



Minnesota Oral Health Coalition Meeting

Friday, March 18, 2011

8:30-11:00



**Proposed Agenda for Coalition Meeting
Snelling Office Park-Red River Room
Friday March 18, 2011
8:30 am-11:00 am**

- 1) Welcome, introductions, plan for the day
- 2) State Plan prioritization and action plans
- 3) The Minnesota Coalition: past/present
- 4) Michigan Coalition: lessons learned
- 5) Overview of options concerning:
 - coalition infrastructure
 - elections
 - governance
 - by-laws
 - finance options
- 6) Transitional Task Force and charge
- 7) Future Meetings:
 - a. Frequency
 - b. Proposed agenda
 - c. Communications
- 8) Wrap up, concerns, tentative date for next coalition meeting
- 9) Evaluations
- 10) Adjourn



Department of the Treasury
Internal Revenue Service

501(c)(3) Status & Election h Rules

To be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3), and none of its earnings may inure to any private shareholder or individual. In addition, it may not be an action organization, *i.e.*, it may not attempt to influence legislation as a substantial part of its activities and it may not participate in any campaign activity for or against political candidates. Organizations described in section 501(c)(3) are commonly referred to as *charitable organizations*. Organizations described in section 501(c)(3), other than testing for public safety organizations, are eligible to receive tax-deductible contributions in accordance with Code section 170.

The organization must not be organized or operated for the benefit of private interests, and no part of a section 501(c)(3) organization's net earnings may inure to the benefit of any private shareholder or individual. If the organization engages in an excess benefit transaction with a person having substantial influence over the organization, an excise tax may be imposed on the person and any organization managers agreeing to the transaction. Section 501(c)(3) organizations are restricted in how much political and legislative (*lobbying*) activities they may conduct. If organizations are unsure how much lobbying they may conduct they should choose the "election h" option. For more information about lobbying activities by charities visit the website www.irs.gov

Additional Information on Election h

Under 501(h), your organization can spend up to 20% of its first \$500,000 exempt purpose budget on direct lobbying. Direct lobbying is defined as any communication, with a legislator, expressing a view about specific legislation. Organizations with budget expenditures over \$500,000 should apply the following formula:

- 20% of the first \$500,000
- + 15% of the next \$500,000
- + 10% of the next \$500,000
- + 5% of the remaining
- = the overall lobbying limit

Grassroots lobbying is defined as any communication with the general public, expressing a view about specific legislation, with a call to action. A call to action refers to four different ways the organization asks the public to respond to its message: (1) asking the public to contact their legislators or staffers; (2) providing the address, phone number, website, or other contact information for the legislators; (3) providing a mechanism to contact legislators such as a tear off postcard, petition, letter, or email link to send a message directly to the legislators; or (4) listing the recipient's legislator, the names of legislators voting on a bill, or those undecided or opposed to organization's view on the legislation. An organization that has made the 501(h) election can never spend more than 25% of their overall lobbying limit on grassroots lobbying. Therefore, a 501(c)(3), that has made the 501(h) election, with an annual budget of \$500,000, would have an overall lobbying limit of \$100,000 and a grassroots lobbying limit of \$25,000. All public charities, including 501(h) electing charities need to keep track of their lobbying expenditures for their 990 Form and in the event of an IRS audit.

**2011 Minnesota
Oral Health Plan**
At a Glance



“Optimal Oral Health for All Minnesotans”



www.state.mn.us/oralhealth

Minnesota Plan to Reduce Oral Disease and Achieve Optimal Oral Health for All Minnesotans: 2011-2020

February, 2011

At a Glance Goals, Objectives and Suggested Strategies

Development of the Minnesota Oral Health Plan
was facilitated by the

Minnesota Department of Health
Oral Health Program

WORKING DRAFT

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Executive summary

The vision of optimal (best possible) oral health for all Minnesotans has been the driving force in rebuilding the state's oral health infrastructure and to better respond to the oral health needs of the people of Minnesota. We recognize that oral health is integral and essential to total health and that many Minnesotans do not enjoy the benefit of total health.

Throughout the plan you will see the emergence of prevention as the top priority for oral disease intervention strategies. The efficacy of the combination strategy of community water fluoridation and pit and fissure sealants in reducing decay in children is well documented. We eagerly seek ways to promote oral health for all Minnesotans by increasing the development of innovative, community-based disease prevention strategies across the state.

While Minnesotans in general enjoy a high level of oral health, there are segments of the population that bear an uneven distribution of the burden of disease. The state recognizes the importance of public health surveillance for the purpose of identifying areas of greatest need in order to target resources where needed most. By developing capacity within the Oral Health Unit to collect and analyze data related to oral health and dental disease risk factors we can improve efficiencies and maximize resources. Increasing the availability of evidence and strengthening our commitment to data-driven decision making is evident throughout the plan.

The past two years have seen tremendous growth in the capacity of the Minnesota Department of Health to address oral health issues. There are many firsts to celebrate: the first state plan, the first open mouth screening of third graders (Basic Screening Survey), the first burden of disease document, the development of a web presence and increased integration with chronic disease, maternal and child health, the department of education, policy and compliance, tobacco control, and the Minnesota Obesity Project to name a few.

This state plan will not exist in print form. It is available in electronic format on the MDH website. It is a dynamic plan that has the capacity to adapt to the ever-changing environment for health in Minnesota. A timeline and process for periodic review, course correction and evaluation is in place so that the plan can be amended as needed. A framework for development of action plans, identification of resources, and lead organizations and individuals will serve to provide guidance for the next steps.

Many people have helped write this plan and it represents more than a year and a half of arduous strategic planning. The result is a comprehensive blueprint for action that will enable development of action plans, resource discovery, and courageous leadership. Thank you to those [list in the appendix] who have given selflessly of time and talent to bring the plan to this milestone in its development. The Minnesota Department of Health Oral Health Promotion Unit will continue to support activities related to the plan and will assist in the development of action plans and timelines as the role of the Oral Health Coalition emerges. The broad scope of the goals, objectives, and suggested strategies encourages those working to improve the health of Minnesotans to contribute to this plan. All Minnesotans are invited to participate in the achievement of success of the plan, enabling Minnesota to surpass Healthy People Targets and address disparity.

Goals, Objectives and Suggested Strategies

(Estimated time frame 5 years)

Goal 1: Minnesota's oral health infrastructure is stable and sustained.

Objectives

1. Fully integrate the State Oral Health Promotion Program into the Minnesota Department of Health infrastructure.

Suggested strategies

- a. *Increase the sustainability of the state oral health program and support the state oral health program as the central agency for oral health promotion.*
- b. *Continue to apply for grants and increase the amount of grant money obtained.*
- c. *Promote integration opportunities with other funded programs.*

2. Support development of a strong Minnesota Oral Health Coalitionⁱ that works closely with the Minnesota Department of Health.

Suggested strategies

- a. *Support the coalition in determining leadership structure and other administrative and organizations issues related to its development into a self supporting organization*
- b. *Work with the coalition leadership to explore pros and cons of establishing the Minnesota Oral Health Coalition as a non-profit organization (501 (C) 3 status)*
- c. *Utilize the CDC frameworkⁱⁱ and other recognized coalition resources to increase the diversity of the membership in the coalition.*

3. Develop and sustain collaborative partnerships to implement the State Oral Health Plan.

Suggested strategies

- a. *Create new partnerships that assure diversified funding is available to implement the Oral Health Plan.*
- b. *Identify innovative action plans that are easily adopted by stakeholders*

4. Seek commitment for long term data collection and surveillance on Minnesota's oral health indicators.

5. Seek funding sources that support review, professional evaluation, and updates to the current state oral health plan.

Suggested strategies

- a. *Oral health leaders and stakeholders seek sustainable funding and program changes to implement the plan.*

6. Assess opportunities for policy change through environmental analysis utilizing tools such as the environmental and policy scan and share results with decision makers.

Suggested strategies

- b. *Utilize resources available through CDC to support a facilitated process for oral health stakeholders to join together to make decisions about priorities based on suggested criteria.*

Goal 2: Strategies are implemented that reduce oral disease and mitigate risks.

Objectives

1. Determine the baseline for the number of providers that use standardized, evidence based oral disease risk assessment tools.

Suggested strategies

- a. Implement an educational campaign that raises understanding of risk assessment, benefits of using risk assessment, and introduces tools used to assess risk.
- b. Promote use of risk assessment (periodontal disease, diabetes, tobacco use, etc.) among medical and dental providers.
- c. Collect data that is valid and reliable on current usage of tools for caries risk assessment in practice.
- d. Choose a tested caries and a periodontal disease risk assessment tool to use in Minnesota.
- e. Utilize the Oral Health At-a-Glance web page as a clearing house for sharing standardized information on caries and periodontal disease risk in Minnesota.

2. Reduce caries experience in Minnesota children

Suggested strategies

- a. Partner with Maternal and Child Health, pre-school, Early Head Start and Head Start oral health programs, early care and education settings on tooth brushing promotion programs targeted toward pregnant women and children under the age of five (review NAEYC accreditationⁱⁱⁱ standards for oral health^{iv})
- b. Partner with Early Head Start and Head Start on oral health programs that help meet Head Start and Child and Teen Checkups (the Minnesota version of EPSDT^v) requirements.
- c. Develop and offer trainings for preschool staff, Head Start Coordinators, home visitors to recognize signs of and identify risk factors for ECC.
- d. Promote fluoride varnish programs as part of immunization and well child visits.
- e. Increase programmatic coordination between risk-reduction programs, e.g., Preschool and WIC program.
- f. Include oral health screening requirement in childhood screenings.
- g. Educate caregivers of infants/toddlers about appropriate amounts of topical fluoride or fluoride toothpaste.
- h. Increase availability and ease of access to oral health supplies.



Chewing surface
before sealant

3. Develop and coordinate comprehensive, state-wide school-based prevention programs that target high risk children.

Suggested strategies

- a. Conduct the third grade BSS^{vi} at least once every five years
- b. Convene a school-based sealant work group that includes providers, school representatives, school nurses, public health professionals, health plans, Minnesota public programs representatives, board of dentistry, researchers,



Tooth protected by
shaded sealant

- community representatives, parent representatives, and PTA.*
- a. *Conduct a needs assessment and compile information on existing sealant activities in the state.*
 - b. *Seek and acquire sustainable financial support, i.e. foundations, Title V funding, industry (3M, dental supply companies), Smiles Across Minnesota^{vii}, Oral Health America^{viii}, etc.*
 - c. *Create and publish a comprehensive state sealant plan.*
 - d. *Create a variety of easily understood messages targeted to parents/caregivers about efficacy and safety of pit and fissure sealants, why they are needed and the importance of sealants in caries prevention.*
- c. *Develop parameters for and post a Request for Proposal (RFP^{ix}) for at least 5 school-based sealant mini grant projects.*
- a. *Plan and conduct projects that provide documentation of components of successful sealant programs and identify barriers to sustainability.*
 - b. *Promote limited authorization/collaborative practice as a model for school based programs.*
- d. *Convene a transdisciplinary panel for review and development of a comprehensive coordinated plan for fluoride varnish programs and to develop quality improvement initiatives i.e. through learning collaboratives and health home initiatives.*
- e. *Create education campaign about how fluoride works and the importance of the appropriate use of fluoride varnish in caries prevention.*
- 4. Ensure that the percentage of public water supply systems providing fluoridated water within the optimal range and meeting the CDC optimal monitoring and surveillance requirements meets or exceeds 90%.**

Suggested strategies

- a. *Collect community water fluoridation information and submit data to CDC on 510 reports.*
 - b. *Identify ways to provide support to communities to maintain or update aging fluoridation equipment.*
 - c. *Support state-wide educational campaigns that promote drinking tap water.*
 - d. *Educate water works operators about the importance of the water fluoridation process and its link to oral health.*
 - e. *Recognize water workers and engineers as oral health leaders on a consistent basis.*
- 5. Ensure that at least 50% of Minnesota’s schools have achieved oral health targets:**
- i. Removed cariogenic foods and beverages from vending machines.**
 - ii. Increased the number of non – cariogenic food items accessible outside the lunch program (vending machines, fund raisers, concessions, classroom celebrations and a la carte) in Head Start and school menus.**
 - iii. Increased tobacco use prevention/cessation and nutrition information in health education programs.**

Suggested strategies

- a. *Provide resources^x to strengthen curricula that emphasize how healthy eating can improve and maintain oral health*
- b. *Reduce the impact of soda/beverage marketing by educating schools to resist marketing strategies.*
- c. *Promote understanding about the preventive properties of xylitol gum and xylitol products and their proper use.*

- d. *Partner with the Minnesota School Nutrition Association^{xi} and the Department of Education^{xii} to collect data on candy and pop available in schools in order to tailor oral health campaigns to school needs.*

6. Promote awareness of the effect of diet and nutrition on oral health among hospital food service directors, older adult service establishments, and nutrition staff.

Suggested strategies

- a. *Partner with the Minnesota Hospital Association (MHA^{xiii}), hospital Food Service Directors, and Registered Hospital Dietitians to provide information about creating tooth healthy menus and increasing health snack choices for patients, visitors, staff, and in vending machines.*
- b. *Provide educational sessions at MHA conferences about the relationship of diet to dental disease.*
- c. *Promote partnerships with assisted living and nursing home providers and organizations to increase understanding about the impact of diet on the oral health of older adults.*

Goal 3: Oral health literacy^{xiv} is increased across all ages and cultures.

Objectives

1. Increase oral health evaluation and caregiver education in early childhood screenings, vaccination visits, episodic care visits, prenatal, and Child and Teen Checkups.

Suggested strategies

- a. *Support health literacy and cultural competency training for health professionals in the community, including healthcare providers and public health officials.*
- b. *Provide technical assistance to those interested in becoming proficient in patient-centered literacy skills.*
- c. *Educate prenatal and maternal health care providers about the importance of increasing oral health literacy among pregnant women so they are well informed about caries etiology, caries prevention and infant oral health care.*
- d. *Create a campaign to increase understanding regarding the importance of tooth brushing and sponsor distribution of oral health information and materials in prenatal and maternal care programs.*

2. Build awareness of oral disease prevention strategies and increase oral health knowledge in school-based^{xv} health systems.

Suggested strategies

- a. *Strengthen partnership with and provide resources to the Minnesota Department of Education and Minnesota School Nurses to evaluate oral health curricula (including early childhood and after school programs) on basis of evidence-based strategies.*
- b. *Develop and disseminate information about the efficacy of pit and fissure sealants, water fluoridation, topical fluoride therapy and other strategies that prevent and control oral disease.*
- c. *Investigate programs to introduce evidence-based xylitol therapy in early childhood programs and schools.*

- d. *Partner with the Minnesota Department of Health Injury and Violence Prevention Unit to develop promotional programs that focus on preventing and reducing oral injury.*
- e. *Develop and disseminate information to parents and schools about fluoride varnish, sealants and the health home.*

3. Increase exposure to oral health knowledge through targeted and culturally sensitive campaigns that focus on prevention strategies.

Suggested strategies

- a. *Develop and disseminate fluoridation messages that provide cultural and age appropriate information to population groups, adults, and children. e.g. “safe to drink fluoridated tap water” messages.*
- b. *Increase oral health literacy among young adults emphasizing smoking, diet, smokeless tobacco, alcohol and tobacco, periodontal disease and importance of oral care.*
- c. *Increase oral health literacy among elderly and their caregivers; emphasizing medications that increase xerostomia (dry mouth), root caries etiology, periodontal disease, and oral cancer.*
- d. *Ensure educational materials are available in multiple languages, including visuals for the non-reading population.*
- e. *Create electronic media and monitor hits/visits to web pages and internet sites*

4. Increase awareness of oral health among policy and decision makers about the benefits of oral disease prevention.

Suggested strategies

- a. *Engage legislators in an annual oral health initiatives forum beginning in January of 2011.*
- b. *Partner with the Minnesota Oral Health Coalition to support oral health promotion policies, tobacco control policies, and to promote policy change.*
- c. *Identify and utilize oral health resources in the state to target areas of greatest need.*
- d. *Increase understanding of federal mandates and funding, or lack of funding.*

Goal 4: Professional integration is enhanced between oral health care providers^{xvi} and other providers in the broader health care system.^{xvii}

Objectives

1. Promote understanding and development of the health home concept.^{xviii}

Suggested strategies

- a. *Create and nurture nontraditional partnerships in oral health to establish a coordinated strategic direction.*
- b. *Gather information and evaluate the effect of reimbursements/incentives for improving care.*
- c. *Increase training opportunities in oral health for non-dental professionals (public health nurses, dietitians, health plan case managers, community health workers, and interpreters) that build patient centered (preventive, therapeutic, and remedial) skills and provide technical assistance for working with patients, clients and the public.*
- d. *Increase the number of local public health agencies that address oral health.*

- e. *Increase integration activities and partnerships with nutrition, obesity, tobacco, alcohol, etc. (i.e. American Dietetic Association, American Lung Association, American Heart Association).*
- f. *Plan demonstration projects that create innovative health home models.*
- g. *Work with educators to investigate the potential role of teledentistry and policy makers to address payment issues.*

2. Increase the number of non-dental provider education programs (physician’s assistant, nurse practitioner, dietitians, medical schools, and nursing schools) that incorporate oral health into their curriculum.

Suggested strategies

- a. *Partner with the Minnesota and American Pediatric Association and the American Medical Association (AMA^{xix}) to determine current continuing medical education curriculum that encompasses an oral health component.*
- b. *Work with the University of Minnesota Continuing Education Division to create continuing medical education curriculum focused on oral health.*
- c. *Use evidence-based strategies to develop core competencies in oral health within educational setting.*
- d. *Provide one conference in each of the next two years for oral health and medical providers that focuses on:*
 - i. *Oral and systemic health interrelatedness in the first year*
 - ii. *Understanding and promoting risk assessment of oral and systemic health*

3. Develop collaborative opportunities throughout the health care community by educating and training physicians, dentists, nurses, hygienists, nurse practitioners, dental assistants, dental therapists, and social workers to work as a single team addressing oral health disparities and unmet dental needs of the underserved.

Suggested strategies

- a. *Promote research on the impact of oral health on overall health.*
- b. *Support development and evaluation of programs that promote disease preventions and increase collaborative health care*
- c. *Support overall supervision that would allow allied dental personal to be supervised by physicians or medical personnel.*
- d. *Reduce barriers to dental hygienists working in public health agencies and other settings.*
- e. *Move primary oral health care into every OB, primary care, family practice, pediatrics, internal medicine practice in Minnesota by incorporating “The mouth is a part of the body” concepts.*
- f. *Investigate further development of innovative collaborative strategies for serving elderly and youth populations with the different provider type.*
- g. *Explore development of a centralized network for identifying excess capacity, sharing resources, and communicating needs that utilizes the public health nurse infrastructure.*

4. Promote collaboration among dental providers and medical care providers that increase information sharing, understanding of eligibility requirements, and access to and utilization of oral health care benefits.

Suggested strategies

- a.

- b. *Create demonstration projects that gather and analyze preventive services utilization data and propose new models that coordinate collaboration between dental and medical providers and eliminate disparities.*

5. Promote the adoption and meaningful use of the electronic dental record.

Suggested strategies

- a. *Disseminate information about the ONC efforts to create standardized guidelines for the utilization of HIT^{xx} and reporting.*
- b. *Improve collaboration and follow up by aligning with at least two objectives of the local and national Office of the National Coordinator for Health Information Technology (ONC^{xxi})*
- c. *Seek funding to create incentives for private and public health dental and medical systems to create and adopt centralized network tools.*

6. Call for the development and promotion of clinical preventive oral health guidelines^{xxii} for use in settings outside the dental office: medical and long term care, prison, juvenile, and hospital settings.

Suggested strategies

- a. *Support and promote the development and use of dental diagnostic codes.*
- b. *Develop partnerships that integrate oral health into the current case management system^{xxiii}.*
- c. *Promote public health research, standardized protocols for care, and use of evidence-based practices.*
- d. *Promote inclusion of oral evaluation in care guidelines for the aging and persons with diabetes and special health care needs.*
- e. *Create a web-based tracking and referral mechanism for oral health information and treatment.*
- f. *Promote HIPAA^{xxiv} compliant communications between dental providers and Primary Care Providers (Family Medicine, Obstetrics, Pediatrics, Internal Medicine, etc.) and allied health professionals, (dietitians, pharmacists, etc.) when assessing and referring for medical conditions and non-dental issues.*

7. Increase the number of primary care medical providers who integrate prevention of oral disease as part of overall health care by 10% for patients of all ages.

Suggested strategies

- a. *Create a recognizable symbol and/or standardized message that captures the concept of the interrelatedness of oral health and overall health.*
- b. *Develop a marketing campaign targeted to medical providers that promotes oral health as integral to overall health.*
- c. *Determine a baseline number (early adopters) and evaluate barriers to utilization of oral disease prevention strategies by medical practitioners.*
- d. *Develop an integrated approach among medical and dental providers that promotes oral exams/evaluation, referral, and access to oral health care by age one.*
- e. *Promote treatment information sharing between pediatricians, physicians and dentists.*

Goal 5: Access to preventive, restorative, and emergency oral health care is increased.

Objectives

- 1. The legislative intent [[Minnesota statutes 150A.10 Subd.1a., 150A.105 and 150A.106]] to increase the supply and distribution of dental services through creation of new dental providers and appropriate utilization of the entire dental team is achieved.**

Suggested strategies

- a. Maximize the opportunity that Minnesota has to provide positive leadership in creating new oral health care providers and innovative workforce models*
- b. Support and engage with other agencies to research the impact of new and existing oral health care providers on improved access to services by collecting and analyzing outcomes data.*
- c. Increase the number of dentists, health care facilities, programs, or nonprofit organizations that employ dental hygienists with limited authorization/collaborative agreement.*
- d. Develop relationships with providers in older adult services settings (e.g. nursing homes, assisted living) to connect providers with elderly populations*

- 2. Increase by 10% the number of underserved Minnesotans who receive evidence-based preventive dental care, with emphasis on children under age one, uninsured adults, people with developmental disabilities, children with special health care needs, low income and immigrant populations, those with chronic diseases, and individuals in long term care facilities.**

Suggested strategies

- a. Educate general dentists to be more comfortable caring for infants and toddlers (0-3 year olds), making appropriate referrals, and using best practices.*
- b. Work with state agencies and commissions to analyze issues (including funding) regarding care for children, adults, the aging, developmentally disabled, and special health care needs populations, low income and under insured, and participate in developing policy recommendations.*
- c. Use Basic Screening Survey (BSS) results to determine preventive service initiatives*
- d. Encourage local and county public health agencies to utilize dental hygienists in prevention programs*
- e. Identify and work with agencies engaged in dental programs to explore alternative delivery systems that improve communication with local dentists, improve sustainability, and increase continuity of care.*
- f. Partner with agencies on a centralized website or helpline for the public to increase access to referral information and information on current systems in place for Minnesota Healthcare Programs and the uninsured.*
- g. Develop compliance initiatives that increase comprehensiveness of oral health programs for children under age one, uninsured adults, people with developmental disabilities, children with special health care needs, and individuals in long term care facilities*

- 3. Reduce the proportion of Minnesotans who experience difficulties, delays, or barriers to restorative oral health care service by 20%.**

Suggested strategies

- a. *Partner with state agencies that have been mandated to document the impact of existing and new Minnesota oral health care workforce models on improved access to restorative services using outcome data.*
- b. *Establish baseline information on barriers to oral health care involving target populations by conducting a state-wide survey and adding questions to both BRFSS^{xxv} and BSS regarding Minnesota's accessibility to dental care.*
- c. *Investigate best practices for sustainability of public health and safety net [insert definition] clinics.*

4. Reduce the number of emergency room (ER) visits for dental related reasons by 15%.

Suggested strategies

- a. *Develop and disseminate materials that educate caregivers about dental injuries and the appropriate response.*
- b. *Collaborate with hospitals and providers in older adult service settings to provide information on local public health dental programs so that patients presenting in the ER are provided with appropriate referral and preventive education information.*
- c. *Develop a campaign to educate the public about seeking professional dental care and guidance after an oral injury has occurred.*
- d. *Develop a campaign focused on oral injury prevention and promoting the appropriate use of mouth-protecting equipment in sports, i.e. mouth guards.*
- e. *Collaborate with hospital medical staff to assure that diagnostic codes are utilized for non-traumatic [add non-traumatic definition] dental related ER visits and are coded correctly in order to establish baseline data.*

5. Increase the number of individuals who receive oral and pharyngeal cancer screenings by 10%.

Suggested strategies

- a. *Determine a baseline number of dental and medical professionals that currently integrate visual oral and pharyngeal cancer screenings into comprehensive exams.*
- b. *Emphasize the importance of screening for oral and pharyngeal cancer and how it can affect critical functions, such as speaking, swallowing, and eating.*
- c. *Increase the number of healthcare providers who deliver consistent and appropriate messages to help people quit smoking.*
- d. *Partner with the National Cancer Institute on developing health care provider competencies in prevention, diagnosis, and management of oral and pharyngeal cancers.*
- e. *Aid the American Cancer Society [insert link to ACS] in incorporating oral and pharyngeal cancer screenings in the "Welcome to Medicare" physical examination.^{xxvi}*
- f. *Promote the development of a community-based oral cancer prevention and early detection program (Such as the Illinois Model^{xxvii}).*

6. Increase the proportion of local health departments that have an oral health program focused on prevention.

Suggested strategies

- a. *Build capacity in local health departments by providing technical expertise and evidence-based oral health information.*

- b. *Determine a baseline number of local health departments that currently have an oral health care program.*
 - c. *In collaboration with existing local oral health care program personnel, identify local health departments that do not have an oral health program and offer resources and guidance in creating and structuring their own oral health component.*
 - d. *Partner with the Minnesota Association of Local Public Health^{xxviii} to convene a conference on integrating oral health into local public health systems.*
7. **Promote policies and programs that ensure that 95% of Minnesotans have access to a dental care provider within a 90 minute drive or by public transportation from their place of residence.**

Suggested strategies

- a. *Conduct at least one public health/nonprofit clinic pilot project to investigate and gather data on current equitable distribution of services.*
 - b. *Promote school based programs, and older adult service settings.*
 - c. *Determine existing excess capacity and transportation services available to patients, including the uninsured and public programs patients.*
 - d. *Work with local safety net programs in supporting existing and creating new volunteer programs that provide patients transportation to and from dental and health appointments.*
 - e. *Convene a conference focused on policy tools that will help achieve equity in population health, featuring best practices and expert panel presentations, moderated discussions, as well as working groups.^{xxix}*
 - f. *Reduce barriers to supervision and collaborative agreements.*
8. **Increase partnerships that explore effective policy initiatives to stabilize the availability of oral health care services to the most vulnerable [define “vulnerable”] populations.**

Suggested strategies

- a. *Develop a planning checklist to move forward strategically once consensus about priorities is achieved.*
- b. *Increase data and information gathering efforts that support policy decisions among stakeholders, oral health care providers and primary care providers.*

Goal 6: The dental workforce^{xxx} is prepared for and addresses the oral health needs of all Minnesotans.

Objectives

1. **Promote innovative and effective oral health care delivery practice models for rural populations.**

Suggested strategies

- a. *Continue to work with Area Health Education Centers (AHEC) to explore and strengthen strategies that will achieve better retention and distribution of oral health care providers graduating from state supported institutions.*
- b. *Develop mentoring programs for the dental workforce.*
- c. *Investigate the role of teledentistry.*

2. Promote broader discussion of ways the social compact^{xxxii} between dentistry and society can be reinforced:

Suggested strategies

- a. *Convene workshops.*
- b. *Promote continuing education programs.*
- c. *Encourage the creation of at least one internship opportunity for students and one work experience for professionals.*

3. Collaborate with agencies (BOD^{xxxii}, ORHPC^{xxxiii}), educational institutions, (DPBRN^{xxxiv}) to gather and disseminate information on practice models, collaborative agreement dental hygiene practice, and the dental therapist/advanced dental therapist management agreement.

Suggested strategies

- a. *Maximize utilization of tools available: support infrastructure for collaborative agreement hygienists and restorative function allied personnel, dental therapist and advanced dental therapist.*
- b. *Convene an educational forum or summit of collaborative practice hygienists and dentists to promote collaborative practice.*
- c. *Identify and develop a method for tracking (database) current collaborative practice agreements and collaborative management agreements in order to increase networking and information sharing among collaborative providers.*

4. Ensure that at least 90% of oral health provider education programs incorporate health literacy concepts and cultural competency training into curriculum.

Suggested strategies

- a. *Promote the CDC health literacy certification program*
- b. *Disseminate information about health literacy and promote use of a usability checklist that assures that oral health information meets health literacy principles^{xxxv}.*
- c. *Partner with professional associations to create continuing education courses for oral health professionals focused on health literacy and cultural competency concepts^{xxxvi}.*
- d. *Seek ways to enhance or support opportunities for Community Health Workers to promote culturally sensitive oral disease prevention strategies in their communities.*

5. Increase cultural competence training related to oral health in health professional education programs

Suggested strategies

- a. *In collaboration with existing local cultural organizations, develop and disseminate cultural competency educational materials for health professionals.*
- b. *Encourage the Board of Dentistry to focus a self-assessment on the subject of cultural competency.*
- c. *Partner with Minnesota state supported higher education institutions to provide community outreach and cultural center personnel with a basic oral health education course*

6. Encourage all oral health provider education programs to focus on recruiting classes that reflect the state's population diversity.

Suggested strategies

- a. *Strengthen existing and develop new outreach programs that recruit potential dental professionals from diverse backgrounds.*
- b. *Seek funding for the expansion of dental education scholarships and loan repayment efforts.*

Goal 7: Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all.

Objectives

- 1. Collaborate with data partners and key stakeholders to identify key oral health indicators and to increase the visibility and effectiveness of the Minnesota Oral Health Surveillance Advisory Group^{xxxvii}.**

Suggested strategies

- a. *Convene the Advisory Group annually*
 - b. *Develop and maintain data sharing agreements with partners.*
 - c. *Acquire and analyze data, and interpret findings.*
 - d. *Prepare and publish the Minnesota Surveillance Plan and the Burden of Oral Disease in Minnesota documents.*
 - e. *Review, update and publish the Burden Document regularly.*
 - f. *Evaluate progress, trends, and direction.*
- 2. Develop a secure, high-tech data system that identifies and tracks key oral health indicators and has the capability to provide specific data affecting policy and existing programs upon request.**

Suggested strategies

- a. *Develop quality assurance measures to ensure accuracy.*
- b. *Continue to develop and implement the At-A-Glance web page.*
- c. *Share summarized surveillance information with local public health, educational institutions, insurers, social services, policy makers, community-based organizations, community – health clinics, and other partners as appropriate.*
- d. *Increase the capacity of the MDH Oral Health Unit to serve as a primary resource for oral health information by providing links to educational materials, oral health initiative information, and oral health curriculum.*
- e. *Monitor and respond to data requests.*
- f. *Ensure data security/confidentiality.*
- g. *Explore use of (or develop) a secure web-based data entry portal (i.e., a web page for sealant grantees to enter data).*

- 3. Increase capacity of the state oral health program to collect data and conduct surveillance activities.**

Suggested strategies

- a. *Investigate ways to sustain the surveillance activities of the oral health program*
- b. *Provide staff and stakeholder training opportunities that increase ability of the program to manage large data projects*
- c. *Evaluate surveillance and outcome data*
- d. *Increase support for acquiring data and increase demand for oral health data.*

ⁱ The Oral Health Coalition is a group of public and private organizations and individuals that share common strategic interest. The Oral Health Coalition educates others within the community about oral health needs and helps to strengthen the state oral health program by guiding oral health program activities.

<http://www.health.state.mn.us/divs/hpcd/chp/oralhealth/partnerships.html>

ⁱⁱ CDC collaborates to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. http://www.cdc.gov/oralhealth/state_programs/pdf/coalition_framework.pdf

ⁱⁱⁱ The National Association for the Education of Young Children (NAEYC) is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age 8. <http://www.naeyc.org/accreditation>

^{iv} "Accreditation." *National Association for the Education of Young Children | NAEYC*. Web. 19 July 2010. <http://www.naeyc.org/accreditation>>.

^v EPSDT is designed to help ensure access to needed services, including assistance in scheduling appointments and transportation assistance to keep appointments. EPSDT works with the child health component of Medicaid to improve the health of low-income children by financing appropriate and necessary pediatric services.

<http://www.hrsa.gov/epsdt/>

^{vi} BSS: The Basic Screening Survey is a standardized set of surveys designed to collect:

- a) information on the observed oral health of participants,
- b) self-reported or observed information on age, gender, race and Hispanic ethnicity, and
- c) self-reported information on access to care for preschool, school-age and adult populations.

<http://www.dphhs.mt.gov/PHSD/family-health/oral-health/documents/BSSChildrensManual2008.pdf>

^{vii} Oral Health America's (OHA) Smiles Across America (SAA) program links local governments, businesses, and funders with care providers and schools to help fight untreated oral disease. SAA offers resources and technical assistance to help communities build infrastructure for school oral health services, particularly those that provide dental sealants. <http://www.oralhealthamerica.org/smiles.html>

^{viii} Oral Health America is a national, non-profit organization that strives to change lives by connecting communities with resources to increase access to care, education, and advocacy for all Americans, especially those most vulnerable. <http://oralhealthamerica.org/>

^{ix} Request for Proposal is a document that an organization posts to elicit bids from potential vendors for a product or service.

^x "Sip All Day – Get Decay" ADA materials

http://www.mndental.org/public_home/educational_activities/sip_all_day_get_decay/

^{xi} The Minnesota School Nutrition Association is a non-profit association of members who work to ensure that all children have access to healthy meals and nutrition education in Minnesota. MSNA provide members with opportunities for professional development and to build relationships that make a difference in the lives of children.

<http://www.mnsna.org/>

^{xii} The Minnesota Department of Education strives to be an innovative education agency serving a wide range of customers by improving educational achievement through establishment of clear standards, measuring performance, assisting educators and increasing opportunities for lifelong learning. <http://education.state.mn.us/mde/index.html>

^{xiii} Minnesota Hospital Association (MHA) works to develop, promote and implement progressive health policy in the state and nation that benefits hospitals' employees, patients and communities. <http://www.mnhospitals.org/>

^{xiv} <http://www.health.gov/communication/literacy/quickguide/healthinfo.htm>

^{xv} Insert reference – what is a "school based health system"

^{xvi} An individual who provides oral health services to oral health care consumers (patients).

^{xvii} An organized plan of health services by which health care is made available to the animal population and financed by government or private enterprise or both. A health care system embraces the following: (1) health care services available to individual animals and to groups through private practices and government veterinary officer services in veterinary clinics, laboratories and hospitals and the clients' own homes and on farms, in stables and other group animal facilities; (2) the veterinary preventive medical services needed to maintain a healthy environment; for example, control of medicine and food supplies, regulation of drugs, and control of the movement of animals intended to protect a given population; and (3) teaching and research activities related to the prevention and treatment of disease.

^{xviii} The medical home concept is based on a relationship between a patient and a primary care provider who serves as the patient's first point of contact. The attributes of a medical home include:

- Patient centered care- where the patient actively participates in health care decisions that affect him or her.
- Accessible care- where the medical home provider is available nights and weekends to respond to patient concerns and avoid unnecessary emergency room use.
- Comprehensive, coordinated care- where the medical home provider proactively engages with other health care professionals and systems to share information and promote continuity of care. This coordination extends across all health care venues (e.g. hospital, nursing facility) and for all types of care (e.g. preventive, acute, chronic, end-of-life)
- Culturally sensitive and linguistically appropriate care.

^{xix} The American Medical Association helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues through promotion of the art and science of medicine and the betterment of public health <http://www.ama-assn.org/>

^{xx} Health information technology (health IT) involves the exchange of health information in an electronic environment. Widespread use of health IT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/index.html>

^{xxi} The Office of the National Coordinator for Health Information Technology (ONC) is at the forefront of the administration's health IT efforts and is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide health information exchange to improve health care. ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS). ONC is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1200&mode=2>

^{xxii} Guidelines: <http://guidelines.gov/search/search.aspx?term=oral+health+preventive+strategies>

^{xxiii} Case Management definition: A traditional term for all the activities which a physician or other health care professional normally performs to insure the coordination of the medical services required by a patient. When used in connection with managed care, it also covers evaluating the patient, planning treatment, referral, and follow-up so that care is continuous and comprehensive and payment for the care is obtained. (From Slee & Slee, Health Care Terms, 2nd ed)

^{xxiv} <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/index.html>

^{xxv} The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. <http://www.cdc.gov/brfss/>

^{xxvi} <http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/medicare-coverage-for-cancer-prevention-and-early-detection>

^{xxvii} www.ihrp.uic.edu/study/oral-cancer-prevention-and-detection-illinois-model

^{xxviii} The Local Public Health Association of Minnesota works statewide to improve and protect the health of the population of Minnesota by providing leadership and advocacy on behalf of public health issues. <http://www.lpha-mn.org/index.html>

^{xxix} Regional Consultation on Policy Tools: Equity in Population Health Report

^{xxx} The dental workforce refers to the number, distribution, and characteristics of dentists, dental auxiliaries, and other support staff involved in the provision of oral health care.

^{xxxi} The right of autonomous self-control gives the dental workforce the responsibility of caring for the public.

^{xxxii} An oral disease burden document describes the status of oral diseases (e.g., dental caries, periodontal disease, total tooth loss) in Minnesota, including any disparities in oral disease status among population groups. It also may discuss the ability of Minnesota's programs to meet these needs by including a description of existing state oral health assets, such as professional dental and dental hygiene education programs and intervention programs that focus on preventing oral diseases. <http://www.health.state.mn.us/divs/hpcd/chp/oralhealth/data.html>

^{xxxiii} The Office of Rural Health and Primary Care promotes access to quality health care for rural and underserved urban Minnesotans by partnering with communities, providers, policymakers, and other organizations. <http://www.health.state.mn.us/divs/orhpc/>

^{xxxiv} The Dental Practice- Based Research Network (DPBRN) is a consortium of participating practices and dental organizations committed to advancing knowledge of dental practice and ways to improve it. Essentially, it is "practical science" done about, in and for the benefit of "real world" daily clinical practice. DPBRN's major source of funding is the National Institute of Dental and Craniofacial Research (NIDCR), part of the US National Institute of Health (NIH). <http://www.dentalpbrn.org/home.asp>

^{xxxv} "Health Literacy - Strategies: Improve the Usability of Health Information." *Www.health.gov*. Web. 19 July 2010. <<http://www.health.gov/communication/literacy/quickguide/healthinfo.htm>>.

^{xxxvi} <http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/cme-credit-offerings.shtml>

^{xxxvi} MOHSAG assists the oral health program in identifying data sources and gaps, providing data for the system, defining the indicators, reviewing data collection methods and processes, interpreting trends, and making recommendations for data communication activities.

^{xxxvi} ICSI is a non-profit organization that brings together diverse groups to transform the health care system so that it delivers patient-centered and value-driven care. <http://www.icsi.org/>

^{xxxvi} MN Community Measurement is a collaborative effort among those who believe that you cannot improve what you don't measure. The Minnesota Community Measurement Project collaborative includes medical groups, clinics, physicians, hospitals, health plans, employers, consumer representatives and quality improvement organizations. <http://www.mncm.org/site/>



Lessons Learned

Patti Ulrich, Prevention Coordinator
Minnesota Department of Health
Oral Health Unit
March 18, 2011

Two Oral Health Coalitions?

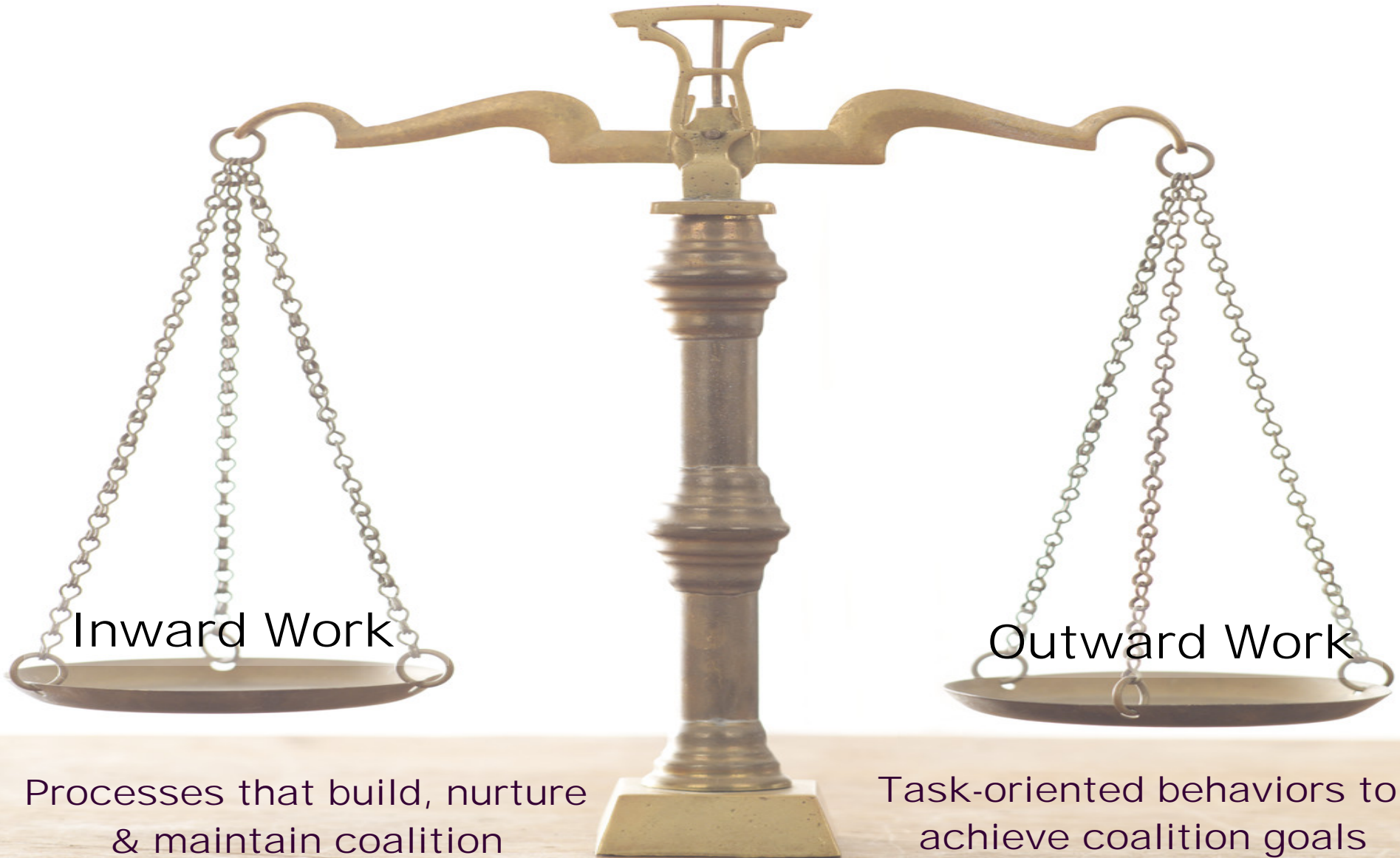
MOHC

- 501c3
- Membership dues
- Staff – Exec. Director
- Office space
- B of D elected annually
(Nominating Committee)
- Website
- Membership Newsletter
- Membership diversity

COHA

- Org. of volunteers
- Non-dues paying
- B of D volunteer for positions
- Membership diversity

Coalitions Work on 2 Levels



In essence, you
must fly the plane,
while you build it ...





Thank you!

Action Plan Framework

Goal:					
Objective:					
Strategy:					
Action	Background/evidence base (statement of need)	Products/Deliverables/Data	Resources needed	Timeline	Lead agency or individual
Outcome Measures of Success:					
Evaluation Plan:					

Please feel free to duplicate as needed.



Volunteer Form

Name and contact information: Please check, and if needed, update this data to ensure the state Oral Health Program has your preferred contact information.

Name: _____

email address: _____

Phone: _____

Address: _____

Please check: _____ Hygienist _____ Dentist _____ Educator
 _____ Other _____

Where are you working in the field of oral health? _____

In what capacity would you be interested in participating with the Minnesota Oral Health Coalition to implement the Minnesota Oral Health Plan?

- Coalition member
- Receive Coalition updates (Mailing list only)
- Member of a committee
- Regular attendance at Coalition quarterly meetings
- Volunteering for State Plan Initiatives/Action Plans
- Assist in finding Financial Support & Fund raising
- Nominee for Steering/Executive Committee
- Member of Policy committee
- Letter of support and occasional attendance
- Promote policy and systems changes that result from the coalition's work
- Strengthening partnerships and communications
- Other _____



Minnesota Oral Health Coalition
 Friday, March 18, 2011 8:30-11:00
 Red River Room at MDH Snelling Office Park
 and
 Regional Sites

<i>Please rate your satisfaction with each of the following:</i>	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
1. Organization of the Coalition meeting <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Presentations were helpful updates and pertinent to the Coalition <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Understanding of Coalition and Work Groups/State Oral Health Unit roles <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The next steps for the Coalition election process were clear. <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Handouts <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall, how satisfied are you with today's Oral Health Coalition Meeting? <i>Comments:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. What were the *most* helpful features of today's coalition meeting?

8. What were the *least* helpful features of today's coalition meeting?

9. Please list your ideas for the next coalition meeting:

10. Is there a person or organization you would like to see included as part of the Oral Health Coalition?

Yes Who? _____