

Strategic & Implementation Plans of the  
Director of Health's Task Force on  
**Oral Health and Access to Dental Care**



2009





## Introduction

In 2000 and again in 2004, the Ohio Department of Health (ODH) convened a task force of key stakeholders to make recommendations for improving access to dental care in Ohio. These processes led to several significant actions including the creation of a dentist loan repayment program and funding increases to support safety net dental clinics by the state and by charitable foundations. Out of concern for the oral health of Ohio's most vulnerable residents, ODH Director Alvin D. Jackson, M.D., convened the 2009 Director of Health's Task Force on Oral Health and Access to Dental Care (DTF).

The recommendations and implementation plan in this strategic plan are the result of the work of the DTF. The group met first in December 2008. At that time, Jackson charged the group to:

- Use quantitative data and qualitative information to determine and prioritize needs,
- Strategically plan realistic ways of meeting the priority oral health/prevention needs in the state and put them into the form of recommendations—not just to ODH or “the state,” but to whoever can take action to make a difference in the lives of Ohioans, and
- Plan how to implement the recommendations.

DTF members took their charge seriously. Their work took on additional significance and complexity as the national economic news grew dramatically worse and major concerns grew out of the state revenue predictions. They convened a series of open community meetings throughout Ohio to gain input from providers, patients, families and advocates concerned with oral health. During their deliberations, they heard presentations by national experts on the compelling issues they considered. Finally, they engaged in active dialogue as they balanced visionary aspirations with the reality of limited resources.

The recommendations and plans contained in this report reflect an awareness that when circumstances are most difficult it is even more important to keep a system's vision and values alive to shape how hard choices are made. In addition, adversity often provides an opportunity to reposition a system so it is able to respond effectively when the situation improves. The short- and long-term recommendations identify opportunities for ODH, funders, decision makers, policy makers, advocates and other stakeholders to secure the present and prepare for the future.

While ODH convened, sponsored and staffed the DTF, it was an independent group. The recommendations in this document reflect the perceptions and deliberations of the group. Some positions may not reflect the official position of ODH or the State of Ohio. Jackson appreciates the work of the DTF and looks forward to working in partnership with people and organizations that share the vision: All Ohioans will have optimal oral health.



# Table of Contents

Introduction .....	1
Table of Contents .....	3
Strategic Map .....	4
Executive Summary .....	5
Director’s Task Force Membership .....	7
Process Overview .....	8

## Strategic Plan

Community-based/Community-wide Dental Disease Prevention [I] .....	12
Financial Barriers: Medicaid & State Child Health Insurance Programs (SCHIP) [II] .....	14
Dental Care Delivery System .....	16
Capacity – Workforce [III] .....	17
Capacity – Safety Nets [IV] .....	18
Capacity – Primary Care Providers and Other Non-dental Professionals [V] .....	19
Public Awareness [VI] .....	21
Individuals with Special Needs [VII] .....	23
Diversity & Cultural Competence [VIII] .....	24
Partnerships [IX] .....	25

## Implementation Plan

Implementation Plan Overview .....	29
Ongoing Plans .....	30
Short-term Plans .....	31

## Appendices (at <http://www.odh.ohio.gov/odhPrograms/ohs/oral/oralfeatures/Taskforce.aspx>)

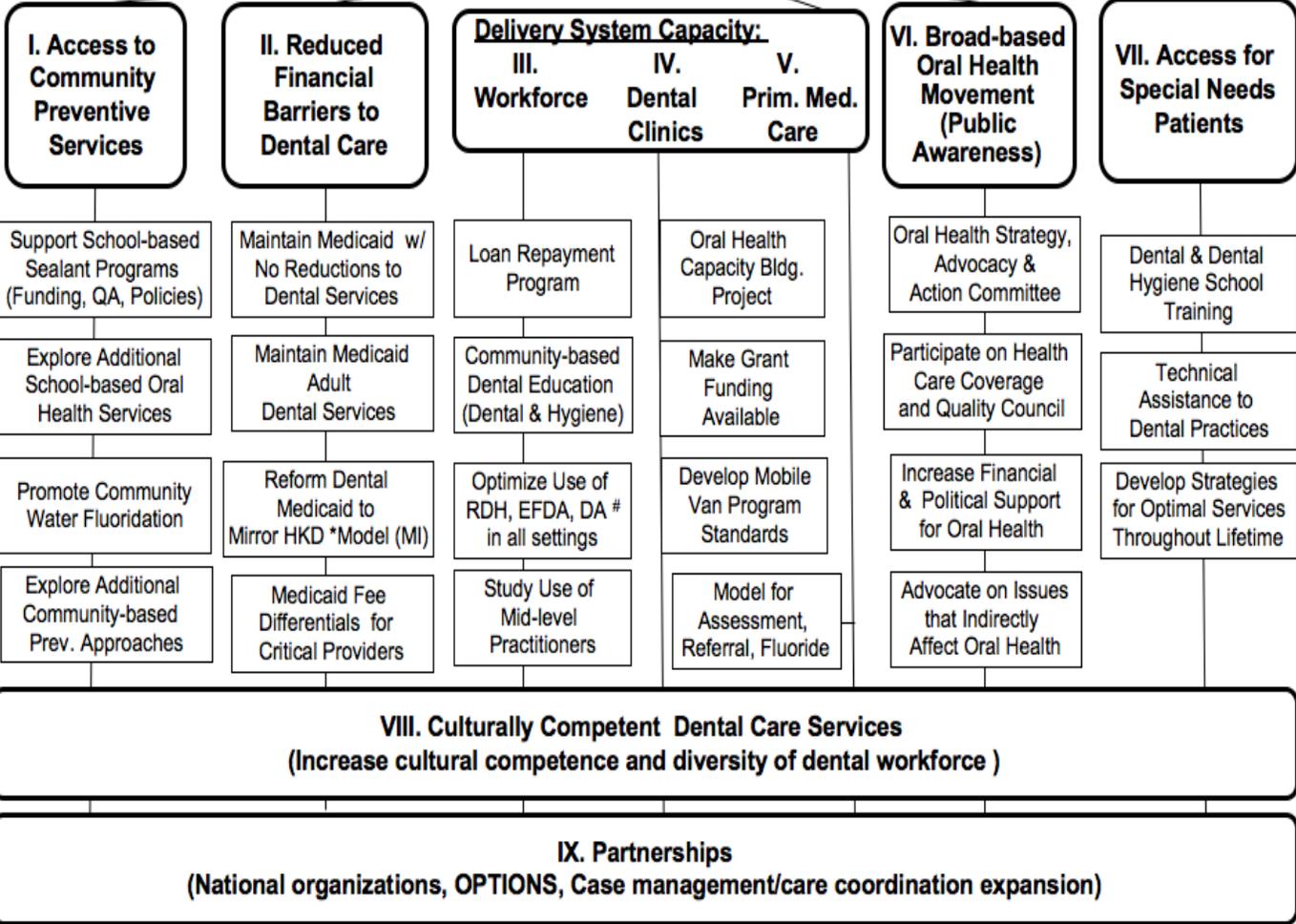
- Appendix 1: Summary of Public Meetings
- Appendix 2: Highlights of Expert Presentations

*Director Jackson and the staff of the Ohio Department of Health, Bureau of Oral Health Services, wish to thank the members of the Director’s Task Force for their hard work during the process and their ongoing dedication to achieving optimal oral health for all Ohioans.*

*In addition, the director and staff thank ChangeWorks of the Heartland for organizing the process, facilitating the meetings and documenting the work of the Director’s Task Force.*

**Director of Health's Task Force on Oral Health and Access to Dental Care, 2009  
Strategic Map**

**Vision: All Ohioans Will Have  
Optimal Oral Health**



\* Healthy Kids Dental (HKD) is the program through which the State of Michigan administers dental care for Medicaid-eligible children in selected counties.

# Registered Dental Hygienists (RDH), Expanded Function Dental Auxiliaries (EFDA), Dental Assistants (DA)

# Executive Summary

**Vision:** All Ohioans will have optimal oral health.

**Strategic Impact:** In order to move toward this vision, it is essential that the Ohio Department of Health (ODH), its partners and other key stakeholders implement strategies *that increase the number of the most vulnerable Ohioans<sup>1</sup> (i.e., people who have Medicaid coverage, those who are uninsured, and other disadvantaged<sup>2</sup>) who receive appropriate oral health care and have optimal oral health.*

**Outcomes, Measurement and Accountability:** DTF members believe that the key to having strategic impact is having outcome-focused strategies. To the extent possible, each strategy in this plan has been framed in outcome-oriented language. There are some tools that will be helpful in tracking progress, including the Ohio Family Health Survey and the *Make Your Smile Count!* oral health survey. However, this plan also acknowledges that for some strategies there are not clear, broadly accepted measures or there are not systems for gathering and interpreting key data. Future implementation plans will need to address these challenges.

## Recommendations:

The following outcomes were developed and affirmed by the DTF as recommendations to the director and others committed to the vision.

- I. **Increase the number of Ohioans who benefit from effective community-based and community-wide dental disease prevention strategies, especially the most vulnerable Ohioans.**
- II. **Reduce financial barriers to achieving oral health and accessing dental care.**
- III. **Increase the number of trained dentists and dental hygienists willing to work with the most vulnerable Ohioans.**
- IV. **Allocate resources to assure support for a meaningful and sustainable dental safety net that can increase the number of the most vulnerable Ohioans receiving dental care.**

<sup>1</sup> Throughout the rest of this document, the phrase “most vulnerable Ohioans” will refer to people who have Medicaid coverage, those who are uninsured and other disadvantaged Ohioans.

<sup>2</sup> **Disadvantaged:** Refers to a broad range of people who face economic challenges, systemic barriers, differential care (intentional or unintentional) and/or have special needs that limit their access, such as those who are very young, very old, homeless, geographically isolated, chemically dependent or have developmental disabilities and other health-related challenges.

- V. Increase the number of primary care providers and other non-dental health professionals who are actively involved in improving the oral health of their patients.
- VI. Build a broad-based oral health movement that is recognized as an important political force that must be accounted for in all public policy deliberations directly or indirectly related to health.
- VII. Increase the number of trained providers, including dentists and dental hygienists treating people with special needs (e.g., developmental disabilities, the very young, the very old and the medically fragile), appropriately throughout their lifetimes, especially those among the most vulnerable Ohioans.
- VIII. Provide all community-based prevention programs and dental care services in a culturally competent manner.<sup>3</sup>
- IX. Increase optimal oral health by reinforcing old partnerships and building new partnerships that recognize and leverage common ground related to oral health outcomes for the most vulnerable Ohioans, while acknowledging and respecting legitimate differences among partners.<sup>3</sup>

**Implementation Plan:** The DTF primarily made three types of recommendations: 1) those that relate to initiatives in place; 2) those that can and should be addressed in the short-term future and require little or no additional investment of scarce resources; and 3) those that are more long term, requiring investment in identifying leadership, building relationships and other resources. One important recommendation calls for convening an inclusive statewide oral health advocacy and action group to continue to carry on with the director's charge and to bring focus and continuity to Ohio's oral health agenda. This plan will be a road map for the group when it is convened. Because this group is likely to play such an important role in implementing the plan, the DTF did not provide implementation details for the entire plan. Nevertheless, this document includes a limited implementation plan that highlights the programs that are in place and short-term strategies. As the advocacy and action group is formed and the economy improves, the long-term strategies will become actionable.

<sup>3</sup> Cross-cutting outcomes that generally must be integrated into the accomplishment of other outcomes.

## Ohio Director of Health's 2009 Task Force On Oral Health and Access to Dental Care

Dr. Homa Amini  
**Ohio Academy of Pediatric Dentistry**  
Department of Dentistry  
Nationwide Children's Hospital

Dr. Carol Anderson, *Dean*  
**The Ohio State University**  
**College of Dentistry**

Ms. Cheryl Boyce, *Executive Director*  
**Ohio Commission on Minority Health**

Ms. Robyn Colby, *Chief*  
**Ohio Department of Job  
and Family Services**  
**Ohio Health Plans**  
Bureau of Policy and Benefit Management

Dr. Henry Fields, *Immediate Past-President*  
**Ohio Dental Association**  
The Ohio State University  
College of Dentistry

Dr. Jerold Goldberg, *Dean*  
**Case Western Reserve University**  
**Case School of Dental Medicine**

Ms. Viola M. Gomez  
Consumer Representative  
Director of Grants & Programs  
**PathStone**

Dr. William Hayes, *President*  
**Health Policy Institute of Ohio**

Dr. Lawrence F. Hill, *Chair*  
**Ohio Coalition for Oral Health**

Ms. Jeanne Huber, RDH, *President*  
**Ohio Dental Hygienists' Association**

Alvin D. Jackson, M.D., *Director*  
**Ohio Department of Health**

Dr. Uma Gupta  
**Ohio Chapter, American  
Academy of Pediatrics**

Dennis G. Murray, *Health Commissioner*  
**Association of Ohio Health  
Commissioners**  
Knox County Health Department

Dr. Mark Siegal, *Chief*  
**Ohio Department of Health**  
Bureau of Oral Health Services

Ms. Kathy Trace, *Director*  
**AHEC and Community Health Programs**  
**College of Osteopathic Medicine**  
**Ohio University**

Ms. Mary Wachtel, *Director of Health Policy*  
**Voices for Ohio's Children**

Dr. Tom Woodruff  
**Ohio Association of  
Community Health Centers**  
Community Health Services (Fremont)

Ms. Theresa Wukusick, *Program Director*  
**The Anthem Foundation of Ohio**  
**The Greater Cincinnati Foundation**

---

### Facilitator

Chris Kloth  
ChangeWorks of the Heartland  
[chris@got2change.com](mailto:chris@got2change.com)

### ODH Staff

Barbara Carnahan  
Carrie Farquhar  
Petra Richards  
Mona Taylor

## **2009 Director's Task Force on Oral Health and Access to Dental Care (DTF) Process Overview**

The DTF convened in December 2008 and completed its work in August 2009. There were four major elements: organization and focus, community meetings, deliberations and decisions. Each is described briefly.

### Organization and focus

The group first met Dec. 4, 2008. Dr. Alvin D. Jackson delivered his charge to the group. Dr. Mark Siegal, chief of the BOHS, provided an overview of past task forces, progress made on past recommendations and an overview of oral health issues facing the nation and the state. DTF members introduced themselves and shared their interests in the process.

The DTF accomplished two important tasks at its first meeting. One was to identify the questions it wanted answered at a series of community meetings planned for January – March, 2009. Members also articulated a decision making process for making their final recommendations. Their desire was to achieve consensus on all recommendations. However, they agreed that if there were any recommendations on matters that were important to address in the plan but were too contentious to achieve consensus on, they would resolve the matter with a majority vote and an invitation to include a minority report in the final recommendations.

### Community meetings

Health care providers, consumers and advocates concerned about oral health were invited to attend a series of regional community meetings throughout the state. When the DTF met for the first time on Dec. 4, 2008, the members identified the following five questions they wanted answered at the meetings:

1. What barriers make it difficult for you or your clients to access or provide oral health care and prevention services?
2. If you have successfully overcome barriers to getting oral health care or prevention services, what or who helped you succeed?
3. What experiences have you had accessing oral health care or prevention services through safety net clinics, private dentists or other providers such as physicians, school nurses, dental hygienists, etc.?
4. Where do oral health care and prevention services fit among the many choices you, your family or your patients face each day? Why?
5. What public policy recommendations do you have related to increasing access to oral health care and prevention services?

The meetings occurred between Feb. 24 and March 18, 2009. They were conducted in seven locations, including three urban locations, two suburban locations and two rural locations. Local agencies and advocacy groups were informed of the meeting schedule and provided tools to support reaching out to and including consumers. An effort was made to hold the meetings in locations near or accessible to consumers, such as local health departments, community action agencies and libraries. Despite those efforts, the DTF members were not satisfied that enough consumers were able to attend the sessions and made suggestions on how to improve outreach for future engagement processes. Of particular concern was the time the meetings were held.

At each location, there were two three-hour meetings, one in the morning and one in the afternoon. The morning sessions focused on consumer issues. The afternoon sessions focused on provider issues. At most meetings, there were advocates who attended both meetings. While there were many differences in perspective between consumers and providers, there was also considerable agreement.

A complete summary of the regional meetings is available at <http://www.odh.ohio.gov/odhPrograms/ohs/oral/oralfeatures/Taskforce.aspx>.

### Deliberations

After the regional meetings, the DTF met five times. The first four meetings each focused on one or two substantial issues affecting oral health access. Subject matter experts were included in each meeting to provide perspectives on national policies and practices, including strategies that had been tried in the past, what was learned from past practices and research and ideas for future consideration.

Each of these presentations was followed by facilitated discussion of the presentation and lively deliberation on how they applied to Ohio. The deliberations were documented by the facilitator on chart pads, with an eye toward identifying the basis for recommendations. DTF members were provided with summaries of each meeting to review and critique to assure they captured the deliberations fairly and comprehensively.

As the DTF deliberative meetings began, there were requests from some stakeholders to attend the meetings, including Medicaid Managed Care providers and funders. While they were not invited to be members of the DTF, they were invited to attend the meetings as observers and, when their perspectives could enrich the deliberations, they were invited to participate in the conversations. They were also provided with meeting summaries and asked to provide feedback.

### Decisions

As the meetings proceeded, the meeting summaries began to include draft language for potential recommendations. Prior to the last meeting, DTF members were provided draft proposals for recommendations. For issues that had conflicting perspectives,

language was offered to reflect divergent perspectives. Members were invited to comment on the draft language before the meeting and the draft language was further revised.

Feedback from the group suggested there was considerable common ground. It also became clear that members wanted a document that balanced vision and practical realities, especially with respect to the economy. They wanted priorities, not a wish list. Based on their feedback, the facilitator developed and provided members with a grid adapted from *nominal group technique* that allowed them to rank issues.

The results of their rankings allowed the facilitator to begin the meeting by summarizing what topics they seemed ready to drop, topics they seemed to agree on and topics there was still disagreement on. After some discussion, it was agreed that the group would use the meeting to address differences. There was lively discussion and the basis for agreement emerged on most issues.

After the meeting, members were provided a draft of the recommendations to comment on. The draft included compromise language based on their deliberation. No member felt the need to provide a minority report.

The recommendations in this document reflect the hard work, good thinking and commitment of DTF members to provide Jackson and other stakeholders with recommendations that balance visionary aspirations and practical realities. It is intended to provide guidance to the ODH and other stakeholders as they strive to help all Ohioans achieve optimal oral health and overcome barriers to accessing care.

# Strategic Plan



## Community-Based<sup>4</sup>/Community-Wide<sup>5</sup> Dental Disease Prevention

During the DTF deliberations, prevention was discussed from at least two perspectives. As the definitions suggest, community-based/community-wide dental disease prevention strategies address large numbers of people within particular communities or population groups, as opposed to clinical prevention activities that occur on a case-by-case basis in a dental chair. Both are important, but they occur on different scales and in different ways. The following recommendations focus on community-level impact, affecting populations.

### RECOMMENDATION



**Increase the number of Ohioans who benefit from effective community-based and community-wide dental disease prevention strategies, especially among the most vulnerable Ohioans.**

## Strategies

### Short Term

1. Maximize the sustainability of school-based dental sealant programs by continuing to fund grants for school-based dental sealant programs.
2. Assure school-based dental sealant program quality through adherence to Ohio Department of Health standards (e.g., manual, standing orders, distance learning curriculum), that have been linked to achieving quality outcomes.
3. Enable school-based dental disease prevention programs (e.g., sealants, fluoride varnish) to utilize staffing patterns that reduce costs and promote efficiency while meeting dental public health standards.
4. Develop alternatives to ODH grant funding to expand access to school-based dental sealant programs for children at higher risk for dental decay (e.g., in areas without critical mass to receive an ODH grant).

As defined by the Task Force on Community Preventive Services:

<sup>4</sup> Community-based prevention: Setting-specific interventions to reduce dental disease in specific populations (e.g., School-based dental sealant programs).

<sup>5</sup> Community-wide: Broad-based strategies to promote health and prevent disease in the population (e.g., community water fluoridation).

5. Convene a task force on school-based services and standards to:
  - a. Develop a model for increasing access to effective school-based programs.
  - b. Promote and expand effective school-based programs.
6. Encourage adoption of community water fluoridation by providing local decision makers and the public with high quality information on fluorides and fluoridation.
  - a. Maintain current information and links to resources on the ODH Web site.
  - b. Provide consultation and other support to communities that wish to fluoridate their public water systems.

Long Term

1. Identify and assess promising community-based oral disease prevention activities and consider adopting, adapting or piloting promising programs that seem well-suited to Ohio.

## **Financial Barriers: Medicaid [including the Child Health Insurance Program (CHIP)]<sup>6</sup>**

In order to move toward the vision of optimal oral health for all Ohioans it is essential that ODH, its partners and other key stakeholders implement strategies that increase the number of the most vulnerable Ohioans who receive dental care. There are many barriers to getting access to care. Most are directly or indirectly related to poverty.

Medicaid is an essential tool in helping the most vulnerable Ohioans. However, the DTF perceives that low enrollments and reimbursement rates that are insufficient to engage a critical mass of dentists limit their impact. The current economic conditions nationally and in Ohio have the potential to undermine the impact of these tools. In the short-term, these recommendations call for maintaining coverage at current levels in the face of potential cutbacks. In the future, it will be important to secure past gains from future threats.

### **RECOMMENDATION**



**Reduce financial barriers to  
achieving oral health and accessing dental care.**

### **Strategies**

#### Short Term

1. Maintain all major aspects of existing Medicaid dental benefits (e.g., fees, patient eligibility and scope of services).

#### Long Term

1. Secure coverage of adult dental services through Medicaid for the future.
2. End the practice of reimbursing claims for diagnostic services (e.g., examinations, radiographs) to providers who do not offer treatment services.
3. Explore and test Medicaid fee differentials for:
  - a. Qualified providers who deliver quality, comprehensive services during convenient hours for patients.
  - b. Qualified providers who see patients with special needs (including very young children, persons with disabilities and frail elderly).

<sup>6</sup> In Ohio, eligibility for the Child Health Insurance Program places a child into Medicaid (rather than a separate CHIP program), where they are most likely to receive services from a Managed Care Plan.

- c. Primary care dentists practicing in designated dental health professional shortage areas (HPSAs).
4. Medicaid and Medicaid managed care plans will simplify policies and practices related to serving people with special needs, such as approving and reimbursing transportation of patient groups to providers' sites.
5. 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 minimum, the dental program should have the following features:
  - a. Fee-for-service payment to dentists at rates competitive with commercial insurance plans.
  - b. From the perspective of dental offices, make Medicaid patients appear administratively indistinguishable from commercially insured patients.
  - c. Ohio Department of Job and Family Services (ODJFS) will report to its Medical Care Advisory Committee and to the Ohio Dental Association the extent to which the third-party administrator meets outcome objectives, including provider participation and percentage of Medicaid beneficiaries receiving quality dental care.

## Dental Care Delivery System

In order to serve the most vulnerable Ohioans, the system relies on a trained *workforce* that is willing to serve those in need and a sustainable network of *safety net clinics*. The report of the *2000 Director of Health's Task Force on Access to Dental Care* states, "The dental care delivery system consists of mostly solo and two-dentist private practices and a relatively small number of safety net clinics. At first glance, there appears to be enough dentists to serve the oral health needs of all Ohioans. However, access to dental care is not simple math. Ohio dentists are disproportionately located in suburban areas, which tend to be higher income, while low-income Ohioans are disproportionately located in urban and rural Appalachian areas." Dentists in both private practice and the safety net are supported by a workforce of dental hygienists, dental assistants and expanded function dental auxiliaries (EFDA). In addition, there are *primary medical care providers and other non-dental professionals* who can help increase access, particularly for young children who are not seeing dentists. While there has been progress in addressing system capacity since 2000, limitations persist.

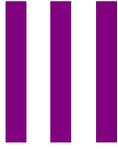
To discuss the capacity of the dental care delivery system in Ohio, as in most states, is to discuss a complex, interdependent system where interdependent parts often act independently, either by design or default. In either case, the actions can limit the capability of the system to operate at its full capacity. Dental schools prepare new dentists, but the graduates may not practice where there is the most need. Safety net clinics serve those who cannot pay but may not have the tools or resources to use the staff they have most effectively. Whether in clinics or private practice, some providers more effectively utilize their own staff and other community resources than others. Complex, interdependent systems are most effective when they strengthen and leverage their interdependent parts, reducing weak links with partnerships, training, technical assistance, data, tools, flexibility and incentives.

Three key elements of system capacity will be addressed in these recommendations: workforce, safety net dental clinics and primary medical care and other non-dental providers.

### **Capacity – Workforce**

There is a shortage of trained dentists and dental hygienists willing to serve those in most need. It is essential to increase the number of providers currently in practice who are willing to serve. It is also important to increase the number in training who will serve in the future. To do so will require attracting and preparing students who have a commitment to serving the most vulnerable. In addition, it will be essential to create system supports that encourage those who choose to work with the most vulnerable to continue to do so throughout their careers. However, given the number of people currently in need of care, it is important to make better use of the capabilities of dentists and dental hygienists already in the system. These recommendations address workforce challenges, recognizing that most of the workforce is in private practice.

## RECOMMENDATION



**Increase the number of trained dentists and dental hygienists willing to work with the most vulnerable Ohioans.**

## Strategies

### Short Term

1. Maintain and, as external funds become available, expand the Ohio Dentist Loan Repayment Program.
2. Provide *community-based dental education* (CBDE<sup>7</sup>) for dental students and residents to prepare dentists to work more effectively with disadvantaged populations and in underserved areas.
3. Provide adequate education for dental hygiene students to work more effectively with disadvantaged populations and in underserved areas.
4. Maintain operation of the Dental OPTIONS dental referral program, a partnership between the Ohio Department of Health and the Ohio Dental Association.

### Long Term

1. Optimize the use of dental hygienists, EFDAs and dental assistants in
  - a. Private dental practices
  - b. Safety Net Dental Clinics
  - c. Community-based prevention programs
2. Study the effective use of mid-level dental practitioners to identify approaches that might be adopted, adapted or piloted in Ohio to increase the capacity of the system to provide care for the most vulnerable Ohioans.

<sup>7</sup> *Community-based dental education* (CBDE) is an approach to dental education that links the pedagogies of experiential learning and service learning. CBDE is not a particular curriculum. For more information, see the *Journal of Dental Education*.

# Dental Care Delivery System

## Capacity – Safety Net Dental Clinics

The dental care safety net is a network of federally qualified health centers (FQHCs) and other government-affiliated or nonprofit clinics. These clinics offer care without regard for one’s ability to pay for services. The demand for safety net dental care services exceeds the capacity. Waiting lists for appointments can be long, which can contribute to high “no-show” rates. Travel time for some people who need care can be great. Given their mission of providing an open door to those who can’t afford private care (i.e., uninsured, Medicaid and other vulnerable patients), safety net clinics are both a unique resource for increasing access and a challenging resource to sustain without financial support.

### RECOMMENDATION

# IV

**Allocate resources to assure support for a meaningful and sustainable dental safety net that can increase the number of the most vulnerable Ohioans receiving dental care.**

## Strategies

1. Continue the Oral Health Capacity Building Project, a collaboration between three Ohio charitable foundations and ODH, to:
  - a. Develop tools and mechanisms that can be used by providers to improve their operations on their own.
  - b. Provide current, accessible (i.e., through <http://www.ohiodentalclinics.com>), high quality information about operating effective and sustainable clinics.
  - c. Provide technical assistance to local agencies on clinical services, business/practice management and working collaboratively.
2. Develop and implement standards for the use of mobile dental vans to provide appropriate dental disease prevention and dental care services (comprehensive and emergency).
3. Make the dental safety net sustainable by funding:
  - a. Operating subsidies to help offset uncompensated care in safety net dental clinics.
  - b. Capital costs when necessary for expansion of existing safety net dental clinics and/or establishment of new sites.

# Dental Care Delivery System

## Capacity – Primary medical care providers and other non-dental professionals

Oral health is one aspect of overall health, and oral disease can compromise one's overall health. Many people, especially young children, are more likely to have contact with primary medical care providers and other non-dental professionals than with dental care providers. The symptoms of oral disease can be observed by primary care providers, school nurses, social workers and others. Any of these care givers can make a referral to a dental care provider. Some prevention services can be delivered by non-dental professionals. The DTF believes that achieving optimal oral health for all Ohioans requires more strategic partnerships with primary care providers and other non-dental professionals.

Case management/care coordination is another valuable service, provided by non-dental professionals, that can positively impact the ability of vulnerable populations to access dental care. A number of people who spoke at the regional oral health community meetings discussed what they saw as the benefits of case management/care coordination and indicated a need to more effectively utilize these services as an access tool.

### RECOMMENDATION

V

**Increase the number of primary care providers and other non-dental health professionals who are actively involved in improving the oral health of their patients.**

## Strategies

1. Partner with primary care providers (e.g., family practitioners, pediatricians, OB/GYNs, advanced practice nurses, geriatric specialists) and other non-dental health professionals (e.g., emergency room doctors, nurses, medical specialists, public health workers) to develop, adopt or adapt an oral health workforce model that recognizes the contributions of non-dental professionals to:
  - a. Assess the oral health status of individuals and families.
  - b. Refer individuals and families to appropriate oral health professionals.
  - c. Provide appropriate preventive services (e.g., fluoride varnish).

2. Expand use of case management/care coordination, while reducing the incidence of multiple care coordinators with overlapping roles for the same patient/family.
  - a. Identify successful interdisciplinary case management models.
  - b. Provide incentives to adopt successful interdisciplinary case management models.
  - c. Engage Medicaid Managed Care providers in assessing, developing, adapting or adopting case management/care coordination models.
  - d. Provide reimbursement for case management/care coordination.

## Public Awareness

Public awareness is essential to the successful implementation of any public policy. In years past, ODH plans have included strategies to increase public awareness from the perspective of influencing the daily oral health choices of individuals. While individual choices made on a daily basis are important in promoting oral health, there is little evidence that past efforts to influence individual behavior have resulted in the kind of significant population-based changes that public policy needs to address.

In this plan, the DTF makes three changes in how it approaches public awareness as a strategic issue. First, the primary focus shifts to influencing the actions of decision makers, policy makers and other key stakeholders who can affect the design and implementation of public policy. In addition, emerging evidence suggests that *social marketing* may be an effective approach to influencing both individual health choices and public policy choices. Finally, as Ohio's demographics become increasingly diverse, there is emerging evidence that suggests adapting core messages for targeted populations is important to influencing individual and collective behavior.

### RECOMMENDATION

# VI

**Build a broad-based oral health movement recognized as an important political force that must be accounted for in all public policy deliberations directly or indirectly related to health.**

## Strategies

### Short Term

1. Create an ongoing, statewide, interdisciplinary oral health strategy, advocacy and action group composed of individuals who are empowered to make decisions on behalf of the influential organizations they represent. Influenced by the DTF recommendations, the group will develop and carry out action agendas intended to influence public policy to increase promotion of oral health and access to dental care.<sup>8</sup>
2. Become actively involved in the work of the Ohio Health Care Coverage and Quality Council (HCCQC), ensuring it includes private practice and public health dentists, as

<sup>8</sup> In preparation for this work, the group will need to invest in building trust and common ground among diverse partners and allies who may not have worked together in the past or may have strongly disagreed on some issues in the past. The group will need to develop clear, compelling messages and make sure they are delivered by all partners and allies in ways that are clear and consistent.

well as dental hygienists on each of its four major work groups, as well as other task groups it creates.

### Long Term

1. Increase oral health literacy through social marketing:
  - a. Develop and implement effective oral health literacy messages, materials and campaign strategies targeted at:
    - i. Decision makers, policy makers and other key stakeholders, as well as
    - ii. Grassroots community groups that can influence the choices of individuals and families.
  - b. Develop and disseminate targeted core messages that reflect an understanding of the needs and challenges of specific populations that are consistent with the recommendations related to cultural competence, diversity and special needs, detailed elsewhere in this plan.
2. Increase financial and political support by elected officials, providers and other key stakeholders for:
  - a. Expanding evidence-based, community-based/community-wide prevention.
  - b. Increasing the number of Medicaid-covered patients, uninsured patients and other disadvantaged Ohioans receiving optimal oral health care.
  - c. Incorporating oral health as one essential aspect of all patient-centered health care and wellness delivery systems.
3. Increase financial and political support by elected officials, providers and other key stakeholders for:
  - a. Expanding evidence-based, community-based prevention.
  - b. Increasing the number of the most vulnerable Ohioans receiving optimal oral health care.
  - c. Incorporating oral health as one essential aspect of all patient-centered health care and wellness delivery systems.

## Individuals with Special Needs

The DTF process made clear that there are particular populations that have special health needs. While some of these groups are much larger than others, the financial and emotional costs for even the smallest group can be significant. Some of the strategies elsewhere in this plan will help address these groups in addition to others. In addition, while some of these groups are not typically included in deliberations on diversity, it seems clear that they share similar barriers with other marginalized populations.

There are many well-established advocacy groups and service organizations that understand the challenges faced by these populations and have valuable perspectives that may help address the challenges. Partnership with such groups will be an essential aspect of improving oral health and increasing access to dental care for these groups.

### RECOMMENDATION

# VII

Increase the number of trained providers, including dentists and dental hygienists, treating people with special needs (e.g., developmental disabilities, the very young, the very old and medically fragile) appropriately throughout their lifetimes.

### Strategies

1. Dental and dental hygiene schools will:
  - a. Provide an adequate number of experiences to students and residents working with people with special needs.
  - b. Increase the number of students and residents participating in experiences treating people with special needs.
2. Provide technical assistance to dental providers to enhance their clinical practices and organizational systems to facilitate working with people with special needs, such as:
  - a. Practice management.
  - b. Case management.
  - c. Taking services to homes and facilities where patients live.
  - d. Other methods for better treating people with special needs.
3. Partner with families and others working with or advocating for people with special needs to develop better strategies for providing optimal services throughout their lifetimes.

## Diversity & Cultural Competence

Ohio's demographics continue to change significantly. In this context, health disparity data suggest the extent to which care is, or is not, provided in a culturally competent manner may lead to compromised oral health outcomes. Nationally and locally there is significant interest in how to address the health challenges related to cultural diversity. While there is ongoing interest in diversity and cultural competence, there is no clear evidence or consensus that particular strategies are more or less effective. Despite the emerging nature of this work, the DTF believes that public health and social justice outcomes require that resources be devoted to diversity and cultural competence. In addition to the public health and social justice outcomes, in the face of changing demographics statewide, providers have a business interest in providing culturally competent care as a strategy for growing their patient base.

The Strategic Map identifies culturally competent dental services as a strategy that cuts across every other outcome and strategy. Diversity is encountered everyday in every aspect of the work of achieving optimal oral health for all Ohioans. Cultural competence speaks to how providers do every aspect of their work. It is not one more task on an already too-long to-do list. Too often it is treated as an extra responsibility that can be delegated to others. Every person who interacts with a patient, from front desk staff to the dentist, influences the patient's experience and comfort.

### RECOMMENDATION

# VIII

**Provide all community-based prevention programs and dental care services in a culturally competent manner.**

### Strategies

- a. Convene a multicultural cultural competency work group to identify or develop cultural competency/diversity indicators, measures, methods, tools and accountability related to the following three strategies:
  - a. Increase the cultural competence of the oral health workforce.
  - b. Increase the cultural diversity of the oral health workforce.
  - c. Design and implement models for building organizations and systems that are culturally competent and reflect the diversity of the workforce in their communities.

## Partnership

The DTF recognizes that partnerships will be essential to achieving optimal health. As the strategic map indicates, partnership is a cross-cutting strategy that should become a part of every other strategy. While some strategies in other sections of this plan explicitly identify or call for partnerships, working in partnership should be implicit in *all* strategies.

As oral health providers and advocates begin building a movement, it will be valuable to focus on three types of partnerships: among peers, across sectors and at the national level. Peers can learn from one another and, if they speak with one voice, be more influential. Other sectors (e.g., human services, education, food quality and access, consumers, families and other professions and systems) affect oral health and are affected by lack of oral health. The national focus on health care reform provides opportunities to partner with government, philanthropy and professional groups to acquire and leverage resources at every level to increase access to dental care for the most vulnerable Ohioans. Gaining allies to advance the vision will require working with others to advance their agendas and inviting others into the oral health sector.

### RECOMMENDATION

# IX

**Increase optimal oral health by reinforcing old partnerships and building new partnerships that recognize and leverage common ground related to oral health outcomes for the most vulnerable Ohioans, while acknowledging and respecting legitimate differences among partners.**

### Strategies

1. Partner with national organizations (e.g., Pew Charitable Trusts) to increase the impact of the key elements of this strategic plan.
2. Create an ongoing, statewide, interdisciplinary oral health strategy, advocacy and action group composed of individuals who are empowered to make decisions on behalf of the influential organizations they represent. Influenced by the DTF recommendations, the group will develop and carry out action agendas intended to influence public policy to increase promotion of oral health and access to dental care.<sup>9</sup>

<sup>9</sup> Although this partnership was first presented as a strategy in the group related to public awareness (VI.1. on p. 21), it is such a fundamental partnership-based strategy that it bears repeating here.



# Implementation Plan





## Implementation Plan Overview

In Ohio Department of Health (ODH) Director Alvin D. Jackson's charge to the Director of Health's Task Force on Oral Health and Access to Dental Care, he asked that it strategically plan realistic ways of meeting the priority oral health/prevention needs within the state and put them into the form of recommendations—*not just to ODH or "the State,"* but to *whoever can take action to make a difference in the lives of Ohioans.* While some of the outcomes and strategies identified are within the scope of responsibilities of the ODH, the more transformational strategies require leadership from, or partnership with, other stakeholders.

The DTF has completed its work and has no ongoing roles or responsibilities. In the past, many organizations and coalitions have been advocates for some aspects of oral health public policy in Ohio as the need arose. Some have been focused on particular issues for a sustained period. Ohio has not had a single group that can speak clearly and forcefully representing the full range of perspectives on, and voices for, oral health, especially for the most vulnerable Ohioans.

ODH and several funders in Ohio have been willing to convene task forces and fund pilot projects and ongoing initiatives. The DTF recommendations call for convening an inclusive statewide oral health advocacy and action group to continue to carry on with Jackson's charge and to bring focus and continuity to Ohio's oral health agenda. Implementing this plan will be a road map for the group when it is convened.

Because this group is likely to play such an important role in implementing the plan, and because the group will include a much broader cross-section of stakeholders, the DTF was not in a position to provide implementation details for the entire plan. However, implementation is important and some of the DTF members will be able to advance portions of the plan while the new group is formed.

This plan recognizes three types of recommendations made by the DTF: 1) those that relate to initiatives already in place; 2) those that can and should be addressed in the short-term future and require little or no additional investment of scarce resources; and 3) those that are more long term, requiring investment in identifying leadership, building relationships and other resources. This Implementation Plan highlights the ongoing and short-term goals. As the advocacy and action group is formed and the economy improves, the long-term strategies will become actionable.

## Ongoing Implementation Plans (Programs in Place)

Strategy	Implementation Responsibility
Maximize the sustainability of school-based dental sealant programs by continuing to fund grants for school-based dental sealant programs.	Ohio Department of Health (ODH), Bureau of Oral Health Services (BOHS)
Assure school-based dental sealant program quality through adherence to ODH standards (e.g., manual, standing orders, distance learning curriculum), which have been linked to achieving quality outcomes.	ODH
Encourage adoption of community water fluoridation by providing local decision makers and the public with high quality information on fluorides and fluoridation. <ul style="list-style-type: none"> <li>• Maintain current information and links to resources on the ODH Web site.</li> <li>• Provide consultation and other support to communities that wish to fluoridate their public water systems.</li> </ul>	ODH
Maintain and, as external funds become available, expand the Ohio Dentist Loan Repayment Program.	ODH
Fund operating subsidies to help offset uncompensated care in safety net dental clinics.	ODH (Safety Net Dental Clinic Grants)
Fund capital costs when necessary for expansion of existing safety net dental clinics and/or establishment of new sites.	ODH (Safety Net Dental Clinic Grants)
Maintain operation of the Dental OPTIONS program of dental referral coordination.	ODH
Provide Community-based Dental Education (CBDE) for dental students and residents to prepare dentists to work more effectively with disadvantaged populations and in underserved areas.	Ohio State University College of Dentistry & Case Dental School
Maintain all major aspects of existing Medicaid dental benefits, e.g., fees, patient eligibility and scope of services.	Ohio Department of Job and Family Services (consistent with direction from Governor's Office and General Assembly)
Continue the Oral Health Capacity Building Project to: <ol style="list-style-type: none"> <li>1. Develop tools and mechanisms that can be used by providers to improve their operations on their own.</li> <li>2. Provide current, accessible, high quality information about operating effective and sustainable clinics.</li> <li>3. Provide technical assistance to local agencies on clinical services, business/practice management and working collaboratively.</li> </ol>	HEALTHPATH Foundation of Ohio (formerly Anthem Foundation), Sisters of Charity Foundation of Canton, Osteopathic Heritage Foundations and ODH

## Short-term Strategies

Strategy	Initial Implementation Responsibility
<p>Become actively involved in the work of the Health Care Coverage and Quality Council (HCCQC), making sure they include private practice <u>and</u> public health dentists, as well as dental hygienists on each of its four major work groups, as well as other task groups it creates.</p> <ol style="list-style-type: none"> <li>1. Contact executive director of HCCQC about how to most effectively become actively involved and influential in the HCCQC.</li> <li>2. As oral health professionals become actively involved in HCCQC, provide input to and participate in HCCQC's small work groups to advance an oral health agenda that includes:               <ol style="list-style-type: none"> <li>a. Promoting the use of a patient-centered dental home as part of the patient-centered medical home strategy.</li> <li>b. Adopting new payment models.</li> <li>c. Promoting informed, active involvement of patients in their health and healthcare decisions.</li> <li>d. Adopt a systematic approach to health information technology.</li> </ol> </li> </ol>	<p>ODH &amp; Health Care Coverage and Quality Council</p>
<p>Convene an ongoing, statewide, interdisciplinary oral health advocacy and action group composed of individuals who are empowered to make decisions on behalf of the influential organizations they represent. (see Implementation Plan narrative)</p>	<p>ODH and Oral Health Capacity Building Project Steering Committee</p>
<p>Partner with national organizations (e.g., Pew Charitable Trusts) to increase the impact of the key elements of this strategic plan.</p> <ol style="list-style-type: none"> <li>1. Identify potential partners.</li> <li>2. Secure funding or other assistance from potential partners.</li> </ol>	<p>ODH</p>
<p>Engage in discussions with charitable foundations to develop alternatives to ODH grant funding to expand access to school-based dental sealant programs for children at higher risk for dental decay (e.g., in areas without critical mass to receive an ODH grant).</p>	<p>ODH and charitable foundations</p>
<p>Convene a multicultural cultural competency work group to identify or develop cultural competency/diversity indicators, measures, methods, tools and accountability related to the following strategies:</p> <ol style="list-style-type: none"> <li>1. Identify or develop strategies that increase the cultural competency in the oral health workforce.</li> <li>2. Identify or develop strategies that increase the cultural diversity in the oral health workforce.</li> <li>3. Review and consider the recommendations, strategies and tactics documented by the national Dental Pipeline Project.</li> <li>4. Identify actionable behavioral indicators of cultural competence and appropriate measures, including those identified by:               <ol style="list-style-type: none"> <li>a. The Robert Wood Johnson Foundation.</li> <li>b. The Ohio Commission on Minority Health.</li> <li>c. Other partners working on promoting culturally competent health care.</li> </ol> </li> </ol>	<p>Ohio Commission on Minority Health (OCMH) &amp; ODH</p>

