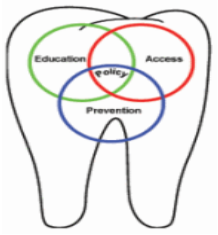
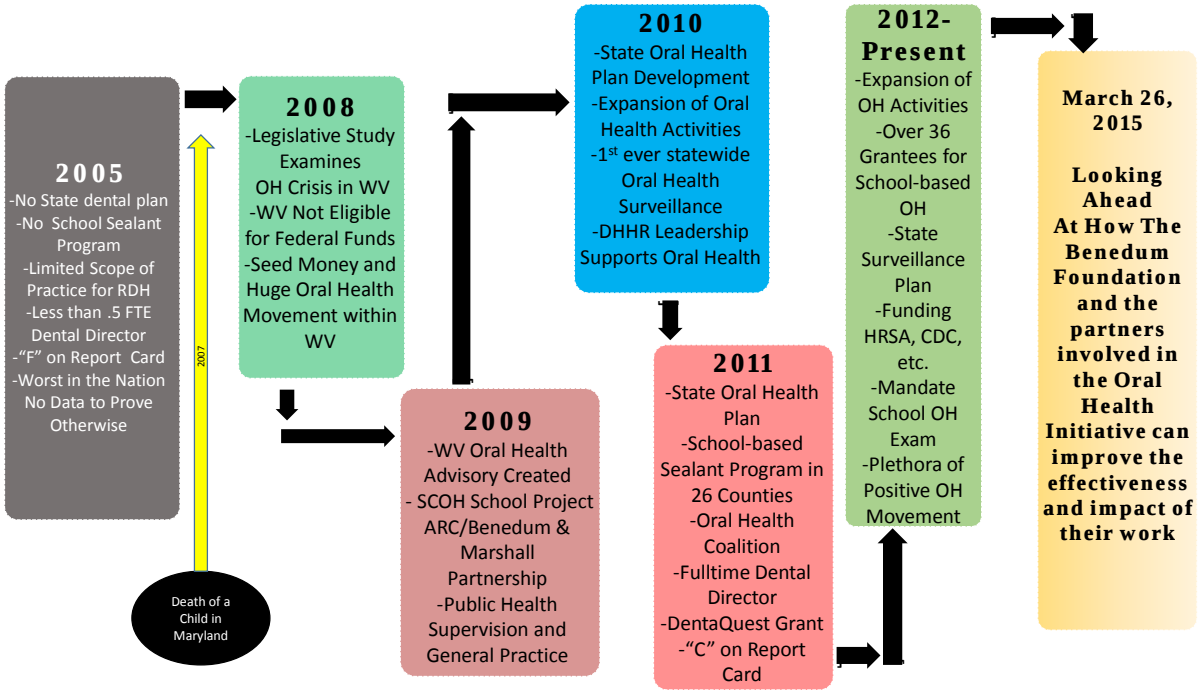


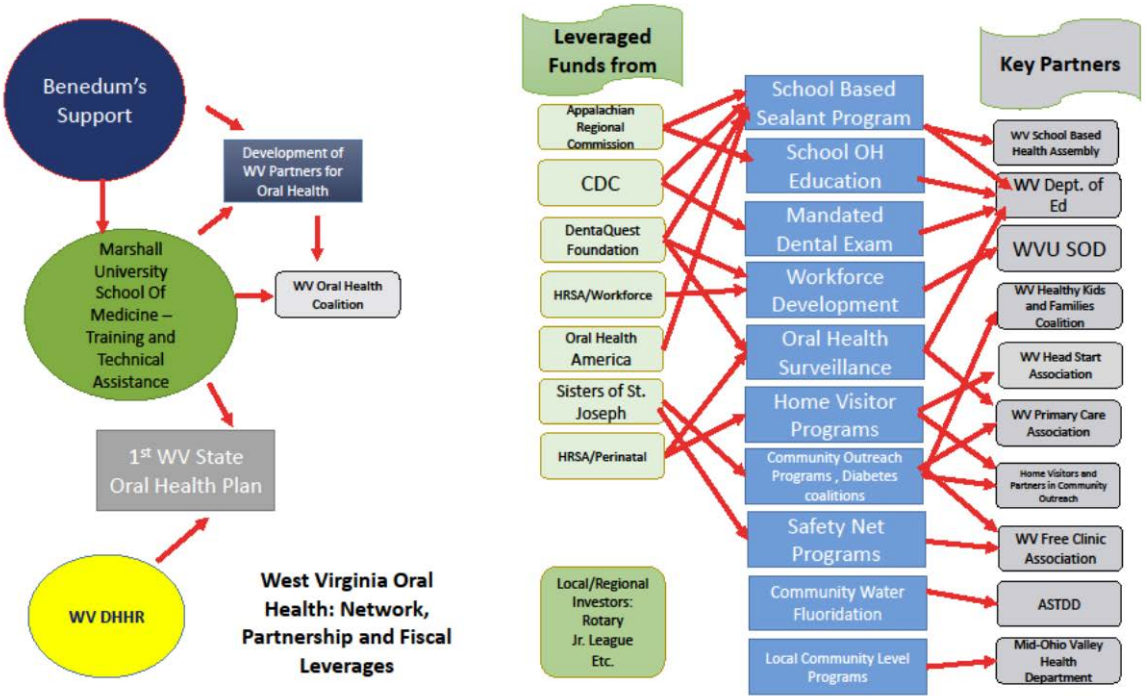
WEST VIRGINIA ORAL HEALTH INITIATIVE

EXECUTIVE SUMMARY

The West Virginia Oral Health Initiative began in 2008 and is anchored in improving the oral health status of West Virginia residents through public awareness, provider training, dental screenings, and access to dental care. The initiative began in 2008 and is anchored in improving the oral health status of West Virginia residents through public awareness, provider training, dental screenings, and access to dental care.



In March 2015, leaders of the initiative and representatives of The Benedum Foundation gathered to discuss lessons learned, the road ahead, and how both parties could improve their effectiveness. What we know is that successful collaboratives are about leveraging resources, knowledge and collective will to achieve an end…with the good fortune of timing, funding and leadership urging them onward. The West Virginia Oral Health Initiative is an example of that formula. It also provides fruitful ground to examine the expansive role of The Benedum Foundation in launching this statewide effort, guiding the work, and positioning the initiative for support by other funders.



The conversation with key leaders yielded the following insights:

1. **The Initiative partners have done a great job organizing at the top and moving the agenda.** Major progress has been made in the area of child oral health in the state.

2. **Little progress has been made for adult oral health**. Largely, the difference between the treatment of children and adults is in relation to the access to care, insurance and affordability.

3. **Medicaid resistance has been very challenging to deal with from the beginning.** To make real change participants felt that they needed to be able to leverage Medicaid resources and also have that agency be part of conversation. Participants felt they had fallen short by not creating a compelling message as to why Medicaid resources should be involved.

4. **In the case of West Virginia, The Benedum Foundation brings credibility and assurance** to other funders and partners, connections, and pivotal funding to spark public action**.** The reputation and credibility of The Benedum Foundation was repeatedly cited as a critical factor in enabling the building of an effective coalition of supporters and participants in the West Virginia initiative,

5. **Knowing the Tipping Point** for an issue. Benedum's program officer and political partners knowing that the timing was right to tee up the Oral Health Initiative was key. Secondly, and equally as important, was Benedum's

willingness to be proactive in investing dollars to jump start efforts to move forward**.**

6. **Not leaving the organizing to happenstance.** Benedum's program officers have played a significant role in assuring collaboration and willingness to work together. By knowing the players and making those introductions to assure success and additional funding opportunities.

7. **Developing a plan that engages key constituents and provides a road map returns great value.** First, people are more willing to participate in the collaborative knowing their opinion is valued. Second, the opportunity to achieve some quick wins builds instant credibility and enthusiasm. Lastly, being transparent and inclusive gives people confidence that there is "not another agenda" at play.

8. **Starting something is easy; staying involved is priceless.** Benedum has had a long tradition of being involved in moving an agenda beyond just providing dollars. Benedum's all in participation on the Advisory Board brings an imprimatur to the high value of the initiative for onlookers and participants.

9. **Little bits of money awarded at the right time can keep momentum going.** Something funders such as Benedum might want to consider; establish a small fund for initiatives such as this to acquire new technology, equipment, and benchmarking trips for direct line service people.

10. **Sometimes funding guidelines make implementing projects difficult.** Things like not funding small equipment such as laptops, out of state travel for networking and information sharing, or funding of multi-year projects.

11. **While participants felt very positive about their collective progress they generally agreed that it was time to set the actual performance bar the state aspires to achieve relative to the people. This initiative will most likely require no less of an effort for the next ten years.** While the initiative has made great strides, a great deal needs to be done before West Virginia has turned the corner on:

    a. Incidence of oral disease including dental caries, tooth loss, periodontal disease, oral and pharyngeal cancer, and cleft lip/palate;
    b. Prevention, including dental screenings, cleaning, sealants, and water fluoridation
    c. Risk factors, including tobacco use, human papillomavirus (HPV), child abuse and domestic violence
    d. Access to care including dental visits, receipt of needed care, reasons for not receiving care, dental insurance, and Medicare and Children's Health Insurance Program (CHIP) claims, and;

e. Dental Healthcare workforce; including dental professionals, school based programs, and community health centers with oral health components.

12. Planning for the future:

a. Setting end game targets. It is really difficult to do this target setting at the creation of a collaboration. Once momentum is created and there is a full appreciation of the landscape surrounding the issue, setting clear targets can be helpful to keeping the initiative focused. Secondly, it gives all stakeholders a shared understanding that all funders will have an exit strategy; as they have limited dollars and multiple requests for support.

b. Periodically look at the constraints and see whether there may be intentional actions to mitigate them. For instance, if the lack of profitability of dental practices is a reality, what could be done to incent sustainable solutions? Or, if messaging to persuade the political leadership that oral health is central to having a healthy workforce, they may consider underwriting a messaging campaign.

What follows is a more detailed historical look at the collaborative and the key points raised during the discussion.

INTRODUCTION

The Benedum Foundation seeks to develop a learning model in which they and a key intermediary or group of grantees can jointly explore how to:

- improve outcomes
- best assess the impact of its grants and the specific interventions

While these sessions obviously are intended to assess performance, it is important to realize that they are structured as a joint exploration of how both they as funders, and the persons doing the direct work, can improve effectiveness. These sessions depend upon open dialog, and criticism of Benedum is entirely appropriate as are questions about grantee performance. However, unlike typical evaluations, the primary purpose is not to assess what has transpired, but instead to determine together what needs to continue, and what might be changed or added, in order to maximize progress.

This report covers session No. 2 which was focused on the West Virginia Oral Health Initiative. The initiative began in 2008 and is anchored in improving the oral health status of West Virginia residents through public awareness, provider training, dental screenings, and access to dental care. The meeting was held at the Charleston Marriott Town Center on Thursday, March 26, 2015. Attendees were:

1) Dr. Jason Roush - West Virginia State Dental Director
2) Dr. Richard Crespo - Marshall University Research Corp (MURC primary oral health grantee and evaluator)
3) Bobbi Jo Muto - MURC – (grantee and West Virginia State Oral Health Coalition board member) School based health center and surveillance
4) Gina Sharps - MURC (used to be at West Virginia University Dental School) - fluoridation and surveillance
5) Dean Borgia – West Virginia University Dental School and dental rotations (grantee)
6) Sister Jane Harrington - West Virginia State board chair of the Oral Health Coalition & West Virginia Healthy Kids and Families
7) Rebecca King – West Virginia Department of Education – School Based Health Centers - Community Schools – West Virginia Oral Health Coalition
8) Patricia Pope – West Virginia Association of Free Clinics (adult and clinical care - grantee)
9) Jackie Newson – West Virginia State Bureau of Children and Families & state home-visiting programs (co-funder with early childhood work and oral health programs)
10) Cynthia Drennan - Executive Director of the Sisters of St. Joseph Charitable Fund (co-funder for the Smiles for Life Program)
11) Benedum Foundation:
    a. Robert Walker, M.D., Trustee;
    b. Pat Getty, President;
    c. Kim Tieman, Program Officer

Facilitator: Kate Dewey, President, The Forbes Funds

WHY ORAL HEALTH?

Oral health is an essential component of overall health and well-being. Oral diseases, whether dental caries, periodontal disease, or oral cancer-- if left untreated-- can result in pain, disability, poor nutrition, and dysfunctional speech, as well as concentration problems, poor appearance, low self-esteem, absenteeism from school or work and premature death. Adults and children alike have unmet dental needs, which influence growth and development and ability to function productively. Oral diseases/symptoms also may be risk factors and/or early indicators of other systemic diseases.

Oral health problems are widespread, largely preventable, often painful and costly. In 2011, $108.4 billion was spent on dental services in the United States. Tooth decay affects more than one-fourth of children aged 2-5 years and one-half of children aged 12-15 years. Gum disease affects a large proportion of adults and advanced stage disease affects four to 12 percent of adults. One-fourth of adults aged 65 and older have lost all of their teeth. And unfortunately, West Virginia placed 3rd in the "Worst States for Oral Health" analysis conducted by Bloomberg analyst in 2012. If it were not for the West Virginia Oral Health Initiative and the partnering agencies, the consultant contends the scores would have been far bleaker. The information below shows the ranking of the 3 worst states which includes West Virginia, the rankings of sister states of Ohio and Pennsylvania, and the Best State which was Connecticut.

Rank	State	Dental health score	Percentage of population living in a dental HPSA	Percentage of adults who visited a dentist in past year	Percentage of seniors with no natural teeth
1	Mississippi	88.4	57.8%	58.1%	27.1%
2	Louisiana	74.6	50.6%	63.9%	25.6%
3	West Virginia	70.2	14.5%	60.5%	36.0%
28	Ohio	34.4	11.2%	71.5%	19.8%
29	Pennsylvania	33.0	14.2%	72.3%	18.0%
51	Connecticut	9.3	12.9%	81.6%	9.2%

15 YEAR WEST VIRGINIA LOOK BACK

2000 The U.S. Surgeon General releases a report "Oral Health in America" which was to serve as a call to action to improve health disparities and improve the quality of life for all Americans. West Virginia did not respond despite the high incidence of untreated decay among children aged 3-5 years.

2002 The West Virginia Legislature passed the Oral Health Improvement Act, which mandated the creation of the state's Oral Health Program and consolidated all of the state's oral health projects under the Office of Maternal, Child and Family Health. 2003 The Surgeon General issued a National Call to Action to Promote Oral Health. The Call to Action built on Oral Health in America: a Report of the Surgeon General (May 2000) and the Healthy People 2010.

2004 The West Virginia Legislature conducted an audit of the state's Oral Health Program and found that the three projects comprising the oral health program were too limited, either in the scope of their activities or the areas of the state that received the service. In 2005, West Virginia's first children's health conference was held in Charleston and included a session on oral health. The West Virginia Healthy Kids and Families Coalition (WVHKFC) and the West Virginia Chapter of the American Academy of Pediatrics (WVAAP) met with professionals from around the state to discuss the status of child health.

2006 The Benedum Foundation provided start-up funding to help build an oral health infrastructure. The West Virginia Legislature released a performance update of the oral health program and West Virginia's First Lady Gayle Manchin hosted the state's first Oral Health Summit.

2007 West Virginia Partners for Oral Health released a policy brief urging the state to develop a comprehensive plan for oral health.

2008 The West Virginia Legislature called for the creation of an Office on Oral Health with a full-time dental director and the establishment of an advisory board to develop a comprehensive plan to improve oral health. This legislation did not pass, but its spirit was implemented by the Office of Maternal, Child and Family Health where the oral health program resides. With Benedum funding work began on a state plan and an advisory committee was established.

2010. In February of 2010, the Pew Foundation[1] issued a national report called *The Cost of Delay: State Dental Policies Fail One in Five Children*. This report

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Pew used the following criteria:

- Number of professionals who can provide high-quality dental care to low-income children.

identified West Virginia is one of eight states to receive an "F" in its report card of children's oral health. In fact, at the time of the report, West Virginia met just two of the eight benchmarks established by Pew's Children's Dental Campaign. The failing grade resulted from the following facts about West Virginia:

- No dedicated full-time dental staff, a deficiency which prevents the state from qualifying for many federal dental health grants;
- No reporting oral health data to the national surveillance system;
- The state lacked a school-based sealant program; West Virginia was one of just seven states that continued to require a dentist to be present while a hygienist applies sealants to a child's teeth; West Virginia did not pay dentists at least the national average of Medicaid payments; and
- The state did not reimburse medical providers for preventive dental health services; and West Virginia had not authorized a new primary care dental provider.

The bright spots in the 2010 Pew report were 1) the state does have fluoridated water for 91 percent of its population on community water systems and 2) it exceeds the national average of Medicaid enrolled children receiving dental services (47%.).

2010 The Office of Maternal and Child Health's Oral Health Program released the state's first Oral Health Plan marking a major milestone in the state's policy efforts. 2011 West Virginia moved from an "F" to a "C" on the Pew Foundation's national oral health report card, thanks to a collaboration of many advocates working to implement the state's Oral Health Plan.

2011. The 2011 Pew report on children's oral health, West Virginia's rating had improved from an "F" to a "C" thanks to "a coordinated effort, funded in part by the Benedum Foundation, to implement West Virginia's Oral Health Plan." Benedum Foundation funding specifically addressed establishment of a school-based sealant program, and the first state oral health surveillance.

The primary drivers for the improved grade were improvements in Medicaid payment rates and an increase in the percentage of at-risk schools with sealant programs, oral health surveillance and a full time dental director. And, in January of 2012, Medicaid also began reimbursing physicians for providing preventive oral health services. This change was the result of sustained advocacy on the

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- Coverage from Medicaid and the Children's Health Insurance Program leads to real care.
- Fluoridated water.
- Programs that provide dental sealants so that all children who need them receive them.

Note: The Pew criteria is different than the Bloomberg Criteria noted in the chart above.

part of the West Virginia Oral Health Coalition, KIDS COUNT and other advocacy groups that have been working together to improve children's oral health."

2012. West Virginia KIDS COUNT's subsequent 2012 special report, *Is West Virginia a Great Place for Kids' Smiles,* chronicles the state's recent progress in improving children's oral health and makes a series of recommendations for further improvements, including expansion of the school-based dental sealant program to all high-risk communities in West Virginia. Due to the implementation of strategies documented in the first state oral health plan 2010-2015 (which was partially funded and significantly guided by the Benedum Foundation) West Virginia moved up to a "B" on the Pew report card.

LEARNING QUESTION:

So what enabled West Virginia decision makers to take hold of the oral health dilemma and move up in the national PEW rankings from an F to a B in 3 years?

THE ANSWER: West Virginia Oral Health Initiative

In the last seven years West Virginia has made significant progress in the oral health particularly with children because of the call to action created by its Oral Health Initiative. The primary focus of the initiative is on:

- **Connecting uninsured populations with dental care providers** through relationships with clinics, dental societies and other groups. Since adult dental benefits are not required under the Affordable Care Act (ACA) or Medicaid expansion, and Medicare and state dental care financing systems typically provide limited or no adult dental benefits, there will still be many dentally uninsured adults and seniors who need assistance from state oral health programs and their partners in finding care.

- **Educating the public** about proven evidence based programs such as community water fluoridation, fluoride varnish, age-one dental visit, and dental sealant programs Community water fluoridation reaches residents of all ages served by fluoridated water supplies, not just those who go to the dentist, and is the most cost effective public health intervention.

- **Supporting school-based dental sealant programs and school-based fluoride varnish programs**, which have been proven to be effective, evidence-based preventive public health approaches. Making these services available at schools and in primary care settings saves parents and children unnecessary absences from work and school to receive care in dental offices.

- **Conducting oral health surveillance**, by collecting data to monitor the population's oral health status and health behaviors through the Basic Screening Survey (BSS), Behavior Risk Factor Surveillance Survey (BRFSS), the Youth Risk Behavior Survey (YRBS), and other surveys. These data are used by state and local agencies to request funding and advocates to implement policy changes to improve the oral health of underserved populations. Medicaid claims data and Head Start Program Information Report data also do not provide information about oral health status (need) but only about care provided.

- **Addressing health inequity** by designing, implementing, and sharing evidence-based health communication and health promotion programs that use culturally, linguistically, and developmentally appropriate oral health activities and materials for diverse populations.

- **Coordinating with other state health agency programs** such as Comprehensive Cancer Control, Diabetes, Tobacco Control, and human immunodeficiency virus (HIV) programs, as well as dental, dental hygiene, medical and nursing schools, and state and local professional associations such as state nursing, medical and pediatric associations to ensure that the relationships between chronic and infectious diseases and oral health are taken into consideration when providing care and planning programs.

- **Working with dental/dental hygiene schools and state and federal loan repayment programs to place dental professionals in communities or clinics,** especially in rural areas, to care for underserved populations.

- **Playing an important role in developing protocols and policies** for handling health hazards that threaten individuals and communities.

- **Informing policy makers' decisions** based on scientific evidence on issues such as the scope of dental practice, mandated oral examinations prior to enrollment in school, oral injury prevention in sports, healthy food choices in schools, loan repayment programs, disaster preparedness, and infection prevention and control in dental settings.

- **Driving internal and external partnerships** and ensuring that oral health is addressed when policies are being considered and programs are being planned. They promote policies based on accurate and current data. They serve as neutral facilitators to help partners focus on meeting the oral health needs of state populations.

HOW DID THE WEST VIRGINIA ORAL HEALTH INITIATIVE COME INTO BEING?

The participants shared that it was the result of the convergence of several threads:

- **Enlightened and Respected Leader.** Ron Stollings was elected Senator in 2006. Prior to his election he was board certified in internal medicine and had been President of the West Virginia State Medical Association. He saw firsthand the negative impact of poor oral health.

- **A Provoking Tragic Headline.** In February, 2007, Deamonte Driver, an 11 year old boy from Prince George's County, Maryland died from a brain infection caused by bacteria from tooth decay. The boy's death garnered nation attention and local embarrassment. An $80 procedure would have prevented his death.

- **Opportunity to Leverage a Plan for Additional Resources.** Senator Stollings approached pressured the West Virginia Department of Health and Human Resources (DHHR) leadership in 2008 to support the creation of a state oral plan with the anticipation that West Virginia could qualify for federal money and other support to improve oral health in the state. Due to lack of oral health infrastructure within DHHR, it was not up to the task. Senator Stollings along with the support of Governor Manchin worked with the Benedum Foundation to invest in development of such plan.

- **Money taken off the table in creating the Initial Plan** because of support provided by Benedum and the Appalachian Regional Commission (ARC) which was orchestrated by Benedum's program office**r.** And because of that plan and Benedum's advocacy, West Virginia hired a dentist to be its first full-time dental director which brought credibility and support to West Virginia Oral Health Program.

- **The Process to Develop the Initial Plan was well executed and created buy in:**
    - 36 community meetings were held throughout the state to gather input into the plan's priority, played a role in giving input.
    - The plan was focused and action oriented which drove the need to collect data to track progress to plan.
    - The development process of this plan was completely funded by the Benedum Foundation.

- **Formidable Partners Led the Initiative.** In 2008, West Virginia Governor Joe Manchin III and ARC Federal Co-Chair Anne B. Pope announced a major initiative on school-community partnerships to promote children's oral health in West Virginia. ARC and the Claude Worthington Benedum Foundation collaborated to fund an initial $500,000 grant for the program that helped establish school-based dental clinics and would be managed by the Robert C. Byrd Center for Rural Health at Marshall University. Since that grant, Benedum has routinely funded Marshall University Research Center (MURC) to collect data from these school based health center sites, assist with new site start-ups, provide technical assistance and training, and to implement new program components.

- **The Dental Advisory Committee was comprised of people in authority that trusted each other.** A dental advisory committee was established by the West Virginia DHHR Office of Maternal, Child, and Family Health's Oral Health Program to provide oversight and accountability to the program. This was established at the recommendation of the West Virginia Legislature. This committee comprised of a list developed and suggested by those policy makers and consisted of representation from all key stake holders throughout the state.

- **The Extra Accelerant.** When the Pew Foundation announced its major emphasis on Oral Health, West Virginia was well along in creating a viable plan to transform oral healthcare by 2020. The output as result of the convergence of these threads follows.

WHAT HAS BEEN ACHIEVED BY THE STATE AND BENEDUM FOUNDATION SINCE THE WEST VIRGINIA ORAL HEALTH INITIATIVE WAS LAUNCHED IN 2008?

Due to the efforts of the Benedum Foundation as a funder and an early on and continuous partner, West Virginia has made major strides in the area of oral health particularly with children.

- The state has undertaken two successful five year planning cycles - the first five-year state plan in 2010 and the second five-year plan in 2015; which has guided the work of the initiative.
- West Virginia has a full time State Dental Director and he is a Dentist.
- The state has implemented a regular oral health surveillance system, a dental sealant program, and worked on many policies that have long impeded oral health screening and treatment for children. (Many states lack these systems).
- The state oral health program is housed in the West Virginia DHHR Office of Maternal and Child Health and they now have a staff of ten. Thanks largely to the support (programmatic and matching funds) from the Benedum; they have received at least five national grants totally more than $3,000,000.

West Virginia now has a healthy number of positive programs and systems to build upon, including:

- West Virginia Kids Count's institutional integration of oral health as an indicator of child well being
- Advocacy and education are part of the West Virginia State Oral Health Plan
- School-based initiative has increased the number of centers with oral health components
- Medicaid payment for physicians providing dental prevention
- Engaged local health care providers at School Based Health Center's to add oral health services

- Conducted oral health surveillance of school aged children, then on to Universal Pre-Kindergarten, working aged adult population, seniors, and pregnant woman
- Documented oral health needs, status, lack of dental home, insurance, etc.
- Fluoridation , community water sources, and the provision of fluoride varnish programs
- School-based dental sealant programs, screenings, basic prevention and restorative care
- Medicaid and Children's Health Insurance Program (CHIP) coverage for kids
- Dental Home concept, with a push to integrate with the Medical Home
- Smiles for Life Adult Dental Services Program (provides adult dental services, case management, hospital ER diversion, awareness of the unmet need through a Mission of Mercy, they have a volunteer cadre of Dentists, piloting a screening and care coordination model, creating a possible documented model to replicate)
- West Virginia University Dental School is developing an ER utilization and financial impact model that can be replicated across the state to document the costs to hospitals for patients presenting with oral health needs. This can be used to work with Medicaid and other payers to start a demonstration project for adult coverage.
- The West Virginia Association of Free Clinics is also documenting a potential adult Medicaid model for the state to consider.

STRENGTHS (Gathered from individual during the discussion)

"If not for the collaborative, we would not have a systemic view of the problem or the solutions; we'd still be only focused on the issue occasionally and locally. Locally, we don't have the resources to address the problems…"

1. **Significant and appropriate partners engaged, collaborating and leveraging resources**
   - Coalition works at both the top level and the grassroots level.
   - The initiative brought together stakeholders who otherwise would not have organized to address the problem. Collective Strengths enables them to compensate for individual weaknesses
   - The Coalition created a public voice and changed orientation of policymakers about oral health.
   - Coalitions are in place that cover almost the whole state.
   - The partners share an understanding of the need and have a

plan so they can move more quickly to policy and best practices to action.

- Benefits that have accrued from Department of Education, DHHR Office of Maternal; and Child Health (that houses the Office of Oral Health) and certain local providers collaborating.

2. Top Level support

- New five year state dental plan in place with direction/leadership of state dental director.
- Increased legislative recognition which has helped to start and sustain programs.
- Additional funding of and recognition of need for adult dental services, esp. by the state legislature

That support and credibility created these strengths:

3. Improved oral health

- Improvement in statewide oral health education & services due to state plan.
- More schools implementing screening and referral for oral health primary & secondary prevention,
- Partnerships with schools and communities with dental practices have added significant value. For instance, integration of Medicaid and CHIP, limited adult dental coverage, increase sealants in school, workforce issues, Health Sciences Center loan program, and fluoride varnish.
- Increased infrastructure, increased surveillance, increased creation of state policy, and increase federal funding because we can monitor and report on progress and vulnerabilities.
- Children: 75% of children entering school decay free.
    - Dental programs for children pretty strong
    - All children access or receive preventive oral health services
    - Mandatory School Dental exam requirement will begin in the 2015-2016 school year (entry into Pre- K/Kindergarten, then again at grades 2, 7 & 12)

- Adults: Lagging but showing gains
    - The sheer number of adults who have received treatment. In the first six months of expanded adult dental services and education, 2,802 unduplicated adults received dental services and 7,378 educational activities were conducted
    - Majority of adults are without dental insurance
- Coverage
    - Oral Health Equality
    - West Virginia is primarily for extraction or pain relief only (with annual limits)

  - West Virginia University Dental School will provide access to critical services for persons in West Virginia who are able to attend their clinics in Morgantown
  - A few of the larger West Virginia Free Clinics, and the Mid-Ohio Valley Health Department provide dental services regardless of the patients ability to pay
  - Need for accessible and integrated oral health care.
  - Medicaid reimbursing physician for fluoride varnish
- Partnerships
  - Schools, communities and dental practices working together on wide scale and collectively own the need to improve
  - Establishment & expansion of school based sealant program. Provide technical assistance, funding of mini grants, to provide dental services on site to students. Started in 2009 – now 29 countries (turned into school – community partnership)
  - Continuing Education credit for those home visitors, supplying supplies to those families
  - Support and integration of oral health education in schools, communities, and medical providers
  - Impact on families based on oral health trainings, show partnership between fed and private funding
  - MURC developed a universal curriculum and training for the West Virginia Partnership of In-Home Visitors, they are also collecting common data sets to measure impact

4. **Oral health embedded in family education – dental home**.
   - Integration of oral health into all health sciences curricula
   - Continuum based upon impact of training, training to staff, staff to family, mother to child, child to dental home
   - Shared recognition of the importance of the dental home
   - Providing much needed resources to at-risk families

5. **Infrastructure developed to support oral health advancement**
   - State dental director brings a stature to our efforts and he has creditability among the dental profession.
   - State dental director has authority within DHHR seen as the "leader" statewide and nationally.
   - Organized and well executed programs
   - Working off of second state plan
   - System operating to collect performance data on regular basis.
   - Mechanism to monitor progress to plan
   - The Initiative can direct new money (e.g. DentaQuest) to immediate productive use

"Without the state efforts/plan we wouldn't have the credibility and momentum we have built …" participant

WEAKNESSES:

1. **Reality:**
   - It is difficult for a Dentist to make a decent living serving the poor or marginally poor in rural West Virginia
   - Oral disease has not been placed on par with other major chronic diseases such as Diabetes, Cardiovascular disease, or Cancer by state government
   - Oral Health is still not a priority to many West Virginian's, there are some cultural norms to combat

2. **Positioning**
   - There is not statewide recognition and buy-in of need for expanded adult dental care coverage. Some areas don't have even a full service clinic to give service beyond extraction & infection to low income populations.
   - Lack of recognition of dental home & importance of promoting that concept from all partners needs more consistent messaging.
   - Professional organization leaders such as the West Virginia Dental Association are not leading change
   - The ever-changing local culture--patients, providers, policy makers, organizations-- is challenging to manage
   - Oral health is still not seen as an economic factor; impacting one's ability to gain and retain employments, missed hours of work, and etc.
   - The impact of poor oral health and its connection to other chronic diseases (such as heart disease and diabetes) is not a common message

3. **Services and Resources**
   - Coverage for adult dental/oral care is still not resolved. Medicaid not motivated to expand existing coverage beyond that of an extraction. A suggested strategy is that the Governor demands that oral health be a priority, putting pressure on Medicaid to expand coverage. These dollars are important to individuals living in poverty receiving proper health care. Medicaid funding for preventive care is greatly needed among this population There is not a payment system for adults especially (other than charity)
   - The state does not have full integration of dental & medical home core components across systems

ASSESSMENT OF CURRENT POSITION IN RELATIONSHIP TO WHAT NEEDS TO BE ACHIEVED?

- **Impact.**
  - Great job has been done organizing at the top: people in authority who can drive change our on the Advisory Board
  - The two plans that have been developed have served as an excellent guide to our priorities and to enable new people to jump right in. Major progress has been made in the area of child oral health in the state, but little progress has been made for adult oral health. Largely, the difference between the treatment of children and adults is in relation to the access to care, insurance and affordability.
- **Communication**. The project gets high marks for communicating to different constituencies, aggregating good stories, and keeping members of the Advisory Board current.
- **Enthusiasm.** The Advisory Board has maintained momentum and is about getting things done.
- **Credential.** Benedum's continued involvement at the state and national level speaks volume to others including other funders about the value of our work and the importance of oral health.

CURRENT CONSTRAINTS:

- **Absence of funding streams to cover oral health.**
  - Medicaid resistance has been very challenging to deal with from the beginning. To make real change participants felt that they needed to be able to leverage Medicaid resources and also have that agency be part of conversation. Participants felt they had fallen short by not creating a compelling message as to why Medicaid resources should be involved.
  - Affordable Care Act does not require any dental or oral health coverage, thus many insurers have chosen to drop such coverage

- **Lack of Public Leadership Interest**. Oral Health not a priority of the governor.

- **Challenges of Rural Strategies.** The normal inefficiencies and local culture issues are challenging to manage.

- **Economics of dental practices**. The cost of dentistry and setting up an office is a disincentive to many trained dentist to set up shop in rural areas, this coupled by high student loans and lack of business knowledge.

- **Absence of Sufficient Targeted Messaging.** The participants felt that given the Governor's lack of attention to oral health and tackling institutional barriers, the

Advisory Board needed to do a better job developing more powerful messages, tagging on that message to other communication efforts, and overcoming the Governor's objections on Medicaid.

- **Oral Health is treated as an Isolated Issue.** One of the biggest challenges is that oral health has historically been treated separately broader public health discussion or agenda. We need to develop unifying messages about oral health, such as:
  - Stay focused on the overall health of the individual
  - Integrate dental and medical home concepts
  - Expand the dialogue about oral health into every conversation/public sphere
  - Create an expectation of health and wellness
  - Assure that systems are equitable and just
  - Increase public awareness about oral health
  - Connect oral health to total health
  - Tackle policy changes that are barriers to treatment and care
  - Be creative with funding options, diversify
  - Public/private partnerships for long term success

WHAT LESSONS HAVE BEEN LEARNED?

"Successful collaboratives are about leveraging resources, knowledge and collective will to achieve an end…with the good fortune of timing, funding and leadership urging them onward."

1. **Foundations bring credibility** to other funders and partners, connections, and pivotal funding to spark public action**.** The reputation and credibility of The Benedum Foundation was repeatedly cited as a critical factor in enabling the building of an effective coalition of supporters and participants in the West Virginia initiative.

2. **Knowing the Tipping Point** for an issue. Benedum's program officer and political partners knowing that the timing was right to tee up the Oral Health Initiative was key. Secondly and equally as important was Benedum's willingness to be proactive in investing dollars to jump start efforts to move forward**.**

3. **Not leaving the organizing to happenstance.** Benedum's program officers have played a significant role in assuring collaboration and willingness to work together. By knowing the players and making those introductions to assure success and additional funding opportunities.

4. **Developing a plan that engages key constituents and provides a road map returns great value.** First, people are more willing to participate in the

collaborative knowing their opinion is valued. Second, the opportunity to achieve some quick wins builds instant credibility and enthusiasm. Lastly, being transparent and inclusive gives people confidence that there is "not another agenda" at play.

5. **Starting something is easy; staying involved is priceless.** Benedum has had a long tradition of being involved in moving an agenda beyond just providing dollars. Sometimes it takes active participation of the funder to demonstrate the high value of the initiative for onlookers and participants.

6. **Little bits of money awarded at the right time can keep momentum going.** Something funders such as Benedum might want to consider; establish a small fund for initiatives such as this to acquire new technology, equipment, and benchmarking trips for direct line service people.

7. **Sometimes funding guidelines make implementing projects difficult.** Things such as not funding small equipment such as laptops, out of state travel for networking and information sharing, or funding of multi-year projects.

8. **This initiative will most likely require no less of an effort from all partners for the next ten years.** While the initiative has made great strides, a great deal needs to be done before West Virginia has turned the corner on:

    a. Incidence of oral disease including dental caries, tooth loss, periodontal disease, oral and pharyngeal cancer, and cleft lip/palate;
    b. Prevention, including dental screenings, cleaning, sealants, and water fluoridation
    c. Risk factors, including tobacco use, HPV, child abuse and domestic violence
    d. Access to care including dental visits, receipt of needed care, reasons for not receiving care, dental insurance, and Medicare and CHIP claims, and;
    e. Dental Healthcare workforce; including dental professionals, school based programs, and community health centers with oral health components.

9. **Planning for the future:**

    a. Setting end game targets. It is really difficult to do this target setting at the creation of a collaboration. Once momentum is created and there is a full appreciation of the landscape surrounding the issue, setting clear targets can be helpful to keeping the initiative focused. Secondly, it gives all stakeholders a shared understanding that all funders will have an exit strategy; as they have limited dollars and multiple requests for support.

b. Periodically look at the constraints and see whether there may be intentional actions to mitigate them. For instance, if the lack of profitability of dental practices is a reality, what could be done to incent sustainable solutions? Or, if messaging to persuade the political leadership that oral health is central to having a healthy workforce, they may consider underwriting a messaging campaign.

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