The seal of the Ohio Department of Health is a circular emblem. It features a central figure of a person holding a staff with a snake coiled around it, a symbol of medicine. The text "OHIO DEPARTMENT OF HEALTH" is written around the top inner edge of the circle. At the bottom, it says "To improve and protect the health of all Ohioans".

**Recommendations
of the
Director of Health's
Task Force
on
Access to Dental Care
2004**

May, 2004

In 1998, the Ohio Department of Health identified *dental care as the No. 1 unmet health care need of Ohioans*. Dr. J. Nick Baird, director of health, charged a task force with studying the issue and making recommendations to improve access to dental care for vulnerable Ohioansⁱ. More than 70 representatives of a broad array of public and private interests contributed to the work of the task force. Later, the background information considered by the task force was compiled and published by the Ohio Department of Health (ODH) and the Ohio Department of Job and Family Services (ODJFS) as a report called *Access to Dental Care in Ohio, 2000*.ⁱⁱ

The task force borrowed from the Institute of Medicine in defining access to dental care as: *"The ability of all Ohioans to acquire timely oral health care services* necessary to assure oral function and freedom from pain/infection."*

The task force specified that the public (people of all ages) requires access to the full range of services necessary to assure oral function and freedom from pain/infection.

Four years have passed and although much has been done to improve access to dental care for underserved Ohioans, the complex problem still demands attention. Dr. Baird reconvened the task force in October 2003 to review and revise the original recommendations, as necessary. This report will:

- Highlight accomplishments since the initiation of task force deliberations, in the year 2000.
- Issue the task force recommendations for 2004.

* For practical purposes, "oral health care services" were defined as being roughly equivalent to those listed in the Medicaid provider handbook.

ACCOMPLISHMENTS

2000-2003 Accomplishments

Subsequent to the release of the Recommendations of the Director's Task Force (DTF) on Access to Dental Care in November 2000, the following significant events took place. Where possible, baseline data are presented for the year ending Dec. 31, 1999, and comparison data for the year ending Dec. 31, 2003. In some cases, however, data for these points in time were not available and the nearest available data points were used:

- A) Commitment to carrying out DTF recommendations was demonstrated by action plans and events:
- The ODH led a delegation to the National Governors' Association Policy Academy on Oral Health Access and Outcomes. This group generated a State Agency Action Plan of commitments that the participating state agencies would make in response to the DTF recommendations (2000-2001).
 - The Ohio Dental Association (ODA) formed a task force on the DTF recommendations and the House of Delegates subsequently passed a resolution establishing the ODA dental care access policy agenda and action plan (2000-2001).
 - The ODH held a Statewide Summit on Access to Dental Care (2001).
 - The Ohio Coalition for Oral Health formed (2002).

B) Medicaid expenditures for dental care (excluding care provided through managed care plans) in State Fiscal Year (SFY) 2002 (July 1, 2001 - June 30, 2002) were more than two and one-half times those for SFY 1999, due, in part, to a January 2000 fee increase. Although the *percentage* of Medicaid consumers who received dental services in SFY 2002 increased by 4 to 5 percentage points compared to 1999, the *number* of Medicaid consumers nearly doubled due to dramatically increased enrollment.

Although the percentage of dentists participating in Medicaid decreased slightly, the number of dentists who saw greater than 50 patients increased from 769 (12 percent) to 910 (15 percent). In addition to being served by individual dentists, Medicaid consumers received dental care in a variety of clinic settings. The number of clinics, essentially all of which treated greater than 50 Medicaid patients, increased between 1999 and 2003. Unfortunately, Medicaid data are insufficient to fully describe the contribution of Ohio's dental care safety net clinics.

Ohio Medicaid Data, SFY 1999-2002	SFY 1999		SFY 2002	
	All Ages	Total 3 Years & Older	All Ages	Total 3 Years & Older
Total expenditures for dental services	\$38,197,762	\$37,969,208	\$97,473,056	\$96,943,067
Medicaid consumer participation and dental care utilization				
Population	11,256,654	10,815,544	11,389,786	10,935,018
Medicaid eligible	1,081,506	966,781	1,701,312	1,509,039
Percent of population eligible	9.6%	8.9%	14.9%	13.8%
All eligibles	1,081,506	966,781	1,701,312	1,509,039
All eligibles with a dental claim	253,700	251,888	467,018	461,940
Percent of all eligibles with a dental claim	23.5%	26.1%	27.5%	30.6%
Eligible ≥ 11 months	578,819	540,339	1,014,757	919,997
Eligible ≥ 11 months with a dental claim	182,805	181,547	360,740	356,565
Percent of Eligible ≥ 11 months with a dental claim	31.6%	33.6%	35.6%	38.8%
Medicaid provider participation				
	Number	%	Number	%
Medicaid providers (individual dentists)	1,669	27%	1,587	26%
1 - 50 Patients	900	15%	677	11%
51 - 249 Patients	382	6%	403	7%
>249 Patients	387	6%	507	8%
Dentists licensed and residing in Ohio	6152*		6069	
Medicaid providers (Clinics: hospitals, dental schools, federally qualified health centers, public health department clinics--including respective satellite clinics for each)	164**		180**	
1 - 50 Patients	117		118	
51 - 249 Patients	24		27	
>249 Patients	23		35	

* 1998 data for licensed dentists

** Hospitals and affiliated satellite clinics account for approximately three-fourths of the clinic Medicaid providers with a dental claim. Most hospitals, however, do not have dental clinics and saw 1-50 Medicaid patients, most likely in emergency departments.

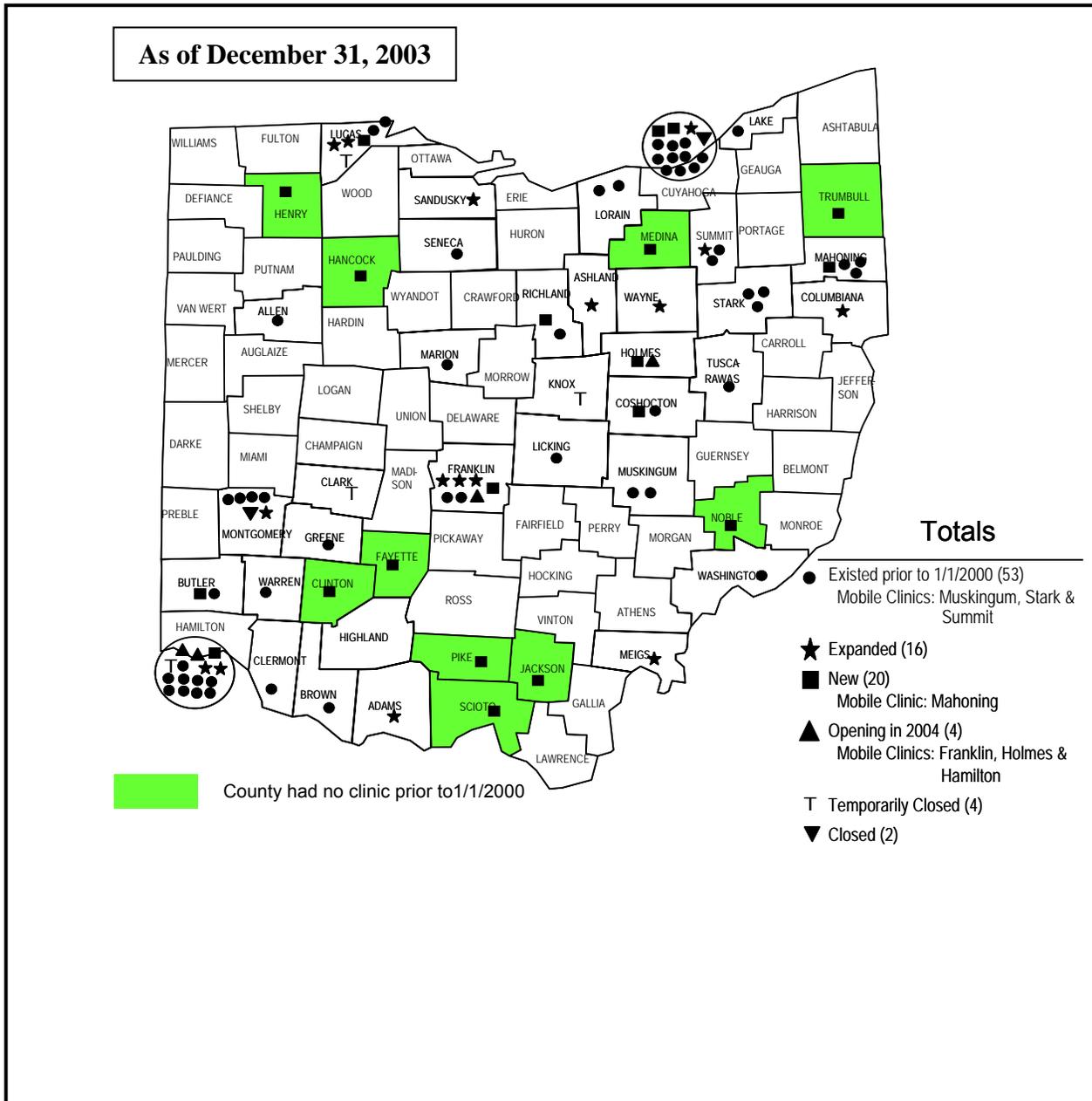
C) Oral health became a priority for several funders. In 1999, slightly more than \$1 million in grants were awarded to 26 Ohio public dental programs, almost exclusively by the ODH. Between Jan. 1, 2000, and Dec. 31, 2003, multiple funders awarded approximately \$21 million in grants to 106 programs across the state. Three-fourths of this funding came from a combination of ODH and at least 10 different charitable foundations. All types of funding sources identified at the time of this report are shown below:

Grant Funding for Ohio Dental Programs, 2000-2003.

	Charitable Foundations	Appalachian Regional Commission	Ohio Developmental Disabilities Council	Ohio Department of Health	Federal (FQHC dental clinic start-ups and expansions)	Other (United Way, Community Development Block Grant)	TOTAL
Safety Net Dental Clinics	\$3,900,000	\$ 732,000	\$ 450,000	\$3,984,000	\$2,521,000	\$ 479,000	\$12.1M
Dental Care Case Management	\$2,055,000	\$0	\$ 25,000	\$1,284,000	\$0	\$0	\$ 3.4M
Community-based Prevention (school sealant programs)	\$1,146,000	\$0	\$0	\$2,911,000	\$0	\$0	\$ 4.1M
Other (e.g., education, fluoride varnish)	\$1,082,000	\$0	\$ 50,000	\$ 164,000	\$0	\$ 129,000	\$ 1.4M
TOTAL	\$8,183,000	\$ 732,000	\$ 525,000	\$8,343,000	\$2,521,000	\$ 608,000	\$21.0M

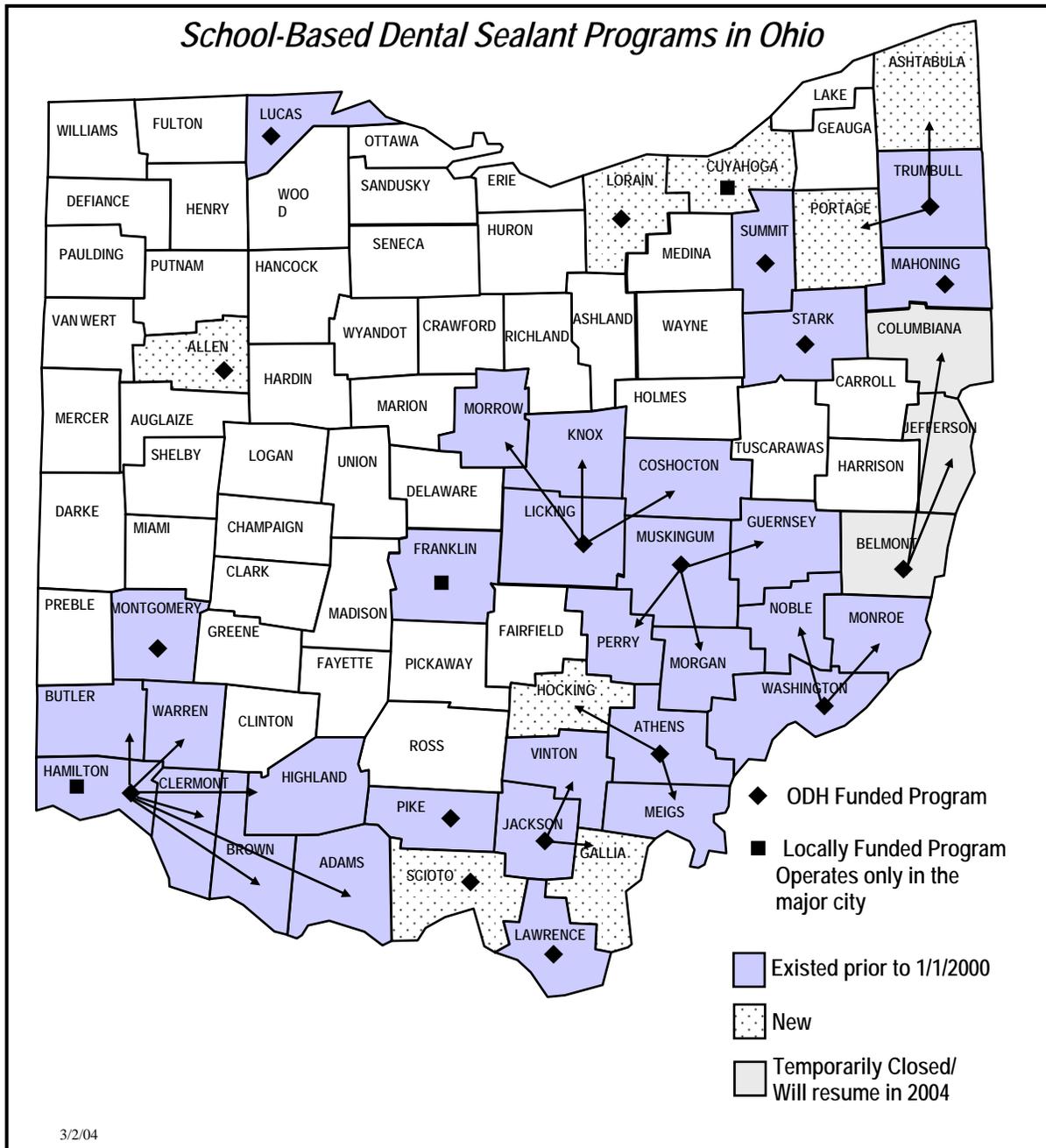
D) The number of safety net primary dental care clinics in Ohio grew from 75 in 1999 to 89 by the end of 2003. In addition, 16 clinics expanded capacity during that time and four received funding to open in 2004. Another four clinics were temporarily closed but expected to reopen in 2004. Funding for clinics came from multiple sources. A new federal requirement that all new federally qualified health centers (FOHC) include dental services was another important factor. Two oral surgery clinics and 12 dental hygiene clinics operated as well, but did not provide primary dental care.

**Safety Net Primary Dental Care Clinic Growth 2000-03
(Includes Fixed and Mobile)**



- E) Dental care case management programs grew in number, scope and productivity. These programs work to link high-risk patients (e.g., Medicaid, uninsured, people with disabilities) with dentists and safety net clinics and to assure that appointments are kept.
 - a. The OPTIONS program grew from providing approximately \$550,000 worth of donated and discounted dental care in SFY 2000 to \$890,000 in SFY 2003. The OPTIONS program primarily serves uninsured, low-income people with disabilities and elderly on fixed incomes.
 - b. Four Ohio charitable foundations (The Anthem Foundation of Ohio, The Osteopathic Heritage Foundation, The Osteopathic Heritage Foundation of Nelsonville and The Sisters of Charity Foundation of Canton) funded eight countywide dental care case management programs. These programs primarily served Medicaid consumers.
 - F) The Ohio State University College of Dentistry received a Robert Wood Johnson Foundation grant for the OHIO Project, with the objectives of establishing community-based clinical education programs and increasing recruitment and retention of under-represented minority and low-income students.
 - G) A state dentist loan repayment program was created in statute in late 2003, to supplement the existing federal National Health Service Corps loan repayment program. The Ohio Department of Health anticipates making the first awards in late 2004.
 - H) ODH partnered with the Indian Health Service and the Association of State and Territorial Dental Directors to develop a comprehensive Web-based dental clinic manual that went online in June 2003.
 - I) ODH, through its OHIO Initiative, provided assistance to local oral health coalitions that formed in 15 communities. At least 12 coalitions spearheaded the establishment of new safety net dental clinics and other oral health improvement efforts.
 - J) Oral health and access to dental care profiles were made available for each of Ohio's 88 counties through the ODH Web site.ⁱⁱⁱ
 - K) Two school-based dental care programs were funded with Public Health Priority Trust Fund dollars from the National Tobacco Settlement (2001-2002).
 - L) ODH awarded grants to fund the development of public awareness/educational campaigns on the importance of oral health and dental care targeted to and developed by socially and economically disadvantaged populations (2001-2002).
 - M) Although not a direct access to dental care accomplishment, Delaware and Athens began fluoridating their public water supplies—a significant public oral health accomplishment.
-

N) School-based dental sealant programs in Ohio reach more children than in any other state. Between 2000 and 2003 the number of children at high-risk elementary schools served by sealant programs grew from 19,958 (452 schools) to 27,767 (498 schools). In addition, one program that had served approximately 1,700 children a year since the late 1980s did not operate in 2003, but is expected to resume in 2004. During this three-year period, the economic downturn had a dramatic impact on the number of potentially eligible schools. The number of schools potentially eligible for sealants increased by approximately 60 percent as many more Ohio families qualified for the school lunch program. An article about the effectiveness of the ODH program was published in the Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* in 2001 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5034a2.htm>).



RECOMMENDATIONS

Recommendations of the Director of Health's Task Force on Access to Dental Care - 2004

I. Reduce financial barriers to dental access by improving and expanding the Medicaid and State Child Health Insurance (SCHIP) programs.

A. Recommendations for short-term action, in 2004:

1. Maintain all major aspects of the existing Medicaid dental benefits: fees, patient eligibility and scope of services.
2. Improve the operation of the Medicaid/SCHIP dental program:
 - a. Provide training, technical assistance and ongoing support to dental practices regarding Medicaid administrative procedures and services by:
 - Enhancing the Interactive Voice Response system, including PIN access for provider-specific information.
 - Expanding internet access to provider handbooks, program communications and claims and eligibility information.
 - Simplifying program claims and prior authorization requirements.
 - Holding regional provider training sessions.
 - b. Maintain ongoing communication between the Medicaid program and the dental community (to regularly review covered and non-covered services, reimbursement rates, and other aspects of Medicaid dental program administration) by:
 - Appointing at least one dentist member and an ODA staff member to the Medicaid Medical Advisory Committee.
 - Maintaining the participation of Ohio Department of Job and Family Services' (ODJFS) Office of Ohio Health Plans and Bureau of Managed Health Care staff as ex-officio members of the Ohio Dental Association's Subcouncil on Access.
 - c. Reimburse physicians for fluoride varnish application (including dental assessment).

B. Recommendations for long-term action (may require sustained activity, building toward future action):

1. Contract with a commercial third party to administer the dental Medicaid program in a manner designed to increase provider participation and use of needed services by Medicaid/SCHIP recipients [similar to Michigan's Healthy Kids Dental program]. At a minimum, the dental program should have the following features:
 - Fee-for-service payment to dentists at rates competitive with private insurance plans.
 - From the perspective of dental offices, make Medicaid/CHIP patients appear administratively indistinguishable from privately insured patients.
 - ODJFS will report to its Medical Advisory Committee and to the Ohio Dental Association's Access Subcouncil the extent to which the third-party administrator meets outcome objectives, including provider participation and percentage of Medicaid/SCHIP recipients receiving quality dental care.
2. Improve the operation of the Medicaid/SCHIP dental program through targeted pilot projects with special populations:
 - a. Explore and test Medicaid fee differentials for:
 - Qualified providers who deliver quality, comprehensive services during convenient hours for patients.
 - Qualified providers who see patients with special needs (including very young children, persons with disabilities and frail elderly).^{iv}
 - Primary care dentists practicing in designated dental health professional shortage areas (DHPSA).
 - b. Utilize case management benefit options or other methods to focus appropriate services on vulnerable sub-populations of Medicaid beneficiaries (e.g., HealthCheck case management, administrative case management for special populations).
3. Expand Medicaid eligibility to include adults with incomes up to 200 percent of federal poverty level.
4. Explore and, if appropriate, implement a mechanism through which dentists can avail themselves to the incentive of deferring Medicaid reimbursement (e.g., the Mississippi program through which providers can defer a portion of reimbursement into the state deferred compensation system [457 plan]).

^{iv} “qualification” will be based on post-doctoral training or successful completion of an approved continuing education course/mini-residency for General Practice dentists (similar to Washington's ABCD program).

II. Increase the capacity of the dental care delivery system to serve vulnerable populations.

A. Recommendations for short-term action, in 2004:

1. The Ohio Department of Health's Bureau of Oral Health Services will implement a state-managed dentist loan repayment program.
2. Create tools and mechanisms to be used to develop and improve the efficiency and quality of safety net dental clinic operation, including:
 - Provide technical assistance to local agencies and coalitions and periodically update the Web-based safety net dental clinic manual (<http://www.dentalclinicmanual.com>) that the Ohio Department of Health developed with the Indian Health Service and the Association of State and Territorial Dental Directors.
 - Utilize and promote as a communication network the Ohio Coalition for Oral Health listserv for use by safety net dental clinics and other Ohio individuals and programs interested in access to dental care.
3. Convene a stakeholders' group to develop strategies to increase educational opportunities for dentists and their office staff, dental students and dental residents on cultural competency in working with diverse populations.
 - The group will include, but not be limited to, representatives from: the Ohio Commission on Minority Health; the Ohio Department of Health; the Ohio Dental Association; the Ohio Dental Hygienists' Association; the Ohio Dental Expanded Functions Association, the Ohio State Dental Board, the state's dental schools, dental hygienist and dental assistant training programs and post-doctoral residency training programs.
4. Increase the number and capacity of safety net dental clinics by funding operating subsidies and by funding capital costs when necessary for expansion of existing sites and/or establishment of new sites.
5. Develop and pilot test a comprehensive, integrated and sustainable model of dental care case management for low-income Ohioans. The model will be formed from the existing systems of foundation-funded local programs that focus on Medicaid consumers and the OPTIONS program that serves primarily uninsured/under-insured low-income individuals, often with disabilities. Pending a positive evaluation of the pilot test, undertake a longer-term effort to expand the model statewide.

B. Recommendations for long-term action (may require sustained activity, building toward future action):

1. Establish a dental workforce task force that will report its recommendations to the director of health. The task force should include, at a minimum, representatives of the Ohio State Dental Board, the Ohio Dental Association, the Ohio Department of Health, the Ohio Coalition for Oral Health, the Ohio Primary Care Association, the Ohio Dental Hygienists' Association and the state's two dental schools. The task force's considerations would include, but not be limited to:
 - a. The adequacy of the supply of dentists to meet the dental care needs of all Ohioans.
 - b. The development of a model for the most appropriate types of providers and auxiliaries and the scopes of their work in order to create efficiencies that will improve access to dental care for underserved Ohioans. In addition to considerations for dental hygienists, dental assistants and expanded function dental auxiliaries, the following would be considered:
 - The role of dental students working as Expanded Function Dental Auxiliaries (EFDA) and dental hygienists in dental offices at appropriate points in their training.
 - The creation of new types of dental health care workers (similar to the New Zealand Dental Nurse model).
 - c. The creation of a cadre of primary care dentists with post-graduate training who spend a significant portion of their clinical training in safety net dental clinics and have an obligation to serve low-income and other vulnerable populations after completion of their training programs (i.e., pediatric dentistry residency, general practice residency, advanced education in general dentistry). This may include approaches such as alternative licensure paths (such as the PGY1 program).
 - d. Recruitment of under-represented minorities into the dental profession.
2. Explore the creation of local dental workforce opportunity zones to provide financial incentives for dentists who participate in Medicaid to open and to maintain practices and provide care in underserved areas by making them eligible for:
 - Interest-free loans.
 - Tax credits.
 - Loan repayment.
 - Professional liability insurance premium subsidies.

III. Support community partnerships and actions to improve dental access and enhance the community level oral health infrastructure.

A. Recommendations for short-term action, in 2004:

1. Provide Ohio Department of Health support for community level partnerships/coalitions:
 - a. Catalyze community partnerships/coalitions and provide staff support and consultation to address dental care access issues at the local level.
 - b. Provide consultation and technical assistance to communities with, or with interest in developing, dental partnerships/coalitions.
 - c. Provide assistance to communities in data collection to identify oral health needs.
 - d. Maintain population-based data collection, analysis and reporting.
2. Expand school-based dental sealant programs to additional high-risk schools and encourage a regionalized approach, where appropriate, through grants.
3. Convene a statewide Head Start oral health summit to develop an action plan for improving oral health through Head Start/Early Head Start programs in Ohio.

B. Recommendations for long-term action (may require sustained activity, building toward future action):

1. Expand and enhance the use of school-based/school-linked approaches to improving oral health:
 - a. Encourage inclusion of periodic dental screenings and follow-up services with vision and hearing screenings (grades K,1,3,5,7,9).
 - b. Encourage the development of model school dental care programs for high-risk children that include:
 - Dental disease identification.
 - Case management or other mechanisms to move children into private dental offices or safety net dental clinics.
 - Preventive services.
 - Treatment services.
 - Integrating with existing school health (non-dental) programs.
 - c. Implement the Head Start/Early Head Start oral health action plan developed at the April 2004 Ohio Head Start Oral Health Forum.

IV. Increase decision-makers' and the public's awareness of oral health and dental care access issues.

A. Recommendations for short-term action, in 2004:

1. Develop and conduct a Medicaid oral health marketing plan in which:
 - A marketing strategy and materials are developed and disseminated to promote awareness (among families, medical care providers and agencies that serve high-risk families and children) that Medicaid/SCHIP/Healthy Start covers dental care.
 - The awareness of county Department of Job and Family Services' Medicaid staff/system is increased with regard to new and existing oral health-related programs.
2. Establish a broad-based oral health information network, guided by a steering committee composed of individuals with expertise in communication and/or oral health. The steering committee will develop a coordinated cross-organization/agency communication plan for raising awareness of the importance of oral health/access to dental care among decision-makers and the public.
 - Initially, the committee will include representatives of the Ohio Dental Association, the Ohio Dental Hygienists' Association, the Ohio Primary Care Association, the Ohio Coalition for Oral Health, the Ohio Department of Health, the Ohio Commission on Minority Health, the Children's Defense Fund, KidsOhio.org and the Asian-American Community Services Council. The committee may add members as it develops.

B. Recommendations for long-term action (may require sustained activity, building toward future action):

1. Maintain the broad-based oral health information network and implement the coordinated cross-organization/agency oral health information communication plan.
2. Through a collaborative effort of the Ohio Dental Association and the state's two dental schools, develop a program that utilizes dental professionals and dental students to work with primary and middle school children in inner-city and underserved areas of the state. The presentations would focus on raising the interest of children about oral health as a potential career.
3. Elevate the priority that high level policymakers place on oral health and dental care services so that dental care will become a mandatory component of the Medicaid program that is funded at a level sufficient to attract a significant number of new dentists into the program.

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