

OHIO DEPARTMENT OF HEALTH

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BOB TAFT
Governor

J. NICK BAIRD, M.D.
Director of Health

Dear Interested Party:

In 1999, I was surprised to learn that dental care was the number one unmet healthcare need of Ohioans. I immediately appointed Dr. David Rummel, Past President of the Ohio Dental Association, to chair a task force on access to dental care. The charge was to study the issue and make recommendations for improving access to dental care for vulnerable Ohioans.

Dr. Rummel worked with our Bureau of Oral Health Services to assemble a task force that included representatives of state and local agencies, the Ohio General Assembly, dental schools and dental residency programs, professional associations, non-profit organizations, consumers, business and labor. Committees of specialists in school programs and in community-based approaches supplemented the work of the task force. All told, over 70 people with a broad range of expertise and experience contributed to the process.

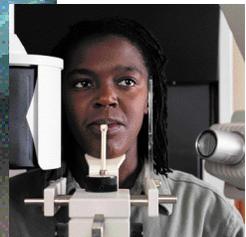
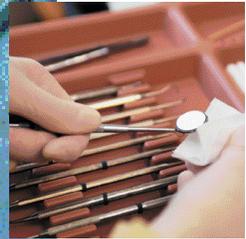
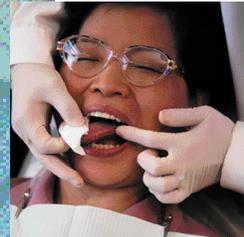
Prior to six monthly meetings for deliberating the issues and formulating its recommendations, the task force considered data on the oral health of Ohioans and their access to dental care. That background information is included in a report on access to dental care that was written by the Ohio Department of Health and the Ohio Department of Job and Family Services.

The recommendations were grouped under four objectives, relating to: Medicaid/SCHIP, the dental care delivery system, community-based approaches and awareness. Under each objective, recommendations believed to have the greatest potential for improving access were categorized as *high*. This document presents the Director of Health's Task Force on Access to Dental Care's recommendations as revised following a two-month public comment period.

I recognize that there are no *quick fix* solutions for complex problems. Therefore, we must persist to make improvements over time. We are committed to using the task force's recommendations as a blueprint for improving access to dental care for vulnerable Ohioans, which is one of the department of health's top ten priorities. We will seek to accomplish those recommendations that fall within our domain and to advocate for other systems to address recommendations that fall within theirs. However, no system can solve the dental care access problem alone. We must work with the private sector, government agencies at all levels and with nontraditional partners who can make a difference. In sharing the task force recommendations, we invite partners in finding solutions to join us.

Sincerely,

J. Nick Baird, MD
Director of Health



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

November 30, 2000

Rummel & Schumacher

Family Dentistry

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November 30, 2000

J. Nick Baird, M.D.
Director of Health
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43216

Dear Dr. Baird:

A year ago the task force that I empanelled first met to address its charge of developing a set of recommendations to increase access to dental care for vulnerable Ohioans. The task force included members from business, labor, consumers, universities, the dental profession, state and local agencies and organizations, and the charitable giving community. The work of over 30 individuals was eventually merged with that of another 40 working on advisory committees specializing in school-based/school-linked and community action issues. After seven months, a set of recommendations was completed.

Last summer, the recommendations were made available for public comment. Most of the 36 comments received supported the need for addressing the problem at hand. Revisions made in response to the comments are reflected in the final recommendations. Many ideas were considered in our thorough and well-organized process. Although some strategies were thought to be valuable, they were not included because they would not impact most vulnerable Ohioans.

These recommendations are an important first step. In presenting them to you, I pledge, on behalf of the Ohio Dental Association, to continue working with the department of health and other partners to improve access to dental care for those in need. While all of the recommendations may be of value, it is necessary to craft an action plan that will result in real change. Some recommendations will likely come to the forefront and others may be held for the longer term. Systematically implementing the action plan represents our best hope for making dental care accessible to vulnerable Ohioans, particularly those who are uninsured or are eligible for Medicaid.

I look forward to working with you to this end.

Sincerely,



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Definition of access to dental care

The Director of Health's Task Force on Access to Dental Care adapted the Institute of Medicine's definition of access to primary care by stating that access to dental care is:

"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 joined the Institute of Medicine in acknowledging that equity, assuring the availability of accessible care for all Ohioans, is a critical element. Finally, 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. The implication being that dental services limited to children or to emergency care or prevention and/or screening are insufficient to meet the health needs of vulnerable Ohioans.

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

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

Medicaid, and now the State Children's Health Insurance Program (SCHIP), are central to public sector attempts to improve access to dental care by paying for care. SCHIP was created to provide publicly subsidized health care coverage to near-poor children who are otherwise uninsured. Ohio implemented SCHIP by expanding Medicaid eligibility for children up to age 19. Therefore, when we speak of Medicaid, we include those eligible through SCHIP.

Medicaid consumers can be grouped into three distinct eligibility markets:

- children in families at or below 200 percent of the federal poverty level*,
- parents at or below 100 percent and pregnant women at or below 150 percent of the federal poverty level, and
- low-income elderly and persons (of all ages) who have disabilities (Aged, Blind and Disabled).

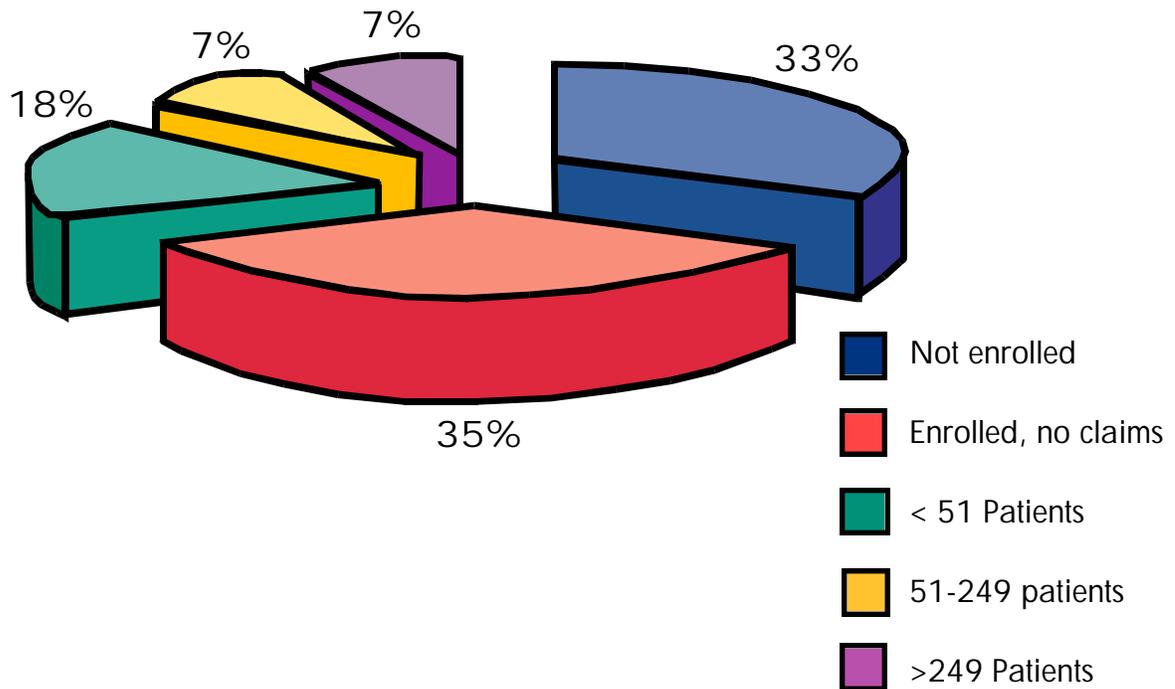
In Ohio, the Medicaid program provided health care to about 1.4 million Ohioans (13% of all residents and 26% of all children) at a cost of approximately \$6.0 billion in state fiscal year 1998#. Prior to a January 2000 fee increase, 1998 payments to dentists through the fee-for-service (FFS) program accounted for less than one percent (0.6%) of all Medicaid expenditures, compared with physicians (4.1%), drugs (10.5%) and hospital outpatient services (3.7%). The two largest categories of expenditures were for nursing facilities (30.7%) and hospital inpatient services (13.7%). Dental care accounts for one percent of the non-institutional budget. The average fee-for-service expenditure per person who received Medicaid dental services in SFY 1998 was \$147.52.

There is considerable unmet potential for Medicaid to improve access to dental care. In 1998, only about 313,000 (25.1%) of Ohioans ages 3 and above in the Medicaid program had a dental visit. Many of the 75 percent of Medicaid eligibles who do not have a dental visit do not seek care at all, while others can not find a dentist who will treat them.

Medicaid relies primarily on private dentists to deliver services reimbursed either directly by the Ohio Department of Job and Family Services (ODJFS) or indirectly through a Managed Care Plan contracted with ODJFS or its agent. The pie chart on the next page, however, shows that most dentists are not active Medicaid providers and only a small group (14%) served at least 50 Medicaid recipients in 1998.

*In 2000, the Federal Poverty Guideline for a family of four was \$17,050/year
#July 1, 1997-June 30, 1998

Ohio Dentist Participation in Medicaid (Fee-For-Service and Managed Care), 1998.



Data Source: Ohio Department of Job and Family Services

Of Ohio dentists who treat Medicaid recipients, almost two-thirds reported limiting them to patients of record, implying that their offices do not accept new Medicaid patients. Dentists most often cite low fees (77%) and cumbersome paperwork (40%) as their primary reasons for not participating in the Medicaid program.*

The Bottom Line:

The following recommendations seek to create a Medicaid dental program that the task force believes will attract and retain more dentists and will improve the oral health of more low-income Ohioans by making more people eligible. The task force felt that the more that Medicaid approximates the reimbursement mechanism and level for most dental patients (commercial insurance), the more likely dentists will be to participate. The centerpiece of the recommendations is the fundamental restructuring of the Medicaid dental program by privatizing it. Subsequent to restructuring the program, are the recommendations for eligibility expansion and a pilot program for small business to “buy in” for their employees.

*Survey of Ohio Dentists, Ohio Department of Health, 1999.

Recommendations: I. Medicaid

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. At a minimum, the dental program should have the following features:
 - Fee-for-service payment to dentists at rates consistent with private insurance plans (at least 85% of Usual, Customary and Reasonable fees, maintained by indexing fees to inflation).
 - From the perspective of dental offices, make Medicaid/SCHIP patients appear administratively indistinguishable from privately insured patients
 - ODJFS, in consultation with a standing dental advisory committee, will closely monitor the third party administrator to assure that outcome objectives are being met in terms of provider participation and percentage of Medicaid/SCHIP recipients receiving quality dental care.
2. *As interim measures, until recommendation #1 has been accomplished, increase fees in the existing Medicaid dental program:
 - a. Rates consistent with private insurance plans (at least 85% of Usual, Customary and Reasonable fees, maintained by indexing fees to inflation).
 - b. Institute 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)#
3. 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.
 - b. Create a standing Medicaid dental advisory committee to regularly review covered and non-covered services, reimbursement rates and other aspects of Medicaid dental program administration.
 - c. Utilize case management benefit options for Medicaid beneficiaries (e.g., EPSDT case management, administrative case management for special populations) so that dental professionals can be compensated for time spent in patient anticipatory guidance, care plan development and case management.
 - d. Reimburse physicians and Advanced Practice Nurses for dental assessment and fluoride varnish application.
4. Phase in an expansion of publicly subsidized dental coverage for low-income Ohioans:
 - a. Expand Medicaid eligibility to include adults with incomes up to 200 percent of federal poverty level (FPL).
 - b. Develop a pilot program for subsidized dental coverage to employees of small businesses in two rural and two urban counties.

*High Priority

"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. Improve the dental care delivery system by increasing the number and quality of dentists who provide services to vulnerable populations.

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. The map on the next page illustrates the distribution of Ohio's resources for dental care.

The current dental care marketplace does not bode well for meeting the needs of vulnerable populations solely through the private sector: Dentists have few financial incentives for treating low-income patients at reduced fees:

- The typical dental student is \$100,000 in debt upon graduation.
- The average net income of full-time dentists in solo private practice increased by 50 percent from 1990 through 1998, at a time when inflation rose 23 percent.*
- In general, dentists seem to be able to fill their schedules with full-fee patients, those who are either insured or able to pay out-of-pocket.

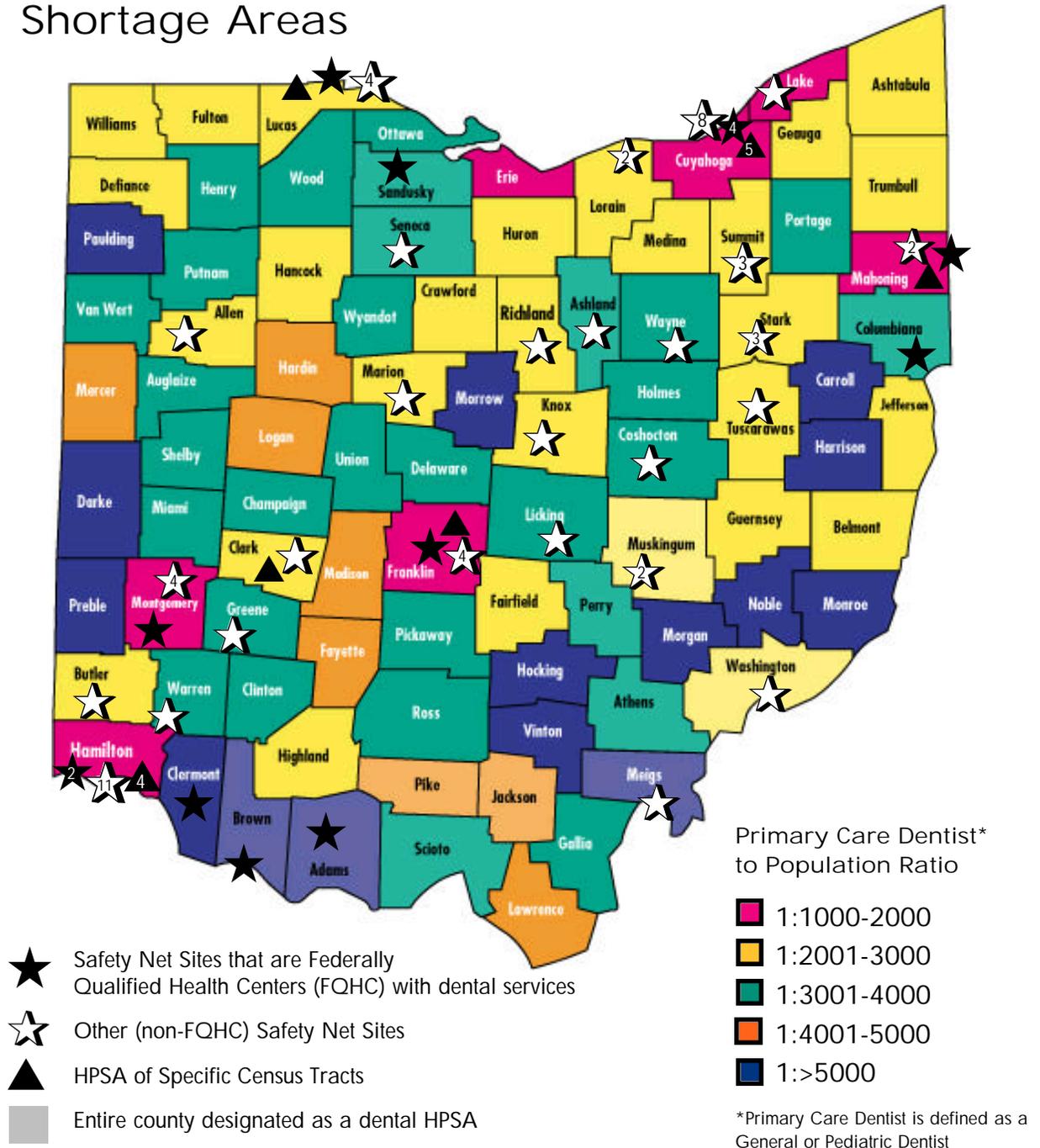
Even the Ohio Dental Association and Ohio Department of Health's Dental OPTIONS program, especially designed to provide dentists a convenient and structured mechanism for giving back to the community through donating and/or discounting care for a number of patients determined by the dentist, has only attracted about 11 percent of dentists despite substantial recruitment efforts.

Safety net dental clinics serve people who can't or won't access the private system, usually for reasons relating to the cost of care. Safety net clinics often arise out of a community's frustration with the inability of its low-income citizens to access dental care in the private sector. While the numbers often fluctuate, at the time of this report, Ohio's safety net primary dental care clinics included city and county health department clinics (19), hospital-based/linked programs (20), Federally Qualified Health Center (FQHC) clinics (14), dental schools (2) and 19 other programs (e.g., United Way agencies, Community Action Agencies, homeless programs, and volunteer programs).

Given the mission of most safety net clinics—serving those who can't afford private care—financial viability is of concern. Their payer mix substitutes low-end sliding scale and free care for higher end self-pay and privately insured patients. Medicaid generally is the best reimbursement that safety net clinics receive. Because of their payer mix, therefore, safety net clinics often require operating revenue subsidy. It appears that, at least in the short term, safety net dental clinics will be necessary to supplement care provided to low-income Ohioans by dentists in private practice.

*American Dental Education Association

Ohio Dental Care Resources and Federally Designated Dental Health Professional Shortage Areas



The Bottom Line:

The task force felt that building delivery system capacity had to include strategies, largely financial incentives, targeted both to dentists in private practice and to safety net clinics. The private practice strategies center on loan repayment/scholarships and tax incentives. The safety net strategies call for capital funding of clinic development (bricks & mortar) and operating subsidy. In addition, there are strategies to increase the cultural competency of the entire dental workforce.

Recommendations: II.A. Delivery System (Private Practice)

1. *Create 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.
2. Expand the current state physician loan repayment program to include dental professionals and institute a scholarship program for dental professionals working in dental Health Professional Shortage Areas (HPSAs). In addition to the traditional use of loan repayment for dentists working fulltime in safety net dental clinics, the programs should include:
 - An option for private practice dentists (including mentoring relationships)
 - A prorated loan repayment/scholarship opportunity for dentists who treat low-income patients while practicing in the HPSA part-time.
3. *Create a cadre of dentists with an obligation to serve low-income and other vulnerable populations after completion of their training programs. This would be accomplished, in combination with loan repayment/forgiveness and scholarship incentives, by increasing the number of:
 - Pediatric Dentistry Residency slots, and
 - General Practice Residency/Advanced Education in General Dentistry slots.
4. Increase cultural competency in the dental workforce by:
 - a. Developing and implementing a model curriculum, for dental students, to address awareness of access and cultural competency.
 - b. Providing incentives to dental schools to train students and residents in American Dental Education Association competencies and the needs of high risk families.
 - c. Creating a standing committee of the Ohio State Dental Board on cultural sensitivity/access.
 - d. Providing cultural awareness/sensitivity/competency training to dental care providers through continuing education and recommend, as mandatory, a component on ethics education.

Recommendations: II.B. Delivery System (Safety Net Dental Clinics)

1. Increase the number, quality, and capacity of dental care safety net clinics:
 - a. *Increase the number of dental clinics and the capacity of safety net clinics in FQHCs and other safety net clinics (capital costs for expansion and/or establishment of new sites –bricks and mortar).
 - b. *Provide operating subsidy funding to increase safety net clinical services at sites across the state using the most effective and efficient strategy for each location (e.g., dentists, auxiliaries, dental students, residents).

(In conjunction with this strategy, the Ohio Primary Care Association will undertake an initiative to increase the number of Federally Qualified Health Centers with dental clinics and expand the capacity of centers with existing dental clinics.)

2. Create tools and mechanisms to be used to develop and improve the operation of safety net dental clinics, including:
 - a. A safety net “how to” model operations manual (paper and web-based versions), and
 - b. A safety net clinic communications network (using mail, telephone, fax, and internet strategies).
3. Revise the Dental Practice Act to maximize the use of dental auxiliaries to provide care in safety net dental clinics.

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

Much of the significant action that affects access to dental care comes down to the local level. Schools, health agencies and social services agencies often are frustrated with their inability to connect their clients, who they know to be in need, with affordable dental care. Many times this frustration fuels local efforts to develop safety net dental clinics. Unless a local agency with sufficient funding takes up the cause, local efforts to establish dental clinics are collaborative in nature. Two keys to success are figuring out whom to bring to the table and what to do once you get there.

Procuring funding for local dental projects is challenging, as there is rarely substantial funding dedicated for that purpose. Planning programs and writing funding proposals generally require population data to describe the problem. Local agencies rarely have such data for dental disease and access to dental care.

Currently, the Ohio Department of Health has a grant from the federal Health Resources and Services Administration to help initiate and support the formation of local action to improve access to dental care. The project is known as The OHIO Initiative, an acronym for Oral Health Isn't Optional.

The Bottom Line:

Recognizing that local groups interested in addressing access to dental care in their community generally have little experience tackling the issue, the task force felt that there was a need to provide support and technical assistance in this area. The recommendations in the area of community action focus on developing capacity in the Ohio Department of Health for catalyzing and supporting local oral health coalitions, making population-based oral health data available to people at the local level, and building on existing school-based programs.

Recommendations: III. Community Partnerships

1. *Provide Ohio Department of Health (ODH) support for community-level partnerships/coalitions:
 - a. Catalyze community partnerships/coalitions and provide staff support and consultation to address dental 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 Requests for Proposal (RFP) language.
3. *Expand and enhance the use of school-based/school-linked approaches:
 - a. Mandate inclusion of periodic dental screenings and follow-up services with the already required vision and hearing screenings (grades K,1,3,5,7,9)
 - b. Provide matching grants to communities that implement an ODH-recommended model for school dental care programs for high-risk children. The model will include:
 - Dental disease identification
 - Case management or other mechanisms to move children into private dental offices or existing dental clinics
 - Preventive services
 - Treatment services
 - Integrating with existing school health (non-dental) programs.

IV. Increase public awareness of oral health and dental care access issues.

While much of the dental care access problem can be addressed through policies that increase the availability of sources of dental care (delivery system) or ways to pay for care (Medicaid/SCHIP), perhaps the most challenging barriers are those related to changing people's attitudes. The problems in this area are varied but stem from a lack of awareness and priority for dental care access issues on the part of consumers, policy-makers, dentists, and others.

Thirty-one percent of children and 37 percent of Ohio adults did not visit a dentist in 1998. Perhaps the largest group that doesn't use dental care does not even try. If they don't have severe dental pain and their faces aren't swollen, they don't perceive a need for dental care. This attitude becomes more common as income goes down. Two-thirds of Ohio adults who did not visit a dentist in 1998 said they did not perceive a need.

Although oral health problems have been associated with heart disease, pregnancy complications, and growth retardation of young children, policy makers generally don't consider oral diseases to be life threatening and are unaware of the decreased productivity, readiness to learn and quality of life issues that make access to dental care important.

Most dentists (68%) are not active Medicaid providers and only a small group (14%) serve at least 50 Medicaid recipients per year. Many dentists perceive the Medicaid program to be unattractive due to low fees, slow payment and complex paperwork that differs from that required by commercial plans. Dentists and their office staff members also may fear how the patients will affect their practices (broken appointments, reactions of middle and upper class patients to the low-income families). Much of the folklore about problems with the Medicaid system and patients is out-of-date but, nevertheless, a resilient reality to many nonparticipating dentists. There is need both to educate dentists on the facts about Medicaid and to train their office staff on how to best negotiate the system.

The Bottom Line:

Recognizing the challenges of changing attitudes, the task force, nevertheless, felt it important to attempt to raise the awareness of three groups: consumers, policy-makers and those who influence policy and perceptions, and dentists and their office staff.

Recommendations: IV. Public Awareness

1. *Provide highly visible, professionally-produced public awareness and health education campaigns for the general public and vulnerable populations.
2. Issue community grants for 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. These campaigns should emphasize the level of needs and degree of disparity.
3. Target awareness efforts to key public audiences:
 - Philanthropic community
 - Business community
 - Public officials (state and local)
 - Education (school administrators, nurses and teachers)
 - The Ohio Department of Education will increase awareness of school administrators, nurses and teachers by targeting urban areas with culturally-specific information in regard to oral health and the importance of dental care and access issues.
 - Faith-based community
 - Non-dental health professionals
 - Continue/expand in-service training (on oral health, the importance of dental care, and access issues) for health professionals, daycare staff, Ohio Family and Children First school readiness centers, etc.
4. Develop and conduct a Medicaid oral health marketing plan in which:
 - Marketing strategy and materials are developed and disseminated to promote awareness that Medicaid/SCHIP/Healthy Start covers dental care. Targets for this strategy include families, medical care providers and agencies that serve high-risk families and children.
 - The awareness of county department of job and family services' Medicaid staff/system is increased with regard to new and existing programs.

APPENDIX

Other Strategies Considered

The following were deliberated by the Task Force but were not included in the final recommendations because they were deemed to have lower potential impact on improving access to dental care for all Ohioans:

1. Establish "Grow-Your-Own Community Dentist" programs in middle and high schools.
 - Recruit high school and college students from high risk communities/neighborhoods to return to the community to practice after having their education subsidized (by community or business).
2. Identify funds to expand the application of teledentistry (i.e. screenings, consultations and the transmission of educational materials and digital radiographs).
3. Initiate collaborative activity with the state departments, the dental community and the disability community for the provision of statewide training and educational outreach to increase awareness of:
 - Obligations of oral health providers under the Americans with Disabilities Act
 - Sensitivity training regarding courtesies and interactions w/persons with various disabilities
 - Basic dental and behavioral techniques that augment oral health services for persons with disabilities.
4. Develop a tool for school nurses/secretaries to collect data on absentee rates due to oral diseases and monitor impact on learning.
5. Offer professional development opportunities to school nurses, curriculum directors and teachers on how to use oral health curricula (e.g., Dental Fundamentals).
6. Investigate the possibility of collaborating with a university research center to conduct a controlled, prospective study of the effectiveness of a coordinated, comprehensive, school-based dental disease prevention program. (Note: CDC Guide to Community Preventive Services will make evidenced-based recommendations in 2001).
7. Develop an electronic, interactive dental health curriculum for students K-12.
8. Enact legislation to limit availability of sugared snacks in school.
9. Conduct focus groups with private office staff.

The following individuals participated on the Director of Health's Task Force on Access to Dental Care and/or its subcommittees:

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