of a community health center, a school-based program, the district dental society, special populations and an Island-based program. Their role is to guide the work and the coordinator of Tri-CCOHE, serve as advisors, insure the quality of activities and oversee the budget.

Every six months, all but one member who offer direct care provide data on capacity, services provided and number of people served in safety net, private practice and school-based settings. During FY 09, 22,336 MassHealth members were served.

Public awareness initiatives during the past year included the press conference and release of the document *Making Headway: Easing the Burden of Dental Disease*. A volunteer dentist and the patient care coordinator offered screenings on Nantucket at both the hospital and human services health fair. During the winter months, the patient care coordinator also participates in the Kids Night at the Mall. The human services community is kept up to date regarding dental issues as the Tri-CCOHE coordinator participates in the Barnstable County Health and Human Services Advisory Council and the patient care coordinator participates in the Barnstable County Council for Children, Youth and Families.

Sustainable, reliable funding for oral health continues to be the focus for advocacy efforts. Medicaid requires participating states to fund oral health services for children and those with disabilities but not for adults. Each budget year, coverage for adult dental care is on the chopping block. Tri-CCOHE relies on Health Care for All's Oral Health Advocacy Task Force to provide leadership and direction for advocacy effort. Requests to contact our federal and state legislators are responded to by the coordinator and forwarded to Executive and Steering Committee members for action, as they see fit. To this point, advocacy efforts have been successful in maintaining MassHealth dental coverage for adults as well as children. However, the current state intention for the upcoming fiscal year, FY 12, eliminates adult MassHealth coverage for restorative care, periodontal care and dentures. This will have a deleterious affect not only on the patients in need of affordable restorative care but also on the safety net providers. Dentists in private practice who have recently agreed to accept MassHealth may be discouraged from further participation.

With the great need for health care providers on Cape Cod and the Islands, often there is discussion about “growing our own.” As far as the oral health workforce is concerned, the Cape is fortunate to have two oral health career preparation programs—the dental assisting program at Cape Cod Regional Technical High School and the dental hygiene program at Cape Cod Community College, one of eight across the state. There are three private dental schools located in Boston at Boston, Harvard and Tufts Universities. This presents opportunities for local internships and recruitment.

Summary

A recent inquiry from an oral health collaborative in its formative stage in Tampa, Florida, reminds us that across the country as well as the state, people look to our 12 year history of collaboration and the accomplishments we have had and want to know how our model can be replicated. There is no doubt that we have made great strides in promoting and improving oral health, but there is still much more work to be done. By working together to collect data to monitor our progress, increase public awareness of the importance of oral health, advocate for much needed programs and services with sustainable funding and foster workforce growth, we come closer to the reality of working as a patient-centered regional oral health system.

**Oral Health Work Plan
Goals and Objectives 2010-2013
Collaboration**

Committee on Collaboration: Michael Buckley/Cape Cod District Dental Society, Courtney Chelo/Health Care For All, Harris Contos/Advocate, Kathy Eklund/Forsyth Institute, Lauren Marvel/Commonwealth Mobile Oral Health Services, Diane Munsell/Cape Cod Healthcare, Biyi Ogunjimi/Better Oral Health for MA Coalition

Global Goal IV: Expand, enhance, integrate and sustain oral health programs and services

Goal	Objectives	By When	Who's Responsible	Progress
A. Develop, support and evaluate a regional system to provide oral health care	1. Convene bi-monthly meetings of the Tri-CCOHE Executive and Steering Committees	Monthly	Staff, BL Hathaway	
	2. Find and take opportunities to engage private and public oral health providers in common efforts	Regularly	Committee	
	3. Examine alternative models for organized care	2010	Committee	
	4. Evaluate the success of the Collaborative to sustain, expand, enhance and integrate services	Annually	Tri-CCOHE Steering Committee	
	5. Evaluate our capacity to meet regional goals and improve oral health status	Annually	Tri-CCOHE Steering Committee	
B. Collect data to monitor regional need, capacity to provide dental care, services provided and people served	1. Document demand	Semi-annually	Providers and staff, BL Hathaway	
	2. Collect local data on safety net services: a) capacity b) services provided c) # of people served			
	3. Collect data on school-based programs: a) capacity b) services provided c) # of children served			
	4. Collect public insurance data of private practitioners a) capacity			

	<p>b) services provided</p> <p>c) # of people served</p> <p>5. Collect data on dental disease related services provided at hospital ERs</p> <p>6. Analyze and interpret data for program and service implications</p>	<p>Annually</p> <p>Annually</p>	<p>Diane Munsell, CCHC</p> <p>Tri-CCOHE Steering Committee</p>	
<p>C. Increase public awareness of the importance of oral health, the link with general health and the need for access to prevention and treatment</p>	<p>1. Participate in outreach events (school health fairs, Friday Kids Night at the Mall, etc)</p>	<p>2010 On-going</p>	<p>Staff, Cheila Mageste, patient care coordinator</p>	
	<p>2. Hold annual public event on aspects of oral health</p>	<p>Annually</p>	<p>Ad-hoc committee</p>	
	<p>3. Define parameters of awareness campaign (what awareness to create with whom)</p>	<p>2011</p>	<p>Committee members</p>	
	<p>4. Define and refine the message and modes of delivery and identify resources</p>	<p>2011</p>	<p>Committee members</p>	
	<p>5. Implement local awareness campaign</p>	<p>2012</p>	<p>Staff and Tri-CCOHE members</p>	
	<p>6. Evaluate impact of campaign</p>		<p>Committee members</p>	
	<p>7. If positive results, institutionalize campaign</p>	<p>2013</p>	<p>All</p>	
<p>D. Advocate for long term sustainability of funding for adult dental care for those insured by MassHealth and other publically subsidized insurance products</p>	<p>1. Advocate with legislators for sustainable funding</p> <p>2. Join with statewide initiatives (Oral Health Advocacy Task Force, Better Oral Health for MA, MDS) to advocate for sustainable resources</p> <p>3. Encourage collaborative advocacy among local oral health initiatives and stakeholders</p> <p>5. Develop a contingency plan in concert with the Oral</p>	<p>On-going</p>	<p>Staff and Tri-CCOHE members</p>	

<p>E. Expand and enhance the oral health workforce</p>	<p>Health Advocacy Task Force for loss of adult MassHealth benefits</p> <ol style="list-style-type: none"> 1. Provide opportunities for Cape and Islands high school and community college students to explore careers in oral health 2. Engage additional bilingual and multilingual providers 3. Support the movement of hygienists into public health settings 4. Expand collaborators beyond the Cape and Islands, such as dental schools 5. Investigate DHPSA as a way to attract providers to the Cape and Islands 	<p>2010/2011</p> <p>As able</p> <p>2011</p> <p>2011</p> <p>2011</p>	<p>Miriam Erickson, CC of CC</p> <p>Dental providers</p> <p>Liaison with hygienists</p>	
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NEXT STEPS

The Committees that formed around the four priorities for the development of *Oral Health 2013*, prevention, access to care, special populations and collaboration, will continue on to the implementation phase. All of the people who participated in a committee, whether oral health service providers or experts in the priority areas, will be encouraged to participate in the implementation of the plan. You are invited to join with Tri-CCOHE in moving from plan to reality as we address the most common chronic infectious disease, effecting approximately 28% of our children and as many adults.

BL Hathaway, Coordinator of Tri-CCOHE, is ready and willing to present this plan and to speak with community groups about oral health. If you are interested in scheduling a presentation, obtaining copies of this document or joining this community-wide effort to reduce dental disease, call Ms. Hathaway at 508.771.1375 or email her at hathawaybl@yahoo.com.