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| Communities of Practice with RDHAP Community | |
| **Date & Time:** | September 23, 2019, 3pm-4pm |
| **Location:** | Zoom link: <https://ucsf.zoom.us/j/484068152>  -or- Phone line: US: +1 669 900 6833  or +1 646 558 8656  Meeting ID: 484 068 152 |
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| Agenda | |
| 1. Introduction and Welcome 2. Introduction to the CoP indicators/focus areas 3. Next steps 4. Next meeting: November 2019 | |
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| **Communities of Practice (CoP) Workgroup Meeting Minutes**  **September 23, 2019**  **3:00 pm – 4:00 pm** | | | | |
| **Agenda item** | **Attended in-person:** | **Attended by phone:** | **Not able to attend:** | **Action Items** |
| Keiko Miyahara | Jay Kumar, Lynn Walton-Haynes, Steve Silverstein, Lisa Berens, Katie Conklin, Katherine Chen, Joanna Aalboe, Rosanna Jackson,  Travis Trammel, Rhoda Gonzales, Gayle Mathe, Elly Francisco, Laurel Bleak, Melody Jackson, Puja Shah, Walter Lucio, Joy Ogami |  |
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| **Review charge of this workgroup** | * Introduction and Welcome * Review elements of CoP and background | | |  |
| **Introduction**  **Focus Areas**  **Barriers and challenges**  **Promotion**  **Insurance**  **Teledentistry** | * **Dr. Kumar –** started with abrief overview of the Communities of Practice (CoP) to the participants. The vision for the COP is to increase the prevalence of sealants in California. * **Elements of the COP** * Domain * School dental sealant program * Community * Dental professionals * Practice * Improving dental sealant rates * **Major theme in the sealant program** * Sustainability * How to have a program that can withstand the test of time * Reach * Unless we reach a significant amount of population at risk for disease, we will not be able to move the needle on the population level * Quality * Sealants are technique sensitive and if not done properly, we will not get the results that we want * Efficiency * School based programs are great ,but hard to make it sustainable. Even if children are available, not efficient it if is not planned properly. * **Eight indicators identified**  1. Rate of participation, based on consent 2. Billing for services 3. Cooperation from schools and parents 4. Quality of services, sealants provided 5. Equipment 6. Using Teledentistry to refer children and link them to a source of care 7. Efficiency, scheduling schools, children 8. Reach, how can we reach the children who need these interventions  * Rhoda – Biggest barrier is participation and getting off the ground. Sonoma County has 75% consent rate however, it took 6 years to establish trust and creating relationships. Getting a buy-in from parents and school administrators take time. * Dr. Kumar – How to improve the trust issue from the beginning so that response rate will be 50% instead of 30 %. * Laurel – Screening should be passive. If screening is done, easier to reach out separately to get active consent for sealants. * Should be a 2 step process * Elly – use community oral health workers * Start at Head Start and WIC sites * San Luis Obispo has done great things. Incentivize by making the return of the consent form a competition. The class that collects the most consent form receives a Pizza party. Best way to increase return of consent is by engaging the teachers, getting them involved. * **Insurance** * Rhoda – collaborate with existing programs. In Fresno, there are two mobile dental vans, owned and operated by Smile America/Big Smiles. Currently working with the counties to go out and start the program. * Travis – parents do not want medical insurance. A lot fear surrounding the insurance, parents feel that they might be traced back. * Involve the PTA and other organization * Fresno has mobile unit, which is operated by Big Smiles and Healthy Smile * Clovis has a Smile Program * Rhoda- if you give them referral, if **not onsite**, you lose 80-90%. Only 10%-20% participate in school linked programs. * Dr. Kumar – Even with best referral, need for repeated screenings; one in 2nd grade, another in 3rd grade. * **Teledentistry** * Dr. Kumar - A professor at UC Davis worked at refugee camps and used intraoral camera, cost is about $50. Teledentistry should not be expensive. * Elly – teledentistry is a triangle. * Teledentistry is not **billable.** If the intraoral camera pictures are not related to VDH, they it will not be billable. * **Next steps** * Continue to work on the **eight focus areas** or other topics discussed by group. * Next meeting: November 2019 | | |  |