



***Oral Health America***  
**Coalition Best Practices Workshop White Paper**  
**August 2001**

**Background**

Coalitions have provided key building blocks for American social and political progress throughout the nation's history. And it's no wonder: Coalitions can bring to bear the strengths of different organizations and points of view in an effort to solve many different types of problems. Furthermore, once a message or program begins to reach fruition, a viable coalition can play an invaluable role in disseminating its message and strengthening its activities.

From its beginning, Oral Health America (OHA) has recognized the vital role of launching and nurturing coalitions in fulfilling its mission and in improving Americans' oral and overall health status. In June 2001, OHA outlined the organization's vision of playing a key role in all US oral health coalitions, meaning that OHA intends:

- to serve as a resource for communities in addressing their oral health care issues and
- to act as a neutral convener for both traditional and nontraditional participants around any issues concerning oral health.

OHA's broad goal in this regard is to work with all such coalitions to identify their communities' oral health needs and to develop programs aimed at improving oral health for all Americans. To advance this goal, OHA began in the fall of 2000 to plan for a "Coalition Best Practices Workshop," which was held on August 6, 2001. Hosted by OHA and supported by the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation, the Workshop brought together 56 individuals from 25 states, who represented 52 different organizations or agencies. Among the states represented were some of the most urban (New York, New Jersey) and most rural (Nebraska) as well some of the most populous (California, Texas) and some of the least populous (Wyoming, North Dakota).

The Workshop's principal intents were to review the activities of existing oral health coalitions and to explore ways in which Oral Health America could assist states, regions, or communities in developing or maintaining oral health coalitions.

To support these overall goals, the workshop targeted the following key objectives:

- to identify states with existing health care or oral health–specific coalitions,
- to identify states in the process of developing a coalition,
- to determine the number of members and organizations participating in the coalitions,
- to survey coalitions’ organizational structures (bylaws, board of directors, meeting frequency, committees, Web site, and so forth),
- to determine whether the coalitions are broad-based—that is, have members from outside the dental professions,
- to survey the projects and programs conducted by the coalitions,
- to identify the coalitions’ resource needs, and
- to identify present funding sources.

### **Present state of coalition building**

The Workshop showed that oral health coalitions have an impressive diversity in size, governance, activities, and needs. Based on the reports obtained during facilitated roundtable discussions during the Workshop, the following sections categorize the results and discuss some of their implications.

The Workshop revealed that 18 states currently have oral health–specific coalitions (either state, regional, or local in focus) and that three other states have emerging coalitions. In addition, 13 states (including some of the 18 just mentioned) have health care coalitions that address oral health issues. These include, for example, PANDA (Prevention of Abuse and Neglect through Dental Awareness), American Cancer Society, CHIP (Children’s Health Insurance Program), Children’s Health Alliance of Wisconsin, ACCESS, SUCCESS, Coalition of Provider Agencies, Health Action, and Project Believe.

Most states reported that their coalitions include fewer than 50 individual members, with three (Illinois, California, and Kentucky), however, indicating more than 100 members. Kentucky’s coalition is also the nation’s oldest oral health coalition, having been around for 12 years. The number of organizations participating in the coalitions ranged from 15 to 60. Eighteen states participating in the Workshop reported that their coalitions were broad-based—that is, they include members from outside the dental professions.

The frequency with which the coalitions meet varies widely: Only six states reported monthly meetings, while eight meet quarterly. Two coalitions meet just twice a year, and one meets three times. Five coalitions indicated no regular meeting frequency, but rather that their meetings are project-focused. Two meet bimonthly, and one meets every four to six weeks.

Coalition governance also ranges widely: Seven states’ coalitions have boards of directors. Other approaches to governance include an advisory board (one); an

advisory committee (one); steering committees (three); a leadership team (one); and an arrangement of chair, co-chair, and subcommittees (two).

### **Programs and projects**

The existing oral health coalitions conduct a great spectrum of projects and programs:

#### *Advocacy/lobbying*

- Access to care
- Advocacy for recruiting a state oral health officer
- Better dental care for people with disabilities
- Government relations
- Legislative advocacy
- Legislative monitoring
- Legislative recommendations
- Lobbying
- Medicaid access
- Medicaid reimbursement

#### *Outreach*

- Best practices models
- Community health programs
- Donated Dental Services
- Education and prevention materials
- Emergency care program
- Fluoride mouth rinse program
- Fluoride varnish
- Georgia Spit Tobacco Education Program (GSTEP), one of 11 states participating in the National Spit Tobacco Education Program (NSTEP)
- Healthy Smiles
- Media campaign
- Mini-grant program
- National Sealant Alliance and other sealant programs
- Needs assessment/oral health plan development
- Oral health plan development
- PANDA
- Public awareness
- Safety net provider
- School-based and school-linked programs and services
- Statewide marketing plan
- Volunteer projects and programs—for example, Special Olympics and Special Smiles
- Wisconsin AHEC (Area Health Education Centers) Dental Training

### *Other*

- Collaborative projects with other health care coalitions or organizations
- Data collection
- Grant writing
- Internal professional education concerning the need for a coalition

### **Current funding sources for coalitions**

Not only do the sizes, programs, and governance of oral health coalitions vary, but the sources of their funding are also varied, reflecting the types of funding streams that support many nonprofit organizations. Such a varied funding structure strengthens coalitions by not forcing them to rely on a single source of support. Coalitions reported that their funding comes from the following sources:

#### *Federal*

- CDC and other federal funding
- HRSA (Health Resources and Services Administration)
- Medicaid
- Mental Retardation Development Delay (MRDD) local match funding

#### *State*

- Dental Society
- State funding—for example, to explore the effects of developing a coalition

#### *Local*

- Dental Society

#### *Corporate*

- Corporate funding
- Delta Dental
- In-kind donations of services and supplies (copying, mailing, printing, and so on)

#### *Private*

- Black-tie fundraiser
- Faith community
- Foundation grants
- Golf tournament fundraiser
- Volunteers (time, money, and services)

#### *Other*

- Membership dues
- Project-specific funding (federal, state, private, or corporate)
- University dental school contributions (both in-kind and financial)

## **Obstacles to developing present and future coalitions**

Coalition members around the country reported a spectrum of obstacles that they feel inhibit their states or regions from either undertaking or continuing to develop oral health coalitions. Reported obstacles fall into three general categories (some of which are further subdivided): dental, legislative, and other.

### **Dental-related obstacles**

#### *Resource shortages*

- Lack of a full-time state dental director
- Lack of a state dental school
- Lack of skill set
- Limitations on responsibilities of registered dental hygienists
- Shortage of workers in the dental professions

#### *Turf issues*

Difference or conflicts over professional responsibilities or authority pose another set of obstacles.

- DDS Diverse initiatives
- DDS/RDH conflicts
- Dental board turf battles
- Dental practice acts (some states' limitations on dental hygienists' and assistants' functions)
- Dentists not part of coalition but are kept informed
- Different organizations' and individuals' differing priorities and agendas
- Local dentists' concerns about school-based dentistry for underserved
- Organized dentistry's lack of interest
- Public vs. private philosophy of practice and systems that support the two state officers—pose challenges to balancing funds
- Public vs. private sector priorities
- Resistance by dental society paid staff
- Resistance from state dental society's executive committee (but it is getting better)
- Self-interest of dentists
- Suspicions about non-members of coalitions or non-dental members of coalitions

### **Legislative-related obstacles**

- Governor's legislative priorities
- Lack of political will among legislators
- Lack of perception of importance of oral health in legislature and general public
- Legislative issues restrict growth
- Medicaid reimbursement
- Professional apathy about proposing new legislation

- Tobacco lobbying

### **Other obstacles**

#### *Resources*

Across the board, funding represents the key resource concern.

- Administrative costs
- Funding
- No resources
- No sustaining funding

#### *Education*

Education obstacles include a range of issues holding back coalitions' development and performance.

- Lack of patient education and compliance
- Safe (such as the need for sealant programs) vs. hard issues (increasing Medicaid fees and access to care)

#### *Logistics*

Coordinating membership and activities represents the kind of logistics issues facing coalitions.

- Bringing on local health departments
- Communication between state and local levels (hard to convince potential local members of the value of a coalition)
- Consensus
- Distribution of dental professionals, exacerbating access to care issues
- Lack of clarity about missions and goals
- Too few coalition members
- Too many coalition members
- Travel obstacles posed by distances between urban and rural areas

#### *Other*

- Department of Human Services
- Diversity of interests and agendas among types or organizations and individuals involved in coalitions
- No obstacle until projects brought forward
- Patience (frustration of getting people organized and maintaining commitment to coalitions' development)

### **Resources needed for growth**

To address their concerns about some of the obstacles to growing coalitions, participants suggested a variety of resources that would support their efforts.

### **Funding issues**

- Funding for a coordinator position

- Funding to become formalized as a coalition
- Grant writer
- Other funding
- Tuition reimbursement for dentists and/or dental professionals

### **Education and communication**

These reported needs encompass everything from getting the message out to the general public to increasing the involvement of other professionals.

- Communication
- Identifying organizations that share concerns
- Input from other professional groups
- Marketing
- Positive reinforcement that coalition efforts are on the right track
- Public relations to bring message to broader audience
- Sharing of information among those involved in coalition development

### **Technical assistance**

Technical assistance is related to funding needs but reflects coalitions' more specific needs to develop their organizations and support their programs.

- Independent review of existing programs
- Leadership development
- Legislative links
- Legislative rapport
- OHA to assist in growing from a committee or commission to a coalition
- Technical assistance to support the development of a coalition
- Training in fundraising
- Training in how other coalitions function.

### **OHA's role in developing coalitions**

Workshop participants envisioned a host of critical functions that OHA might perform in helping to get new coalitions off the ground and in supporting the work of currently existing coalitions. Analysis of their suggestions reveals that potential roles for OHA fall into five general categories.

### **Advocacy/lobbying**

- Advocacy at national level
- Bring in federal and national funding
- Lobbying for incorporating public health in dental schools and dental hygiene schools
- Need to have a strong Washington presence
- OHA to be an oral health advocacy group, to carry the voice of state and local issues. Interact with HRSA/HCFA initiative
- Spokesperson for critical issues, such as handicapped care and access to care

### **Education and communication**

- Central access (information clearing house)
- Communication (network to share knowledge)
- Ideas
- Mentoring
- National ad campaign
- Public health curriculum in dental hygiene and dental schools

### **Funding and other direct support**

- Development of specific fundraising projects
- Direct funding
- Finding financial support
- Staffing
- Workshops to share information

### **Technical assistance**

- Assist with strategic planning
- Data
- Leadership training
- Networking opportunities—local, regional, state or national
- Technical support (including education)

### **Other suggested ideas**

- Best practices policies
- Debate at ADEA meeting or dental schools regarding responsibility of dentists to the community
- Liaison between national organizations (dental schools and organized dentistry) and local coalitions
- National forum debate with ADA
- Oral Health America Mission Program (could include: organizing a skill-building program in areas in need to, for example, pull teeth for a week with no liability; get CEOs involved; family trip; confidence building for local providers; and easing shortage of oral surgeons and specialists)
- Replication of successful programs, with ability to customize
- State-specific projects

### **Conclusion**

Against this background of programs, resources, and needs, OHA will clearly have its work cut out for it during the next few years. Assisting oral health coalitions across the United States in getting started and in continuing the efforts that they have already begun will be key in continuing to fulfill OHA's mission.

Important follow-up actions to the August 2001 “Coalition Best Practices Workshop” might include:

- Development of a national coalition policy—that is, guidelines on how to build and sustain an oral health coalition.
- Development of a resource network database.
- Development of a conference of coalition delegates to present their projects and programs to other new and ongoing coalitions.

In terms of helping to launch new oral health coalitions and to further develop current ones, OHA should consider working toward the following goals:

***Within one year:*** Hold a follow-up workshop focusing on input from the 25 states not represented at the August 2000 Workshop.

***Within three years:*** Create an annual conference where state, regional, and local coalitions can showcase their successes and share ideas for new projects and programs.

***Within five years:*** By creating a model of a national oral health coalition policy, OHA to function as the national leader in developing coalitions and resources. Funding gained through this process to be distributed at state, regional, and local levels.

OHA will continue to act as a key resource of ideas for states, regions, communities, organizations, and individuals concerning the kinds of projects and programs that will improve oral health in their areas. Beyond being a provider of such ideas, OHA also acts as a neutral convener for those same entities when they need facilitation and guidance in organizing themselves into oral health coalitions. Specific examples of states that have developed and sustained their oral health coalitions through OHA facilitation include Minnesota, Kentucky, and Georgia. Furthermore, in those states and others, OHA has helped states, regions, and so forth realize their own need for developing coalitions that can advance the vital agenda of improved oral health.

Careful consideration of the results reported in this white paper will play an important role in assisting OHA in achieving its mission to develop resources for the improvement and promotion of the nation’s oral health. Much, however, remains to be accomplished in order to continue to move forward with that mission. This Workshop produced a large amount of data and discussion concerning how much work lies ahead to make certain that oral health coalitions can be developed wherever they are needed throughout the United States. A strong message coming out of this Workshop is that people concerned with the whole array of oral health issues want and need to be brought together to start and to continue efforts that will support oral health coalitions. OHA can only continue to provide that support if a pool of unrestricted funds is established that can be used to continue the kinds of activities that are reported on in this white paper—and to bring

those and related activities to areas that still do not enjoy the benefits of an oral health coalition.

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