



Greater Richmond-Petersburg Area Oral Health Forum

Presented by the Virginia Oral Health Coalition

With generous support from the Richmond Memorial Health Foundation

Monday, May 22, 2017 | 9:30 a.m. – 2:00 p.m.

4200 Innslake Drive, Glen Allen, VA 23060

Meeting Facilitator: Kathy Greenier, Floricane, LLC

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Proceedings

Welcome & Introductions

- Mark D. Constantine, President/CEO of Richmond Memorial Health Foundation opened the meeting with a welcome
- Meeting facilitator Kathy Greenier led introductions at tables.

Overview of the 2016 Virginia Oral Health Report Card & Greater Richmond-Petersburg Region

Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

- [Click to download a copy of Sarah's presentation slides.](#)

Data Walk Activity

- Kathy invited participants to break into groups of three and provided instructions for the Data Walk activity. The goal of this activity was to provide participants with a snapshot of the region's oral health and prompt them to ask questions about what the data shows.
- The groups viewed posters with charts and maps of oral health data ([click to jump to the charts/maps](#)).
- Each group member recorded their responses to a set of question prompts about the data as they viewed the posters ([click to jump to a detailed compilation of the data walk responses](#)).
- Highlights of participants' responses:
 - Education is needed to increase awareness among Medicaid beneficiaries about their coverage and options to help them get to appointments.
 - Providers, insurers, and community-based organizations have a role to play in helping patients navigate the system to boost utilization and improve outcomes.
 - Many noted that Hispanics have higher utilization of services (among Medicaid eligible children), but high rates of tooth decay; adults have low utilization of services, but low rates of tooth extractions. Many were curious about this phenomenon and whether or not it is representative of the "immigrant paradox" (immigrants are healthier when they first arrive to US compared to later generations, implying that the structural environment of the US is unhealthy).
 - Many were alarmed by the racial/ethnic, income, and education disparities across all the indicators.
 - Many were surprised by the absence of Medicaid dental providers in Charles City County, Surry County, and Sussex County, the low number of Medicaid dental providers in Petersburg, and the high number of providers in Emporia City.¹ When overlaid with other social/demographic data, it is clear that there are areas of need in Petersburg and Southside in particular.
 - Many noted a lack of data about specific populations such as pregnant women and older adults, and a need for a breakout of all the dental health indicators by sex.
 - More granular data is needed to better understand areas of greatest need.

Population Group Discussions

Dr. Maghboeba Mosavel, Virginia Commonwealth University, introduced the afternoon activity, and Kathy gave the instructions. Meeting attendees assigned themselves to different groups by

¹ There is a high concentration of dentists in Emporia, presumably because it is a central location. There are no Medicaid dental providers in Charles City, Surry, or Sussex Counties. There may be a free clinic with a locum tenens dentist. The data used for these maps is based on Medicaid claims and only full-time equivalent (FTE) dentists; locum tenens dentists are not included in that count.

population category: adults; children ages 0-5 and pregnant women; children and adolescents ages 6-18; individuals with special health care needs; and older adults. Each group responded to a set of two question prompts. [Click here to jump to a summary of the discussions for each population group.](#)

Closing Remarks

Sarah (VaOHC) thanked attendees and reminded everyone that meeting materials (including handouts and powerpoints) will be shared after the meeting.

Sarah encouraged attendees to fill out a sign-up sheet to get involved with a regional workgroup and/or one of VaOHC's state-level [workgroups](#).

Next Steps – Regional Workgroup

- Complete [doodle poll](#) for regional workgroup interest meeting by Wednesday, June 14, 2017.
- Join our [email list](#) to receive monthly updates.
- Contact Lauren Gray, VaOHC Program & Engagement Manager, to get involved in a regional workgroup: lgray@vaoralhealth.org or 804.299.5506.

Compiled Responses from Data Walk Activity

Overarching Comments for All Posters

What most surprises you about this data? Why?
<ul style="list-style-type: none">• Coverage ≠ Access ≠ Utilization• Expected a bigger gap between region and state for permanent molar sealants
What information is missing? Why is this missing information important?
<ul style="list-style-type: none">• Awareness/education – are people aware of resources and services that can help?• The “why’s” are missing. Why is there such a huge difference between the categories and why do Medicare packages note include what they need for dental care? It’s important because without the why’s, one can only wonder versus understand.• Percentage of cultural groups that go back to their countries to receive dental care.• Why are families not accessing services? That would tell us what we need to do to inform families.• Emergency department dental data.• It would have been very informative to see how oral health (or the lack of it) follows the same pattern as other health problems specific to geographical areas.• Information about the impact of nutrition on oral health.• Information about cost to the systems – such as the cost associated with ED visits for preventable dental conditions or costs for extractions.
Do these data help you understand oral health inequities in this region? Why or why not?
<p>Yes, because...</p> <ul style="list-style-type: none">• Good visual representation• Already have knowledge of many of the disparities, yet seeing it charted and discussing it with the group is eye opening• It also goes along with the County Health Rankings and how the inequalities are spread• It highlights race and income differences• It is wonderful to see the common issues of the region• You can see the areas where poverty is, which causes inconsistent participation in oral health care especially for young children• Side boxes are helpful• The data demonstrate that as poverty level increases, oral health is negatively affected. <p>No, because...</p> <ul style="list-style-type: none">• Average data can be misleading for disparities

- Are there correlations between certain indicators, especially among race/income/public program eligibility/disease status?
- Need to understand why disparities exist
- Need more information about culture and specific beliefs/traditions

What questions do you have about these data?

- How can we access these (online) to share with stakeholders?
 - All meeting handouts – including the data walk posters – will be posted to the Virginia Oral Health Coalition website: www.vaoralhealth.org.
- Who's educating the community?
- How can people find funding? What are the resources?
- Are there transportation services available? Is the public aware?
- How do we get this information to policymakers?
- How will the data be used to advocate for better dental coverage at the federal, state, and local levels?
- How can we as dental team members help to educate the community about the availability of health coverage and what it covers?
- I wonder what the barriers are that cause these outcomes.
- How was data gathered for certain populations?

Population-Specific Comments

Where comments were made about a specific chart or group of charts, the page number is listed in parentheses. Comments that overlapped were summarized rather than repeated.

Adult Oral Health Bar Charts	Children Oral Health Bar Charts	Medicaid Dental Provider Maps
What most surprises you about this data? Why?		
<i>All charts, pp. 26-34</i> <ul style="list-style-type: none"> • Hispanic adults have lower prevalence of extractions than other racial/ethnic groups 	<i>All charts, pp. 21-25</i> <ul style="list-style-type: none"> • Covered individuals who do not receive care 	<i>All maps, pp. 36-41</i> <ul style="list-style-type: none"> • No Medicaid providers in Charles City County, Surry, or Sussex

<ul style="list-style-type: none"> Adults' lack of access and coverage Covered individuals who do not receive care <p><i>Percentage of Central Virginia Adults (18+) Who Have Lost At Least One Tooth to Decay/Disease, pp. 26-29</i></p> <ul style="list-style-type: none"> Surprised that 34% of high-income individuals (making \$50,000+ annually) had lost at least one tooth (p. 26) High percentage of people with diabetes who have lost at least one tooth compared to overall percentage for region and state (p. 28) 40% of college educated people in the region have tooth loss, which seems high. Are they not getting care? No insurance? (p. 27) So many individuals with less than a high school degree had lost at least one permanent tooth (p. 27) <p><i>Percentage of Central Virginia Adults (18+) with a Dental Visit in the Last Year, pp. 30-31</i></p> <ul style="list-style-type: none"> Surprised at the close percentage of adults 18-44 and 65+, indicating that those folks pay out of pocket or have 	<ul style="list-style-type: none"> So many places where "easy" and important services hover around 50% - they should be much higher. <p><i>Percentage of Central Virginia Third Graders with Tooth Decay by Free Lunch Status, p. 21</i></p> <ul style="list-style-type: none"> More children on free lunch needed urgent care, and more kids in Central Virginia overall had urgent need compared to state <p><i>Percentage of Children (1-20) Enrolled in Medicaid/FAMIS with Any Dental Visit by Race/Ethnicity, p. 24</i></p> <ul style="list-style-type: none"> Hispanic children have higher % of dental visits that other racial/ethnic groups in almost every locality in the region and state overall How many Hispanics are receiving care due to eligibility Under-utilization of Medicaid dental for children <p><i>Percentage of Children (1-20) Enrolled in Medicaid/FAMIS with a Preventive Dental Service by Age & Locality, p. 25</i></p> <ul style="list-style-type: none"> Under-utilization of Medicaid dental for children Low percentage of young children 1-2 utilizing care compared to 1-20 	<ul style="list-style-type: none"> High number of Medicaid dental providers in Emporia There are more providers in some areas with low outcomes than you would think – rural areas – Emporia. Not many providers (or none) in areas with high poverty. <p><i>Medicaid Dental Providers by Percent Population Living in Poverty, p. 37</i></p> <ul style="list-style-type: none"> Percent of population living in poverty was surprising – Sussex >25% pop. below 100% federal poverty line (FPL) Areas like Petersburg & Dinwiddie have high % of pop. in poverty, but low number of Medicaid dental providers <p><i>Medicaid Dental Providers by Total Number of Uninsured Individuals (18+), p. 39</i></p> <ul style="list-style-type: none"> Surprised by the number of providers for 18+ in certain counties Urban areas appear to have more uninsured
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<p>medical condition that prompts payment</p> <p><i>Percentage of Central Virginia Adults (18+) with No Dental Coverage, pp. 32-34</i></p> <ul style="list-style-type: none"> Does 18-64 age group include people with Medicaid limited benefit? (p. 35) The older adults have a higher percentage with no dental coverage (65+). I thought Medicare did have some type of coverage. We think it's related to fixed income, even though issues now might be even more expensive. 	<ul style="list-style-type: none"> Similar utilization rates across all localities for preventive dental care Rural Goochland and Powhatan not seeming to utilize Medicaid benefit for 1-2 year-old children – not surprising, but would like to find ways to encourage areas like this to seek care early Age break down between 1-20. Highlights important information and differentiation between age groups; i.e., a 5 y/o and a 19 y/o have very different health factors affecting them and their usage. Would also allow for more tailored intervention. Importance of education to families who qualify for Medicaid/FAMIS 	
<p>What information is missing? Why is this missing information important?</p>		
<p><i>Pregnant Women</i></p> <ul style="list-style-type: none"> Basic Screening Survey of WIC Pregnant Women not included in oral health data summary for Central Virginia region. Pregnancy Risk Assessment & Monitoring Survey (PRAMS) data is self-reported and contains no dental indicators (mentioned in oral health data summary). 	<p><i>All charts, pp. 21-25</i></p> <ul style="list-style-type: none"> Pediatricians play a role – their education and recommendations to parents encourage early preventive visits. Can Medicaid managed care organizations (MCOs) impact preventive visits? Need more data on ages 0-5. <p><i>Third Grade Children, pp. 21-23</i></p>	<p><i>All maps, pp. 36-41</i></p> <ul style="list-style-type: none"> Where is the mirrored data as it relates to medical Medicaid utilization? Does it compare? Medicaid providers by PCI – dental provider info missing for some counties. Color coding not clear. Should overlay dental providers with transportation availability.

<p><i>Demographics</i></p> <ul style="list-style-type: none"> • Comparison by sex (men vs. women) • It would be interesting to see where the utilization occurs by race/ethnicity, which group(s) is impacted, and what the opportunities are • Detail breakdown on 65+ population, more data on geriatric population in general • Oral health literacy 	<ul style="list-style-type: none"> • Those children not participating in the [Basic Screening Survey of Virginia's Third Grade Children]? • Give trend data • Likelihood of second occurrence of tooth decay once first occurs. Can education be given after first? • Would help to have comparison of children at the school level – rural vs. urban schools • What is the effect of nutrition/sugary beverages? <p><i>Children in Medicaid/FAMIS, pp. 24-25</i></p> <ul style="list-style-type: none"> • Breakdown of where care is being provided and who is providing care (private practice, public health clinics, free clinics, DDS/RDH, or in public schools) • Breakdown of Medicaid utilization by age 	<p><i>Medicaid Dental Providers by Total Number of Uninsured Individuals (18+), p. 39</i></p> <ul style="list-style-type: none"> • Total number of 18+ (%): this misses so many population differences
<p>Do these data help you understand oral health inequities in this region? Why or why not?</p>		
<p><i>Percentage of Central Virginia Adults (18+) with a Dental Visit in the Last Year</i></p> <ul style="list-style-type: none"> • Dental visits lower for individuals with lower income level (p. 30) 	<p><i>All charts, pp. 21-22</i></p> <ul style="list-style-type: none"> • Disparity between kids on free and reduced lunch and those who are not. 	<p><i>All maps, pp. 36-41</i></p> <ul style="list-style-type: none"> • Central region has greater need on many posters for uninsured and providers available • Especially shocking to see the disparity within Henrico – Western Henrico has more access than

<p><i>Percentage of Central Virginia Adults (18+) Who Have Lost At Least One Tooth to Decay/Disease</i></p> <ul style="list-style-type: none"> Diabetes greatly increases risk of tooth loss (p. 28) 		<p>Eastern and that pulls the whole county down. Why is there such a disparity within the county?</p> <ul style="list-style-type: none"> Yes, but there is a lot going on underneath, such as travel distances, population at base.
<p>What questions do you have about these data?</p>		
<p><i>Racial/Ethnic Disparities</i></p> <ul style="list-style-type: none"> What is the role of the immigrant paradox (phenomenon where first-generation immigrants have better health outcomes than their children)? What population of Hispanics really have access to dental care? Does it include undocumented immigrants? What role do language/cultural barriers play in access to dental care in the region? (E.g., do some Hispanics not seek care due to documentation status, afraid to register or not understanding paperwork?) <p><i>Age Group Disparities</i></p> <ul style="list-style-type: none"> How do adults 65+ who have higher rates of being dentally uninsured have 68% with a dental visit in the last year? 	<p><i>All charts, pp. 21-25</i></p> <ul style="list-style-type: none"> Some charts specified a “dental visit” – were these preventive visits? Pain visits? <p><i>Percentage of Children (1-20) Enrolled in Medicaid/FAMIS with Any Dental Visit by Race/Ethnicity, p. 24</i></p> <ul style="list-style-type: none"> Pie charts were a little confusing What population of Hispanics really have access to dental care? What factors are behind Hispanic percentage being highest for Medicaid usage? How does Medicaid utilization breakdown by age (not just 1-2 and 1-20 age groups)? Is there more information for kids with untreated decay? Why don’t more providers accept Medicaid/FAMIS? 	<p><i>All maps, pp. 36-41</i></p> <ul style="list-style-type: none"> Why so many Medicaid dental providers in Emporia? Do individuals living in Sussex and Surry travel to Emporia for care? Why are there such poor outcomes in Emporia if they have the most Medicaid providers? If Petersburg has such poor outcomes, how come we have the fewest Medicaid providers? How can we get more provider/government funding? How do you find dental providers who accept Medicaid? Some accept it but it’s not advertised. <p><i>Medicaid Dental Providers by Percent Non-White Population, p. 36</i></p> <ul style="list-style-type: none"> I’m not sure what this is conveying

<ul style="list-style-type: none"> How do we provide additional support for the elderly (retired) community? <p><i>Dental Coverage</i></p> <ul style="list-style-type: none"> Any info on employer-provided dental coverage in conjunction with income level? Data on mobile oral health care providers? 	<ul style="list-style-type: none"> Are there going to be initiatives to educate parents to help them navigate Medicaid system for their children? This is not an easy process. <p><i>Early Childhood</i></p> <ul style="list-style-type: none"> Childcare at home vs. Early Head Start data – oral health awareness? Training? Do we have data? 	<p><i>Medicaid Dental Providers by Total Number of Uninsured Individuals (18+), p. 39</i></p> <ul style="list-style-type: none"> Uninsured individuals should be represented by a percentage instead of a count per locality to better understand.
<p>Do these data remind you of any personal or client experiences/anecdotes that you’ve seen in your work? Please share, if you are comfortable.</p>		
<ul style="list-style-type: none"> Years ago, I worked in an Intensive Care Unit (ICU) where a young African American man was admitted with breathing difficulty and a tooth abscess. He ended up passing away after turning septic. So sad. – <i>Nurse</i> As a dentist at the only community health center in Petersburg with a dental department, I see on a daily basis that folks have a hard time getting in for an appointment. So access is an issue. Folks in Petersburg could really benefit from another dental provider or group that accepts Medicaid. – <i>Safety net clinic dentist</i> We know that seniors over 65 have little to no coverage. Need to 	<ul style="list-style-type: none"> Children of Hispanic origin (undocumented) have no access to dental insurance, therefore dental needs are unmet. – <i>Public school nurse</i> We struggle with kids 1-10. Drop-off after age 8 is huge and visits by 1 as well. – <i>Safety net clinic dental provider</i> Parent wanting child to have dental care in school setting because she had no access to care. – <i>Mobile dental care provider</i> I have had to transport clients to another locality/health district for service. – <i>Home visiting service provider</i> 	<ul style="list-style-type: none"> I am always bothered with the disparity between Western Henrico and Eastern Henrico. I didn’t see that represented. – <i>Researcher</i>

<p>improve that. They are all living longer and the need is there. – <i>University administrator</i></p> <ul style="list-style-type: none"> • One woman seen at an office visit used fake fingernails to serve as her front teeth because she had none and could not afford dental care. – <i>Dental hygienist at senior living community</i> • In my former job, I worked with adult clients (Medicaid) in need of dental insurance. Because they were unable to afford preventive dental care, they ended up having to have all teeth pulled before the age of 40. – <i>Medicaid agency employee</i> • When presenting dental health and chronic disease info to seniors and caretakers, 100% of comments and questions are about coverage. Frustration about no Medicare coverage for dental. – <i>Health department employee</i> • We have different “younger adult” data that would contradict some ethnicity data presented in certain demographics. Probably due to black and white races in health exchanges. – <i>Dental hygienist at safety net clinic</i> 	<ul style="list-style-type: none"> • WIC education to pregnant women and parents with infants about prevention and care – so important to start early! – <i>Local health department health educator</i> • Preventive care during pregnancy for mothers is a struggle. Consequently, health care must start with mothers. – <i>Head Start program</i> • Pregnant teens had coverage, but had not accessed it until really urgent care was needed. – <i>Home visiting program manager</i> • I know I’m tired of seeing kids with more metal in their mouths than war veterans who got hit with shrapnel. – <i>Insurance company outreach person</i> 	
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Compiled Responses from Population Group Discussions

Prompt 1

Taking into account the regional snapshot you saw, the context of your work and experience, relevant health indicators, and the unique needs of your population:

1. Identify one critical priority that, when addressed, will create enduring change for the oral health of your population. E.g., "Increase the percentage of African American children in Greater Richmond and Petersburg who have dental sealants."
2. Frame that issue as an outcome statement; e.g., "By 2022, the sealant prevalence among African American third grade children will improve by 5% in the Greater Richmond and Petersburg area."

Prompt 2

Building on the priority you have been discussing, answer the following questions together:

3. What is already working well in our region to address this priority issue?
4. What is missing? If nothing is currently happening in this region, what examples elsewhere might inform our work?
5. Identify 1 or 2 high-level strategies that address the barriers surrounding the priority you identified. These strategies can build on existing efforts identified in question 3, or they can fill gaps addressed in question 4. E.g., "Identify school districts in the Greater Richmond and Petersburg area that would benefit from partnerships to implement school-based dental care."

Children ages 0-5 & pregnant women (group 1)	<ol style="list-style-type: none">1. Priority: Utilization of preventive dental visits and services (e.g. fluoride varnish) by young children is low.2. Outcome statement: By 2022, increase the number of Medicaid pediatric providers applying fluoride varnish to 25% from baseline of 5% in 2014-2015.3. What is working well:<ul style="list-style-type: none">• Free CE re: fluoride varnish for all office staff• Create a mechanism for referrals4. What is missing:<ul style="list-style-type: none">• Expansion of activities to address barriers like: limited provider education around options to integrate oral health with medical (e.g., reimbursement available in Medicaid for fluoride varnish).5. Strategies:
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	<ul style="list-style-type: none"> • Increase awareness among families that kids and pregnant women have a comprehensive dental benefit in Medicaid • Ensure pregnant women know dental care is safe and necessary during pregnancy • Increase utilization of the preventive dental benefit through medical-dental collaboration, incentives, and increased awareness of transportation services, etc.
Children ages 0-5 & pregnant women (group 2)	<ol style="list-style-type: none"> 1. Priority: Pregnant women are unaware of the importance of oral health for young children; begins from conception and continues after child is born. 2. Outcome statement: By 2022, increase the percentage of pregnant women with a dental visit to 50% from a baseline of 44% in 2010-2011. 3. What is working well: <ul style="list-style-type: none"> • Programs targeting parents <ul style="list-style-type: none"> ○ Preterm birth classes at subsidized housing Resource Centers ○ Bootcamps for dads • Co-located, integrated model of primary care, OB/GYN, and dental services (e.g. CrossOver free clinic) 4. What is missing: <ul style="list-style-type: none"> • Baseline survey of pregnant moms' knowledge/awareness of a) importance of oral health for selves and young children, and b) services available (e.g. comprehensive Medicaid dental benefits) • Additional use of informational materials (e.g., pamphlets, waiting room videos) • Effective patient navigation services • Financial incentives for providers (especially physicians in large health systems) to practice oral health integration, screening/assessment, prevention • Tracking of the percentage of pregnant women that return for a follow-up visit after initial consult; roll off Medicaid benefits at 60 days post-partum 5. Strategies: <ul style="list-style-type: none"> • OB/GYN visits <ul style="list-style-type: none"> ○ Providers incorporating parent education on importance of mother's dental visit and age 1 dental visit for child

	<ul style="list-style-type: none"> ○ Provider incentives through value-based payments for outcomes; currently most VBP arrangements target older adults with chronic diseases rather than groups like pregnant women. ○ Integrate oral health into providers' electronic health records (EHR) • Culturally competent care <ul style="list-style-type: none"> ○ Education for providers to increase cultural competency to reduce language/cultural barriers • Patient engagement and navigation <ul style="list-style-type: none"> ○ Streamline process to find providers – collaborate closely with Department of Medical Assistance Services (DMAS) ○ Utilize community health workers (CHWs) and lay health promoters
Children ages 0-5 & pregnant women (group 3)	<ol style="list-style-type: none"> 1. Priority: Pregnant women – increase the utilization of dental services. 2. Outcome statement: By 2020, increase by 5% the number of pregnant women who utilize dental services. 3. What is working well: Community health workers to include early childhood home visitors, local community action groups, resource centers (housing projects) and church health ministries. 4. What is missing: Coordinated campaign focused on the utilization of dental benefits by pregnant women. 5. Strategies: Identify areas for disseminating information (through PSAs) about utilization of dental services during pregnancy to include: churches, radio stations, community groups, OB/GYN providers, WIC, health departments.
Children ages 0-5 & pregnant women (group 4)	<ol style="list-style-type: none"> 1. Priority: Increase the educational awareness among low-income Medicaid population. Barriers: finding providers, training of students/residents, OB/GYN-dental provider connection, transportation. 2. Outcome statement: By 2022, there will be a 25% increase in educational awareness among pregnant women about the Medicaid dental benefit and importance of dental care. 3. What's working well: <ul style="list-style-type: none"> • Education of providers, such as OB/GYNs and childcare professions • Pre-service training • Home visiting education • Educational pamphlets working (in dental safety net clinic) 4. What's missing:

	<ul style="list-style-type: none"> • Online services (text-for-babies) • DentaQuest – app to find providers <p>5. Strategies:</p> <ul style="list-style-type: none"> • Identify online and other resources already available • Identify partners like DentaQuest, Division of Childcare • Utilize VDH Live Well site, Facebook, other social media
Children & adolescents ages 6-18 (group 1)	<p>1. Priority: Increasing preventive dental sealants among school-age children.</p> <p>2. Outcome statement: Every year for the next five years, have all parental consent for school-based sealants in schools where free/reduced lunch is $\geq 50\%$.</p> <p>3. What is working well: Didn't get to discuss.</p> <p>4. What is missing: Identify champions in schools like school nurses, superintendents, parent-teacher org leadership</p> <p>5. Strategies:</p> <ul style="list-style-type: none"> • Foster collaboration within each school to make dental sealants a social norm (principals, nurses, teachers, parent-teacher organizations, etc.) • Foster friendly competition within and between regions by sharing outcomes data that identifies most successful schools/counties and least successful (maybe with a prize; e.g., cash prize).
Children & adolescents ages 6-18 (group 2)	<p>1. Priority: Ensure children entering kindergarten have dental exam and that families are educated about oral health importance and prevention practices.</p> <p>2. Outcome statement: By 2022, Code of Virginia regulations shall require children entering kindergarten to have a dental exam and shall require all Virginia public school students grades 1-6 and their parents to receive oral health education. (Education = prevention & health-related complications.)</p> <p>3. What is working well: Didn't get to discuss.</p> <p>4. What is missing:</p> <ul style="list-style-type: none"> • Help parents maneuver the barriers to get their kids to care • Education/awareness – what age/when to go • Health literacy – good brochures and flyers aren't always enough; people need to be able to understand what they're reading • Population of 2nd generation immigrants don't qualify for coverage

	<ul style="list-style-type: none"> • Oral health is at the bottom of people's list of priorities • No requirement for dental amongst other health requirements for entering school, and that overall health requirement only happens entering kindergarten <p>5. Strategies</p> <ul style="list-style-type: none"> • Sealants, etc. should be attached to other school requirements • Consent forms for schools need to be in several languages • Need a mobile van at schools and in neighborhoods outside of normal dental office hours • Add oral health to school lessons/get fluoride in schools • Parent education and help navigating the system – kids at certain ages can take responsibility too • Pass a law by: <ul style="list-style-type: none"> ○ Building a grassroots call for the law – poll parents at kindergarten registration day, etc. ○ Recruit providers as part of a grassroots movement – use them as spokespeople when lobbying; they can provide evidence and data. ○ Use technology like text-based education to spread information to parents. ○ Use evidence and data (must collect it first) when lobbying. ○ Lobby! ○ Incentivize increase in providers to meet the demand new law will create.
Children & adolescents ages 6-18 (group 3)	<p>1. Priority: Increase the percentage of Medicaid enrollees in Greater Richmond and Petersburg who are utilizing the dental benefit.</p> <p>2. Outcome statement: By 2020, the Medicaid dental benefit utilization will increase for enrollees of all races by 5%.</p> <p>3. What's working well: Didn't get to discuss.</p> <p>4. What's missing: Didn't get to discuss.</p> <p>5. Strategies:</p> <ul style="list-style-type: none"> • Funding for mobile dental van – VDH – used by Bon Secours • Education to Department of Social Services (DSS) – talking points to inform public about benefit advantages • Transportation for clients

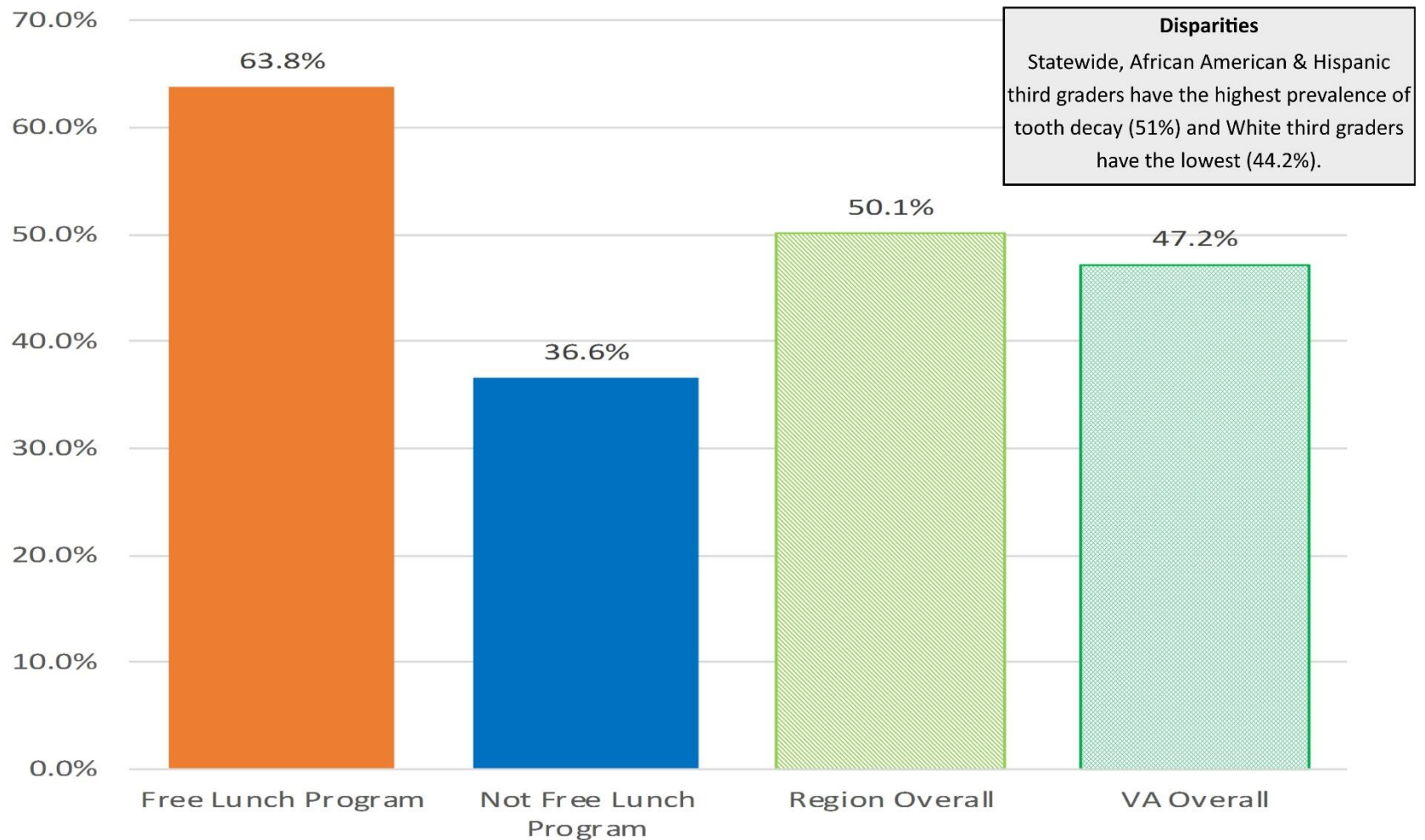
<p>Adults ages 19-64 (group 1)</p>	<ol style="list-style-type: none"> 1. Priority: Establish an adult comprehensive dental benefit in Medicaid and promote the education of its use among the adult population. 2. Outcome statement: By 2019, develop an education campaign for legislators and constituents that contains a cost-benefit analysis of the long-term impact of an adult dental benefit. 3. What is already working well: <ul style="list-style-type: none"> • Virginia Oral Health Coalition • Data collection and aggregation • Report Card • Stories of individuals • EMR visits/medical • American Dental Association & Dental Hygienist Association involvement • Collaboration in health professions 4. What is missing: <ul style="list-style-type: none"> • Integration into health education of practitioners • Mid-level providers to handle increase in need • Expand hygienists' opportunities to become mid-level providers 5. Strategies: <ul style="list-style-type: none"> • Identify legislators in Greater Richmond & Petersburg area to educate and champion the need for an adult comprehensive dental benefit. • Conduct a cost-benefit analysis of data – not sure which data.
<p>Adults ages 19-64 (group 2)</p>	<ol style="list-style-type: none"> 1. Priority: Focus on adults in central Virginia who are not offered health or dental insurance by their employers (or cannot afford the insurance premiums/uninsured) and do not qualify for Medicaid. 2. Outcome statement: By 2027, this adult population will have a 5% increase above the baseline for preventive dental visits. 3. What is working well: <ul style="list-style-type: none"> • Job readiness programs • Dental students • Some low-cost providers: Daily Planet, CrossOver, Bon Secours Care-a-Van

	<p>4. What is missing: Gaps in areas that have dental provider shortages and a lack of referrals to low cost services. Need to get more people to qualify for dental insurance (e.g., expand Medicaid?) and make it affordable. This will include advocacy for coverage and demonstrating that prevention is cost-effective.</p> <p>5. Strategies:</p> <ul style="list-style-type: none"> • Should include motivating our state governments to want to move up on the health rankings • Change the culture of health to include oral health • Expand on programs that are working/resource allocation • Address low literacy of dental health in adults • Help employers understand their options for offering dental coverage to their employees
Individuals with special health care needs	<p>1. Priority: Identifying individuals who need dental assistance</p> <p>2. Outcome statement: By 2022, uniform screening processes are in place across Virginia to ensure individuals needing assistance with preventive oral health practices are identified and provided necessary tools to brush and floss.</p> <p>3. What's working well: Some providers are already</p> <ul style="list-style-type: none"> • Inviting caregiver into conversation from the beginning (in some practices) – taking more time to educate patient and caregiver • Using reflective listening to hear what the needs are of the patient and caregiver, which can act as a screening (Richmond resource centers, CrossOver, etc) • Soft handoffs and close partnerships <p>4. What's missing:</p> <ul style="list-style-type: none"> • Time – ability to do reflective listening and meet the numbers at same time • Human interactions with doctors/dentists – interpersonal connection • Look at other states – safety net, incorporating oral health on automated screens • Educate stakeholders • Community conversations and folks with special concerns – grassroots approaches • Contacting health information channels to include oral care • CHWs – meet with someone before dentist • Uniform booklet/materials to all dental offices – have all hygienists ask patients if they experience challenges brushing teeth • Targeting commercials to folks who need assistance (DSS, other state agencies, hospitals)

	<p>5. Strategies:</p> <ul style="list-style-type: none"> • Uniform question that everyone is asked – whether they need assistance brushing/flossing <ul style="list-style-type: none"> ◦ VaOHC – packet sent to everyone • Educate dental offices so team can better address individuals needing extra support/assistance (not just dentists/hygienists – entire team, possibly including CHWs)
Older adults ages 65+	<p>1. Priority: Data (from adult day centers, nursing homes, assisted living facilities, home) on</p> <ul style="list-style-type: none"> • Need • Cost analysis <ul style="list-style-type: none"> ◦ Emergency department (work with Petersburg hospital) ◦ Prevention • Settings • Transportation <p>2. Outcome statement: By 2020, increase data to be able to improve or raise awareness of need and resources for older adults. Specifically, awareness needed among legislators, providers, residents on the lack of dental coverage and utilization in the older adult population.</p> <p>3. What is working well:</p> <ul style="list-style-type: none"> • Community Health Day in Petersburg <ul style="list-style-type: none"> ◦ Could have participants fill out surveys for data (demographics) • Lucy Corr partners with Petersburg Pathways and visits usually bi-monthly to perform screenings and referrals <ul style="list-style-type: none"> ◦ Collect data ◦ Lifespan education <p>4. What is missing:</p> <ul style="list-style-type: none"> • Staffing for dentists in Petersburg community health Central VA Health Services – registered dental hygienists (RDH) needed <p>5. Strategies:</p> <ul style="list-style-type: none"> • Remote supervision for dental hygienists <ul style="list-style-type: none"> ◦ Teledentistry (smart glasses) ◦ Can collect data, educate • Involve CHWs

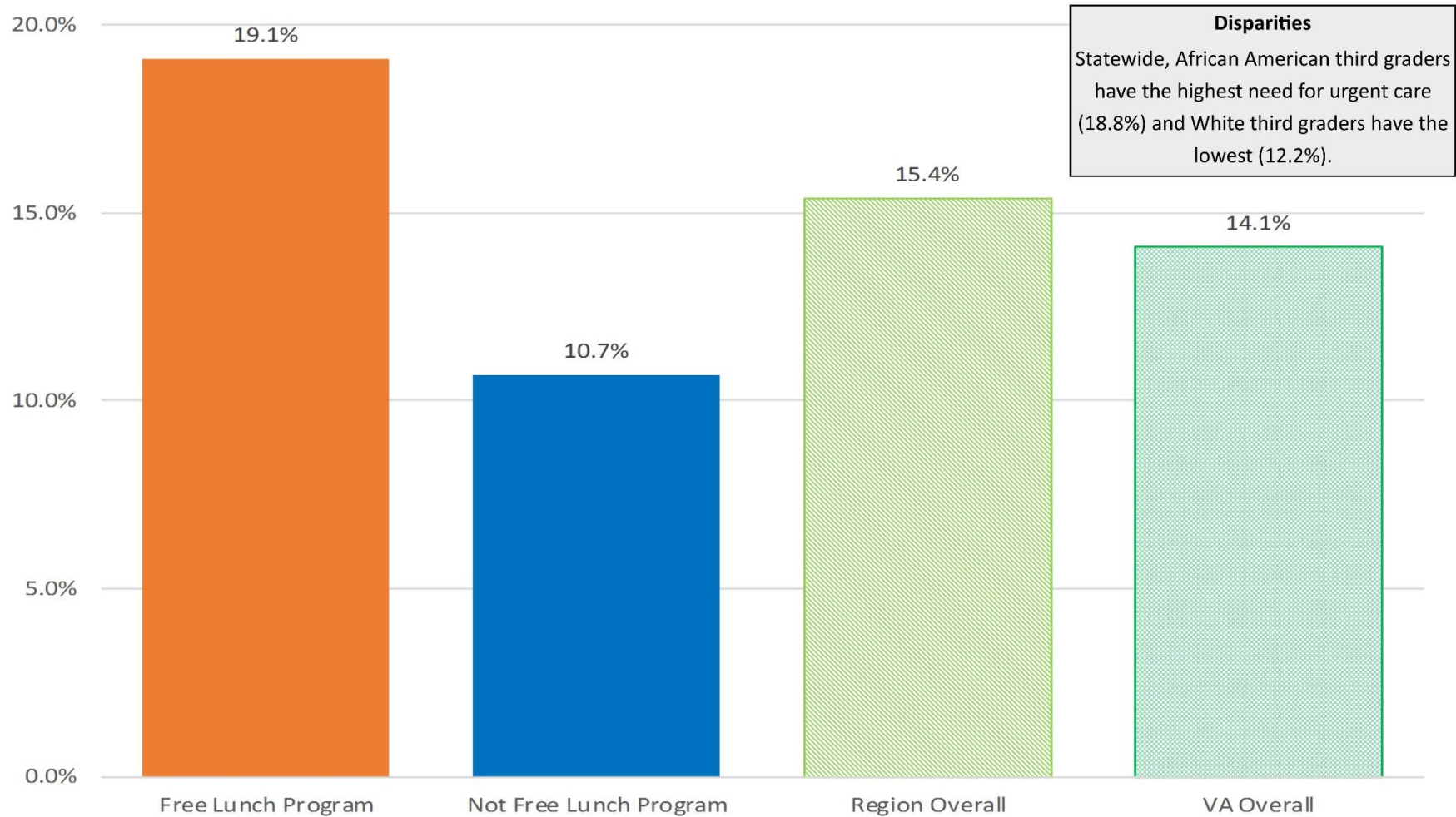
- | | |
|--|--|
| | <ul style="list-style-type: none">○ VDA community dental health coordinators can collect data and educate• Separate committee at VaOHC for older adult dental |
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Percentage of Central Virginia Third Graders with **Tooth Decay** by Free Lunch Status Compared to the Central Virginia Region & State Overall, 2014-2015



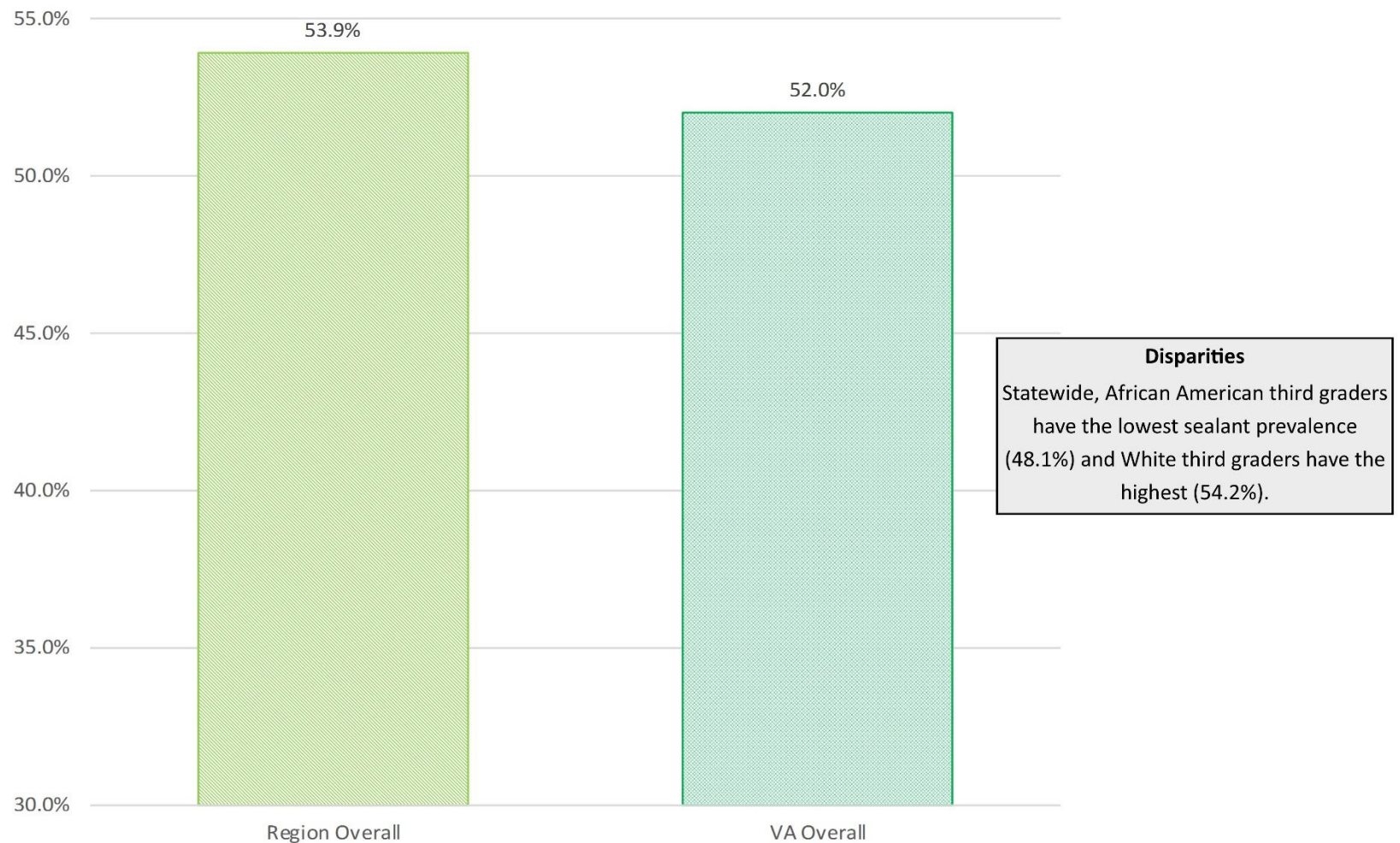
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Weighted for population level estimates.

Percentage of Central Virginia Third Graders with **Urgent Dental Care Need by Free Lunch Status** Compared to the Central Virginia Region & State Overall, 2014-2015



Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Weighted for population level estimates.

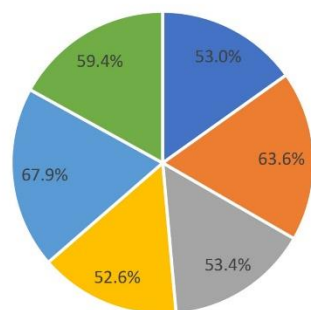
Percentage of Central Virginia Third Graders with **Sealants on Their Permanent Molars** Compared to the Central Virginia Region & State Overall, 2014-2015



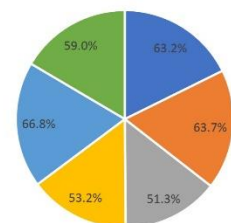
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Weighted for population level estimates.

Percentage of Children (1-20) Enrolled in Medicaid/FAMIS with **Any Dental Visit** by **Race/Ethnicity & Locality, 2014-2015**

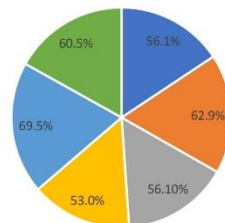
Region Overall



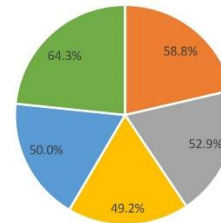
Amelia, Chesterfield, Colonial



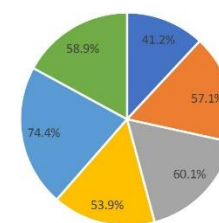
Charles City, Henrico, New Kent



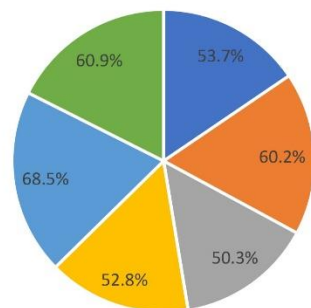
Goochland



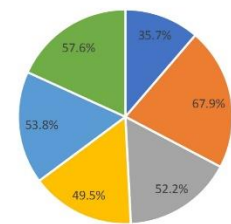
Hanover



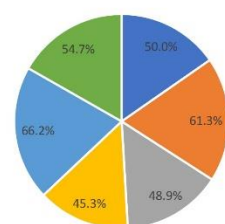
Virginia Overall



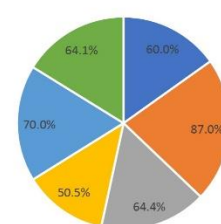
Hopewell City



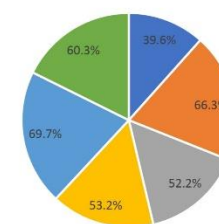
Petersburg City



Powhatan



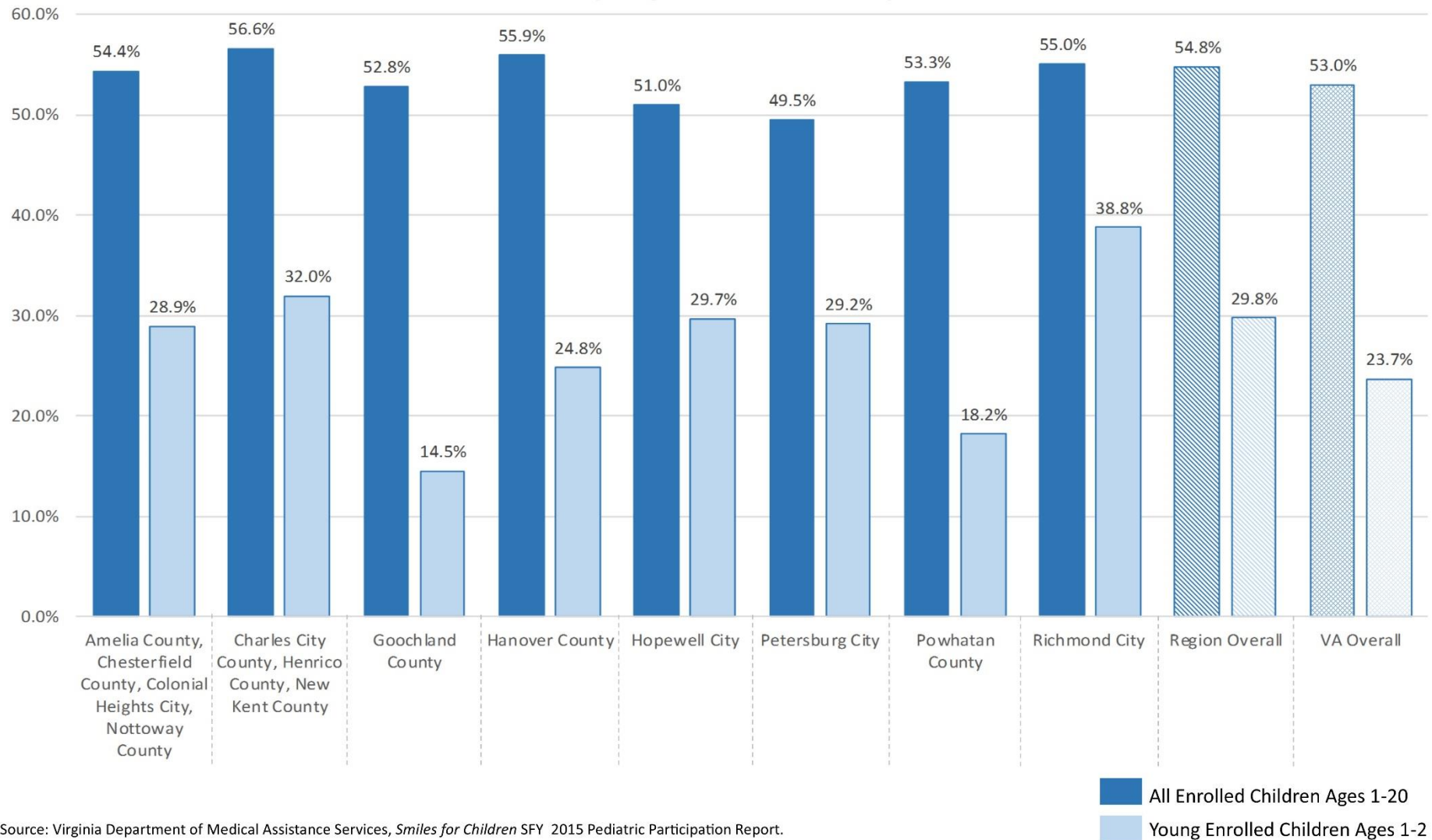
Richmond City



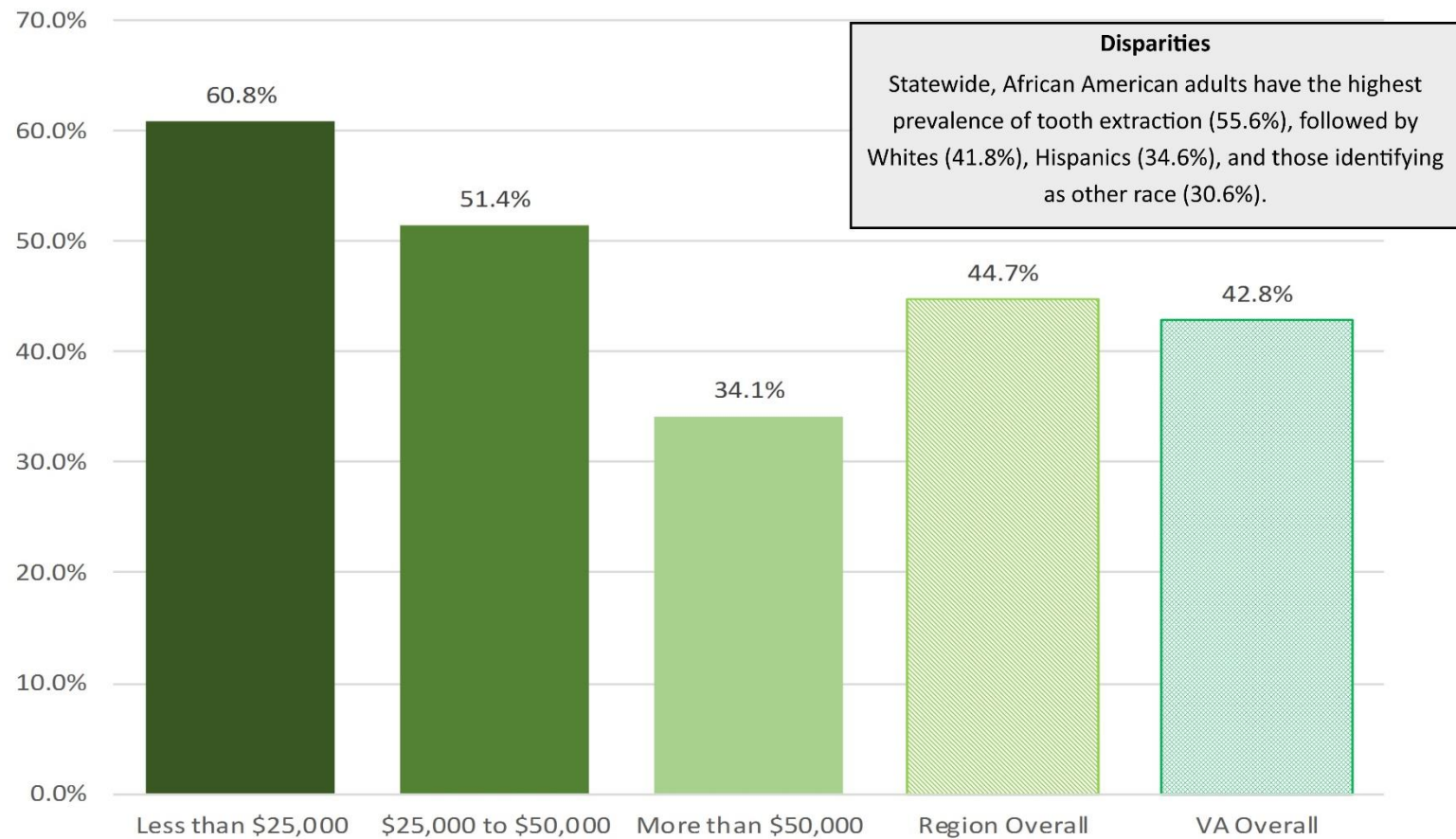
- American Indian or Alaska Native
- Asian or Pacific Islander
- Black
- Caucasian
- Hispanic
- Not provided

Source: Virginia Department of Medical Assistance Services, *Smiles for Children* SFY 2015 Pediatric Participation Report.

Percentage of Children (1-20) Enrolled in Medicaid/FAMIS with a **Preventive Dental Service Visit by Age and Locality, 2014-2015**

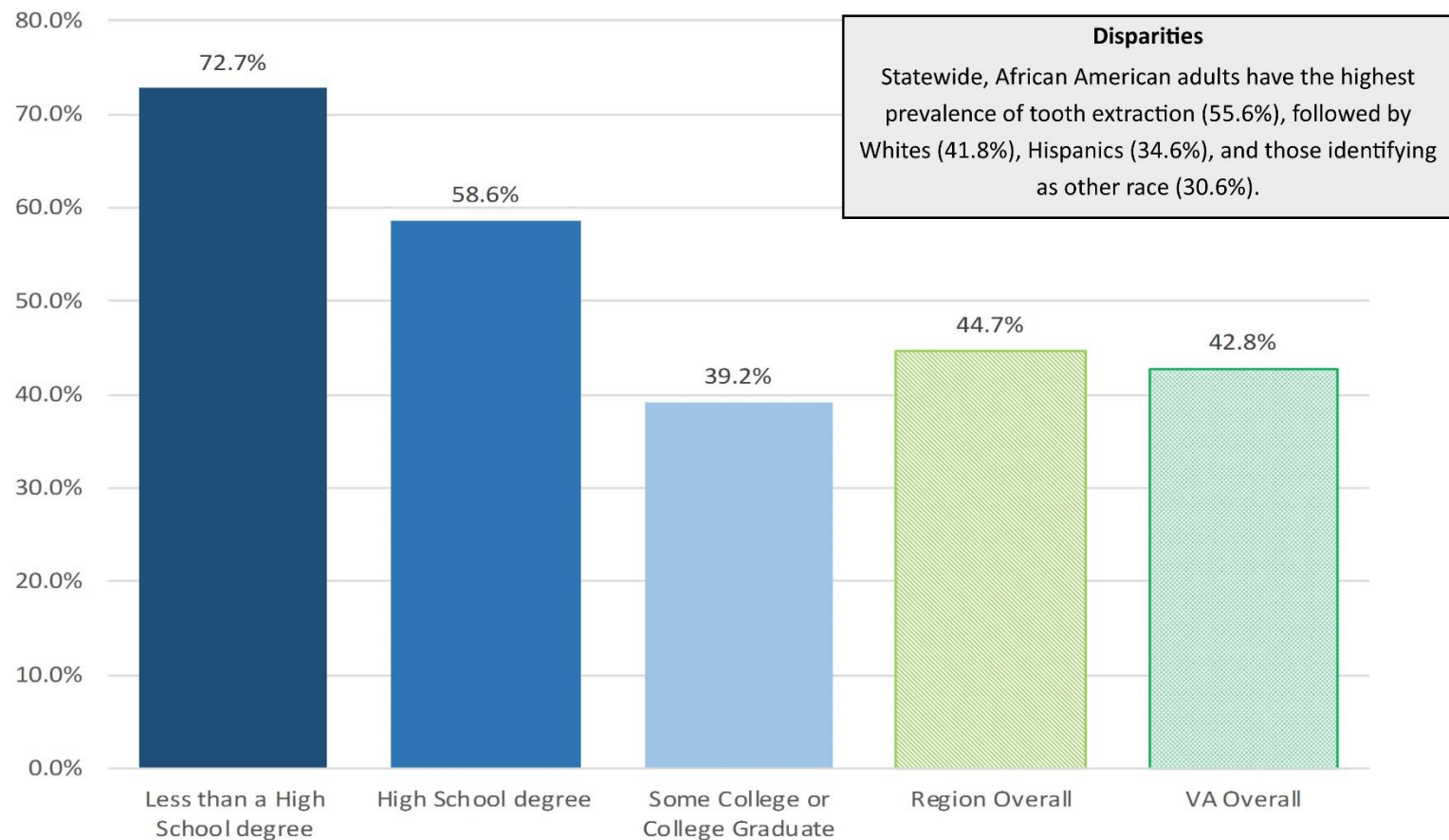


Percentage of Central Virginia Adults (18+) Who Have **Lost At Least One Permanent Tooth to Decay/Disease by Income** Compared to the Central Virginia Region & State Overall, 2015



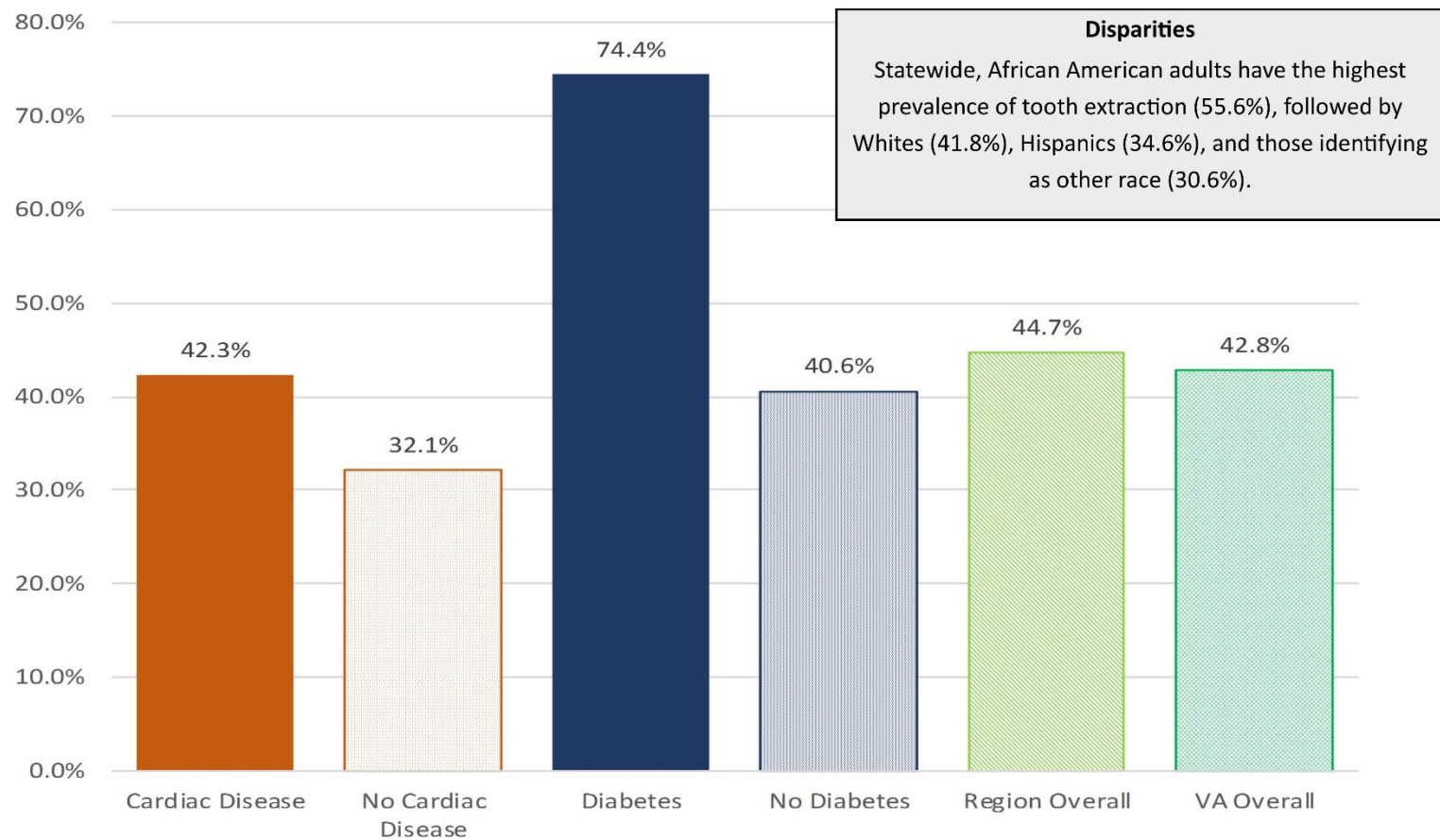
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) Who Have **Lost At Least One Permanent Tooth to Decay/Disease by Education Level** Compared to the Central Virginia Region & State Overall, 2015



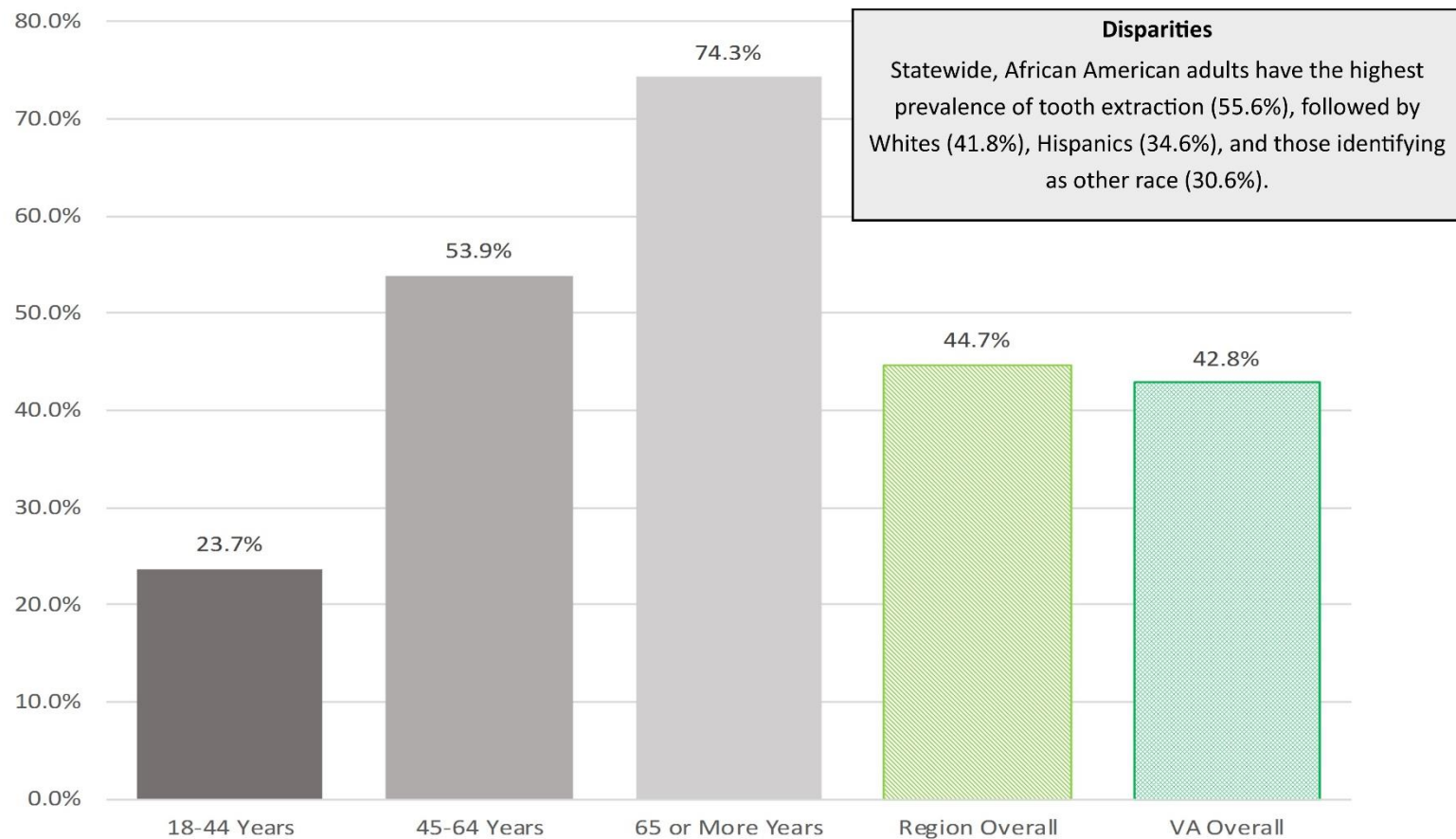
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) Who Have **Lost At Least One Permanent Tooth to Decay/Disease** by Disease Status Compared to the Central Virginia Region & State Overall, 2015



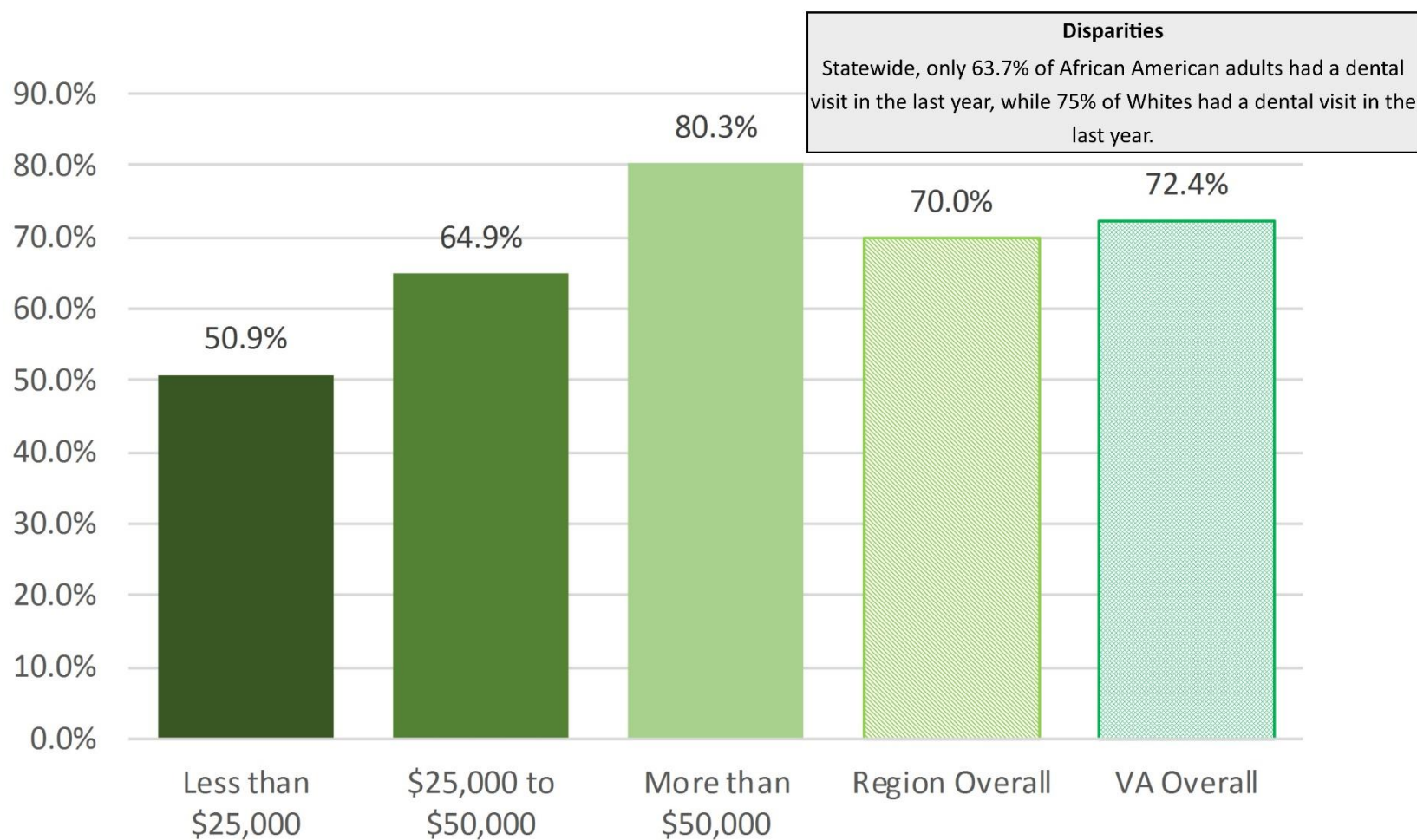
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) Who Have **Lost At Least One Permanent Tooth to Decay/Disease by Age Group** Compared to the Central Virginia Region & State Overall, 2015



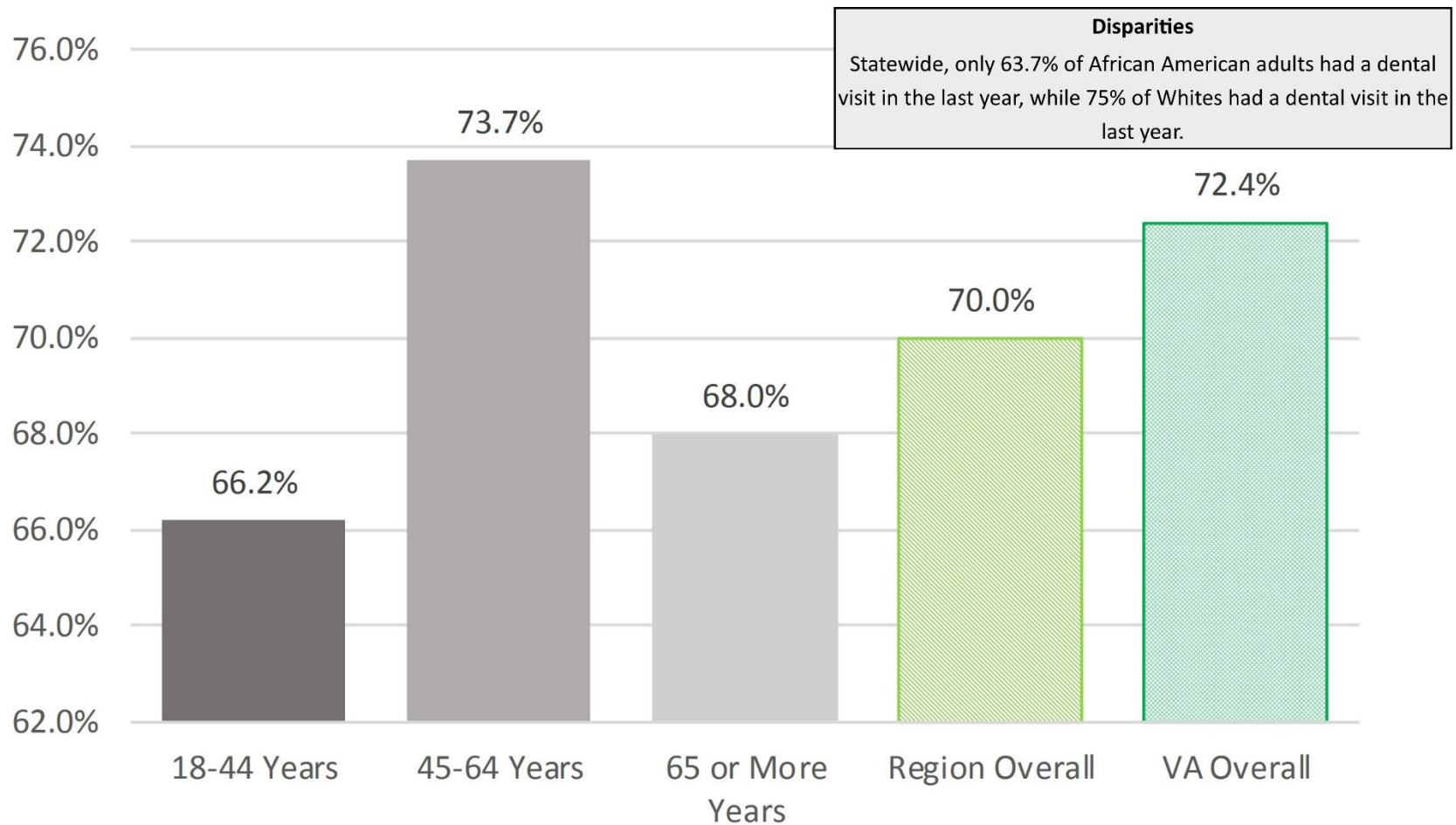
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) with a **Dental Visit in the Last Year** by **Income** Compared to the Central Virginia Region & State Overall, 2015



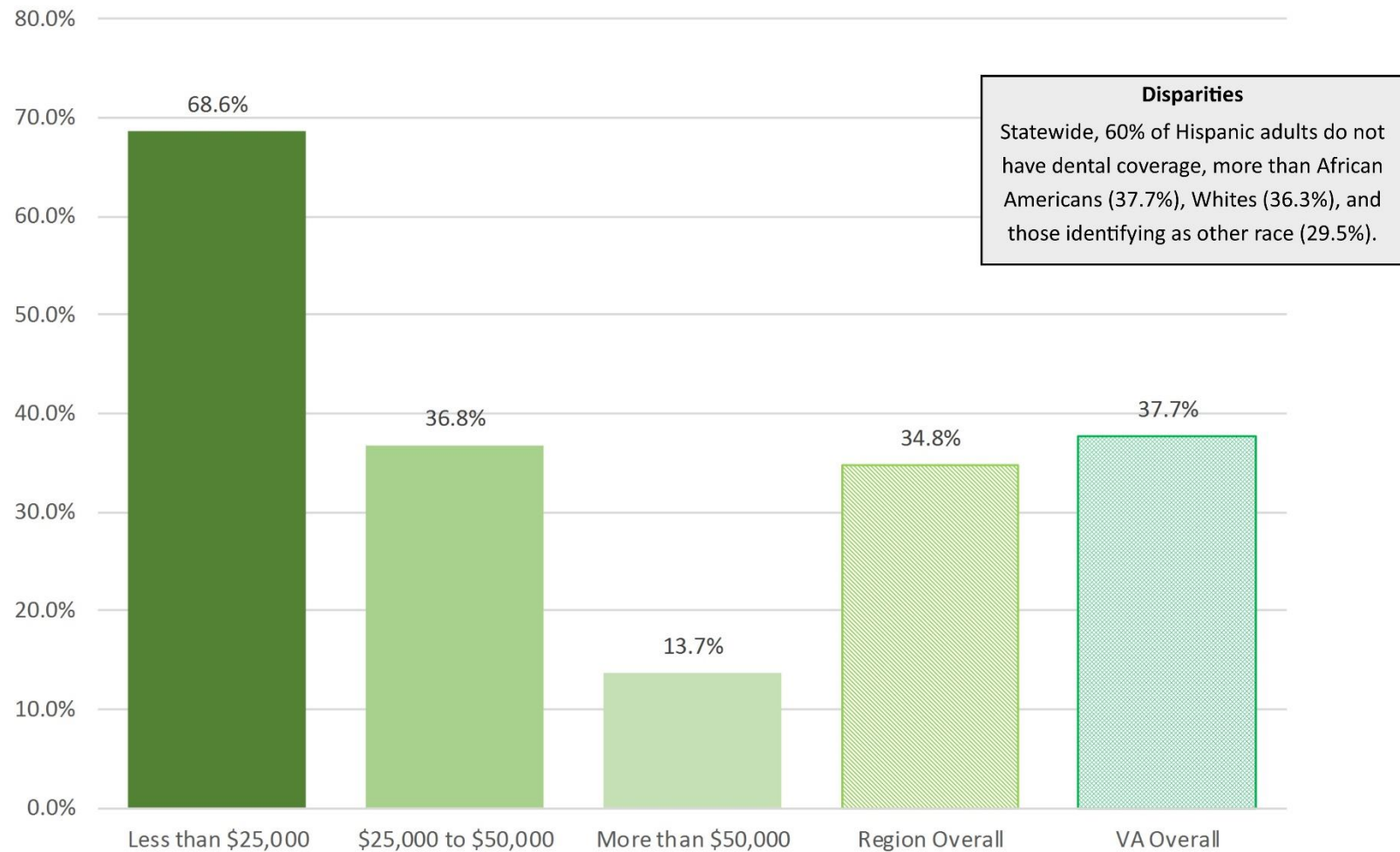
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) with a **Dental Visit in the Last Year by Age Group** Compared to the Central Virginia Region & State Overall, 2015



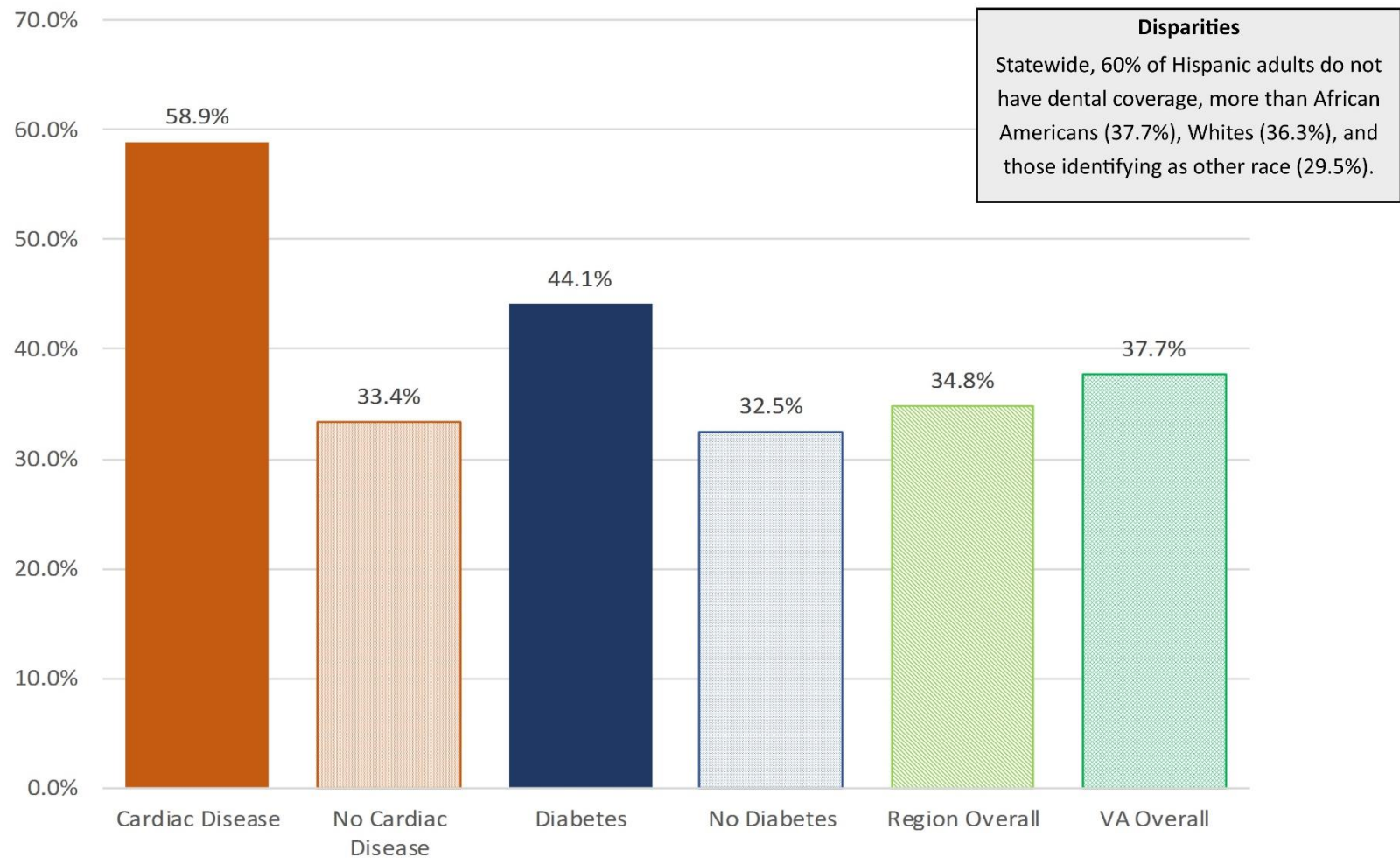
Source: CDC, Behavioral Risk Factor Surveillance System, 2015. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) with **No Dental Coverage** by Income Compared to the Central Virginia Region & State Overall, 2013



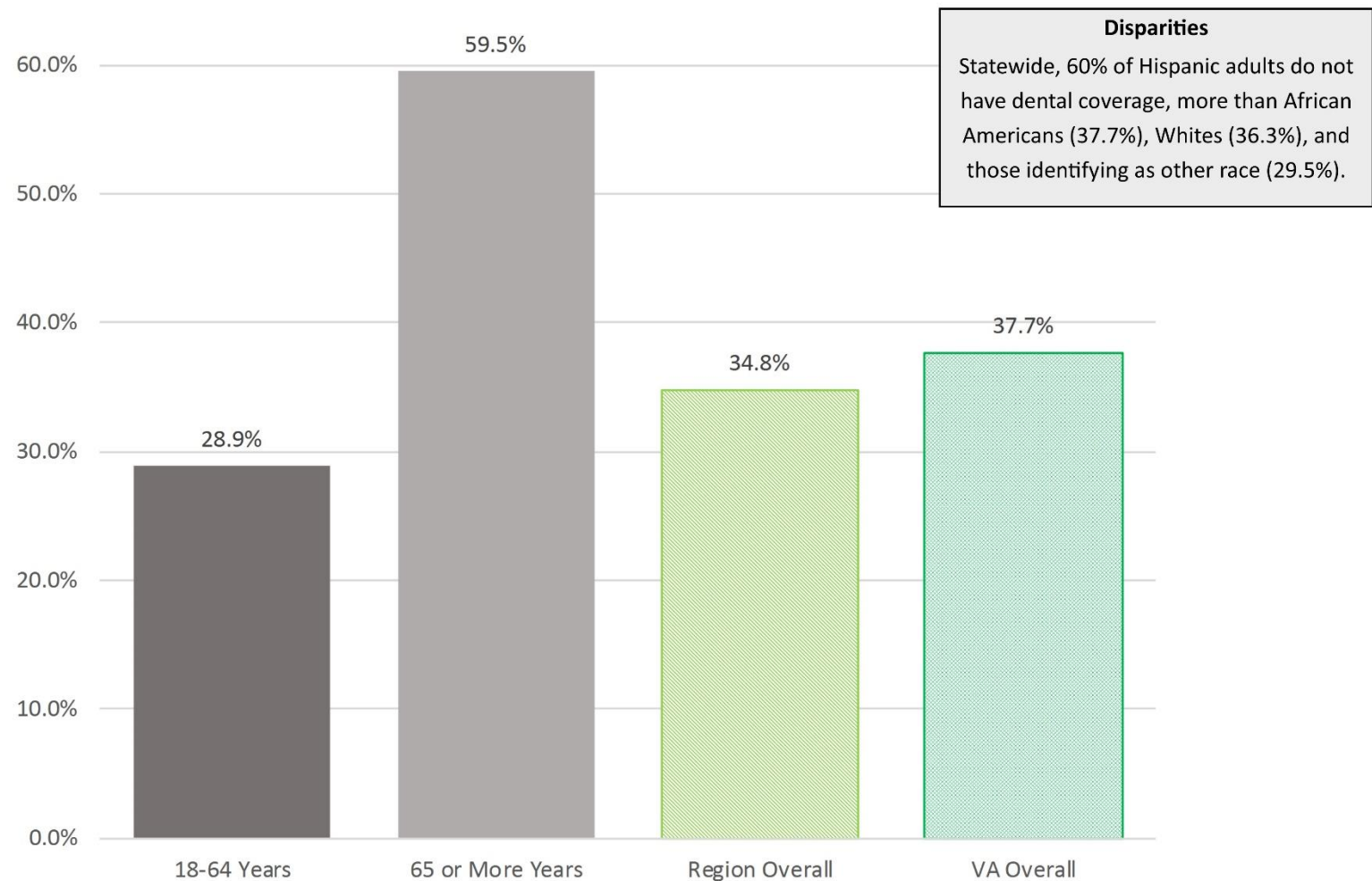
Source: CDC, Behavioral Risk Factor Surveillance System, 2010 & 2013. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) with **No Dental Coverage by Disease Status** Compared to the Central Virginia Region & State Overall, 2013



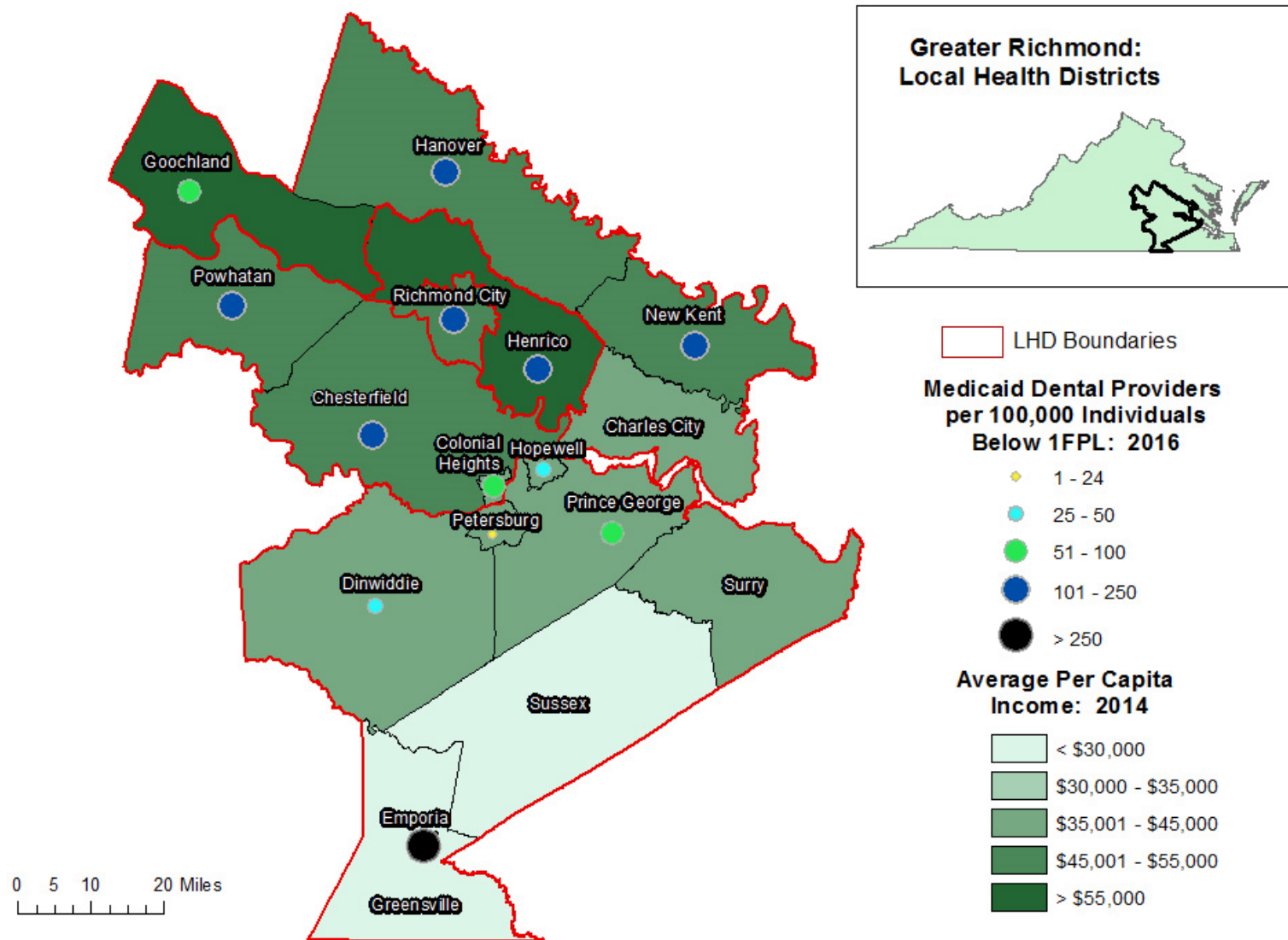
Source: CDC, Behavioral Risk Factor Surveillance System, 2013. Weighted for population estimates.

Percentage of Central Virginia Adults (18+) with **No Dental Coverage by Age Group** Compared to the Central Virginia Region & State Overall, 2013



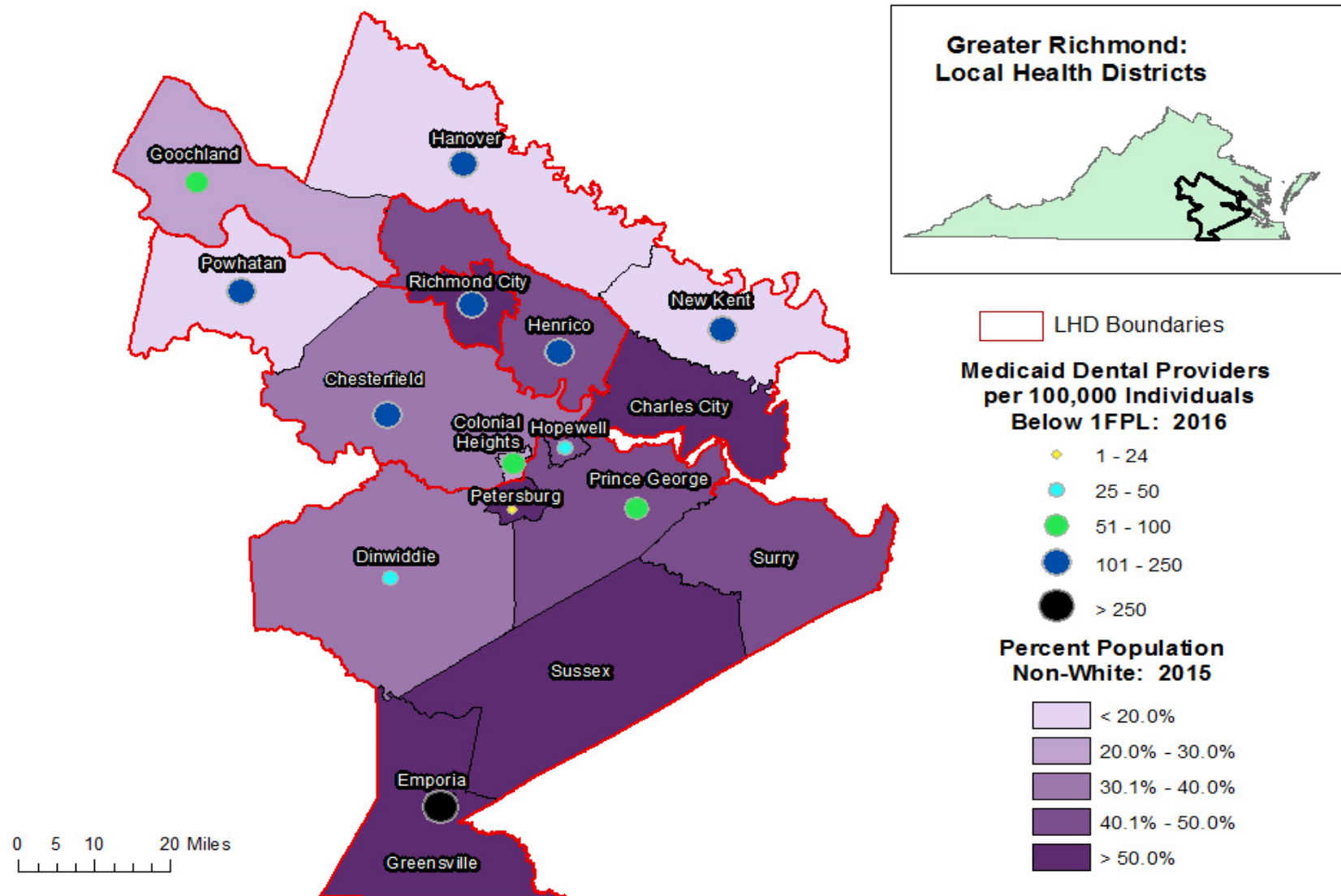
Source: CDC, Behavioral Risk Factor Surveillance System, 2013. Weighted for population estimates.

Medicaid Dental Providers by **Average Per Capita Income**: Greater Richmond Counties and Local Health Districts (LHDs)



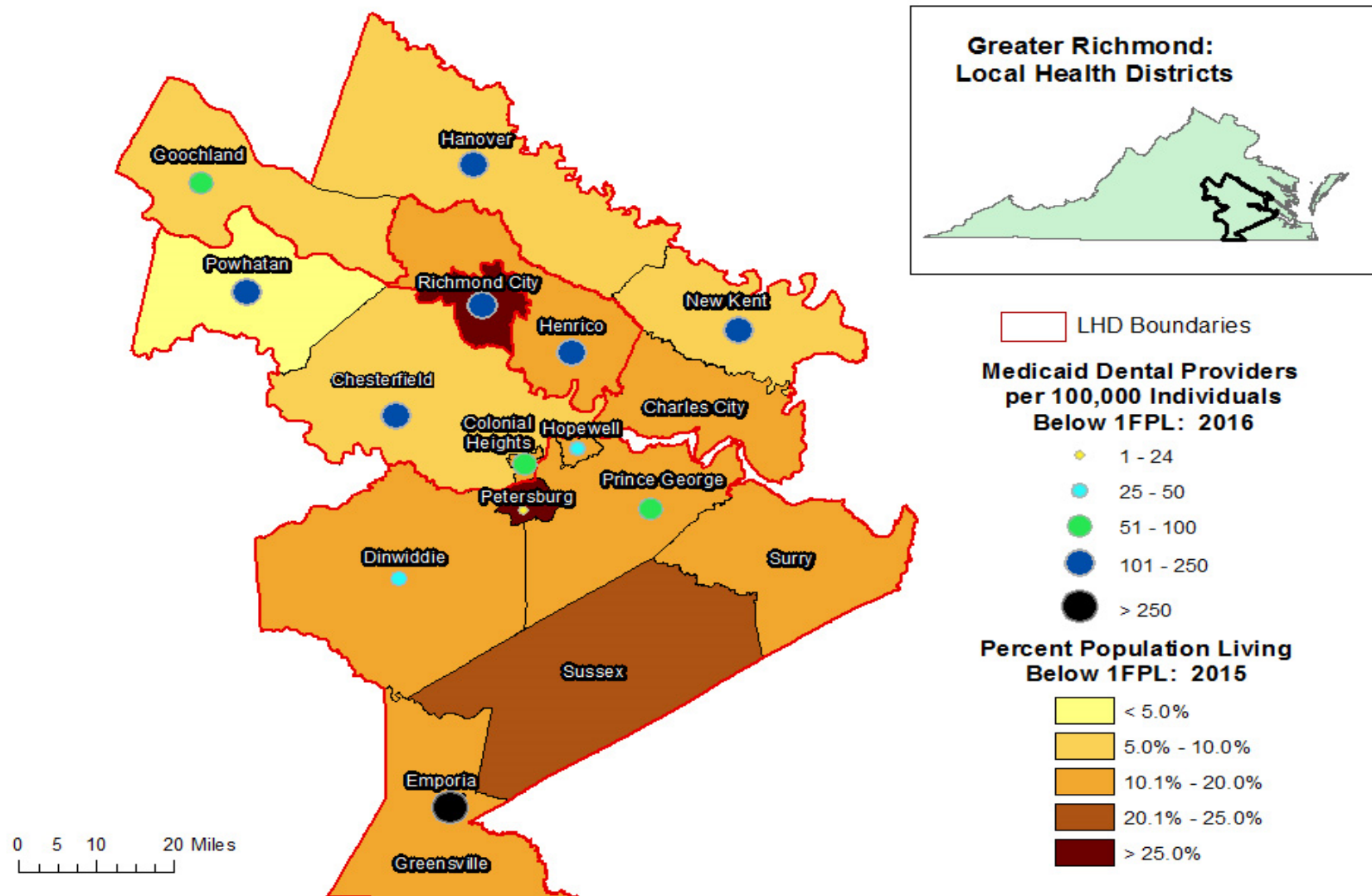
Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Income information: U.S. Bureau of Economic Analysis, 2014.

Medicaid Dental Providers by **Percent Non-White Population**: Greater Richmond Counties and Local Health Districts (LHDs)



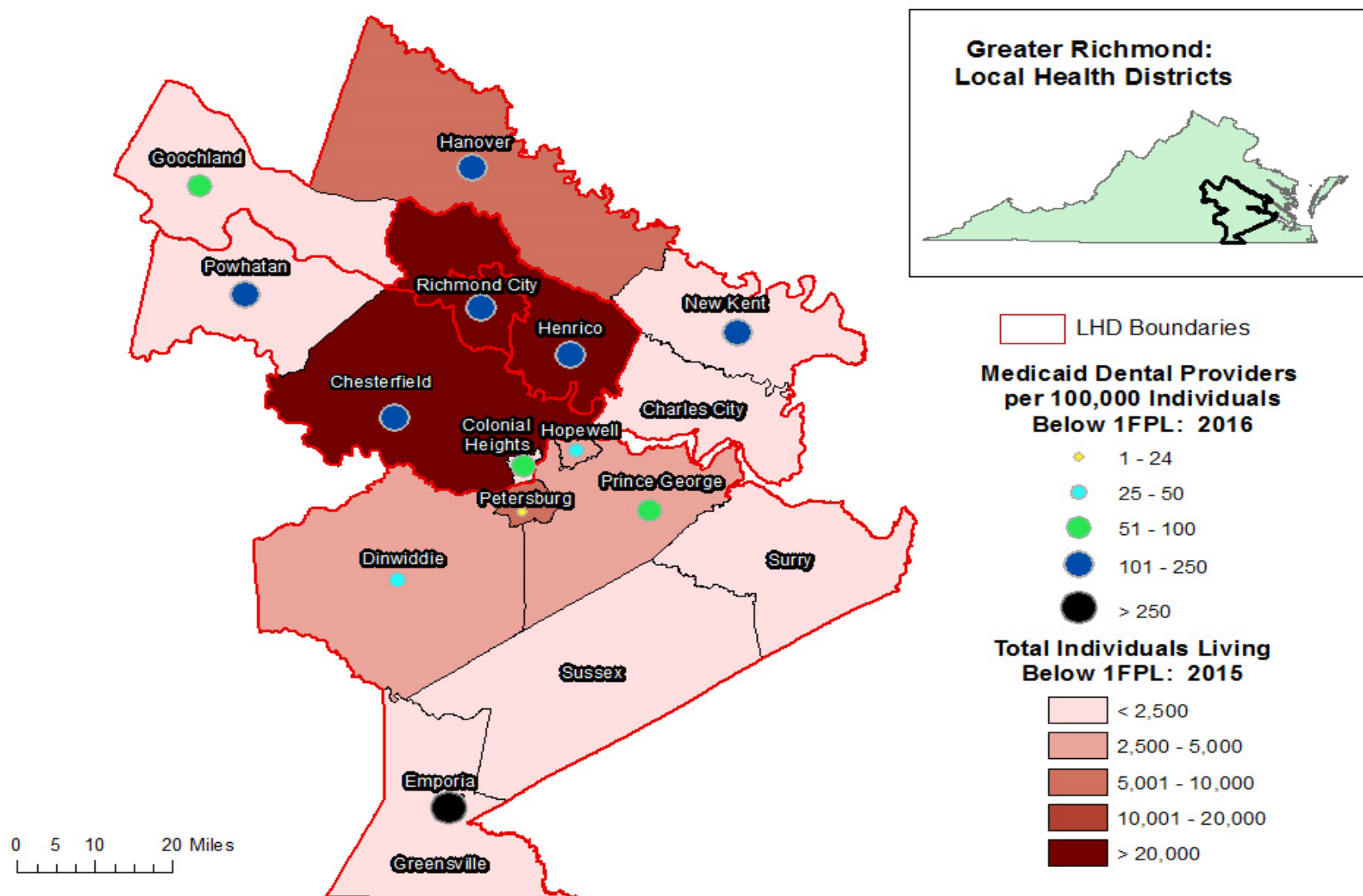
Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Percent Non-White Population information: American Community Survey, 2015.

Medicaid Dental Providers by **Percent Population Living in Poverty**: Greater Richmond Counties and Local Health Districts (LHDs)



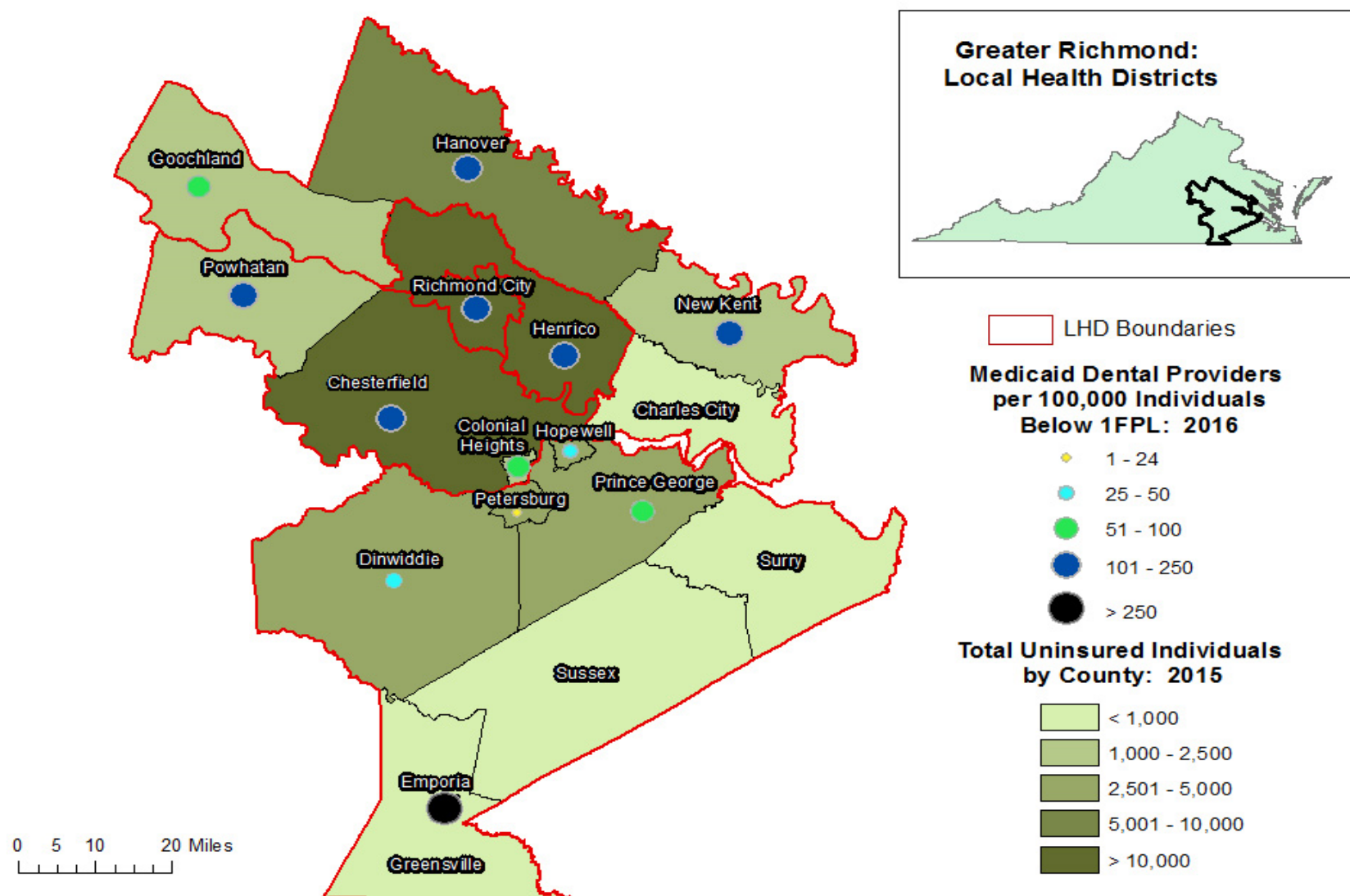
Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Percent population living in poverty information: American Community Survey, 2015.

Medicaid Dental Providers by **Total Number of Individuals Living Below the Federal Poverty Level***: Greater Richmond Counties and Local Health Districts (LHDs)



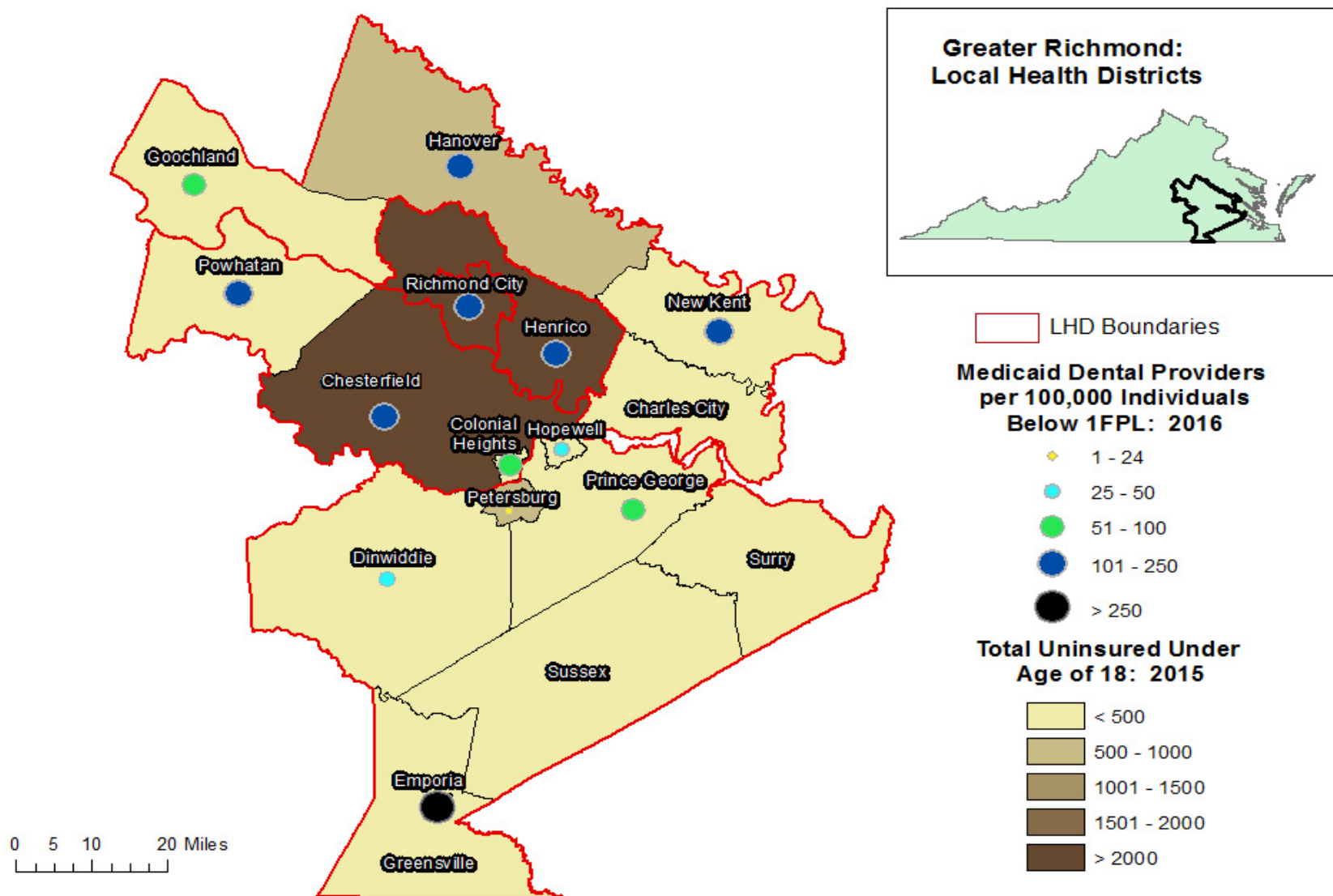
Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Total number of individuals living below the Federal Poverty Level information: American Community Survey, 2015. *The FPL for a family of four in 2015 was an annual household income of \$24,250.

Medicaid Dental Providers by **Total Number of Uninsured Individuals (18+)**: Greater Richmond Counties and Local Health Districts (LHDs)



Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Total number of uninsured individuals (18+) information: American Community Survey, 2015.

Medicaid Dental Providers by Total Number of Uninsured Children Under Age 18: Greater Richmond Counties and Local Health Districts (LHDs)



Source: Medicaid Dental Provider information: Virginia Department of Health Professions & Virginia Department of Medical Assistance Services, 2016. Total number of uninsured children (<18) information: American Community Survey, 2015.