Indiana Strategic Oral Health Initiative (SOHI)

Project Report

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CENTER FOR HEALTH POLICY

SCHOOL OF DENTISTRY
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Table of Contents

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INTRODUCTION

Oral health is an essential and integral component of health throughout life. According to the Surgeon General's Report on Oral Health in America (2000), approximately 25 million Americans live in areas lacking adequate oral health services. This access problem is complicated by the fact that more than 20 percent of dentists will reach retirement age in the next 10 years; the number of dental graduates by 2015 may not be enough to replace retirees. Despite significant advances in dental productivity, access problems remain for specific geographic areas and populations. Therefore, the Health Resources and Services Administration (HRSA), part of the U.S. Department of Health and Human Services, has awarded a one-year grant to the State of Indiana, represented by the Indiana State Department of Health, to develop a strategic plan designed to improve the State's oral health workforce and service delivery infrastructure for the underserved.

To address critical oral health needs in our state, the Indiana State Department of Health implemented Indiana's Strategic Oral Health Initiative (SOHI), in partnership with the Indiana University School of Dentistry and Indiana University Center for Health Policy. SOHI incorporated a strategic framework, including the following components:

- ASSESSMENT: A statewide needs assessment was conducted to measure oral health needs and related workforce issues throughout Indiana
- STRATEGIC PLANNING: Indiana's oral health priorities were identified and addressed in the State's strategic plan
- CAPACITY BUILDING: Key stakeholders from oral health, primary care, and minority health communities as well as representatives from social service agencies and others interested in the oral health of Indiana's residents came together to collaborate in the Statewide Planning Council

This report includes all documents created as part of the SOHI initiative: The oral health needs assessment, Indiana's strategic oral health plan, and a process evaluation.

Indiana Strategic Oral Health Initiative (SOHI)

Oral Health Needs Assessment Report 2009

BACKGROUND

Oral health is an integral part of overall health and wellbeing throughout life. No one can be truly healthy unless he or she is free from the burden of oral and craniofacial diseases and conditions (U.S. Department of Health and Human Services, 2000b). Damage to oral structures can result in lowered self-esteem, decreased social interaction, poor nutrition due to eating difficulties or pain, and speech limitations that affect learning and academic achievement. Every day, millions of children and adults in the United States are afflicted with oral diseases that significantly affect their quality of life, even though there are effective measures and approaches to prevent and treat these common diseases.

The oral health of the U.S. population improved in recent decades due to fluoridation of public water supplies, knowledge about causative agents and risk factors for oral disease, and the development of effective and safe treatment and prevention measures. As a result of water fluoridation, for example, the U.S. population experienced a one-half to two-thirds decrease in the prevalence of dental caries (Horowitz, 1996). However, water fluoridation has not been enough to prevent dental caries, and there is some evidence that caries prevalence may be increasing, especially in certain population subgroups.

Dental caries and periodontal disease continue to be some of the most common and prevalent diseases in the United States. According to the Centers for Disease Control and Prevention (CDC), about 78 percent of Americans have had at least one cavity by age 17 (Centers for Disease Control, 2004). Eighty percent of caries in permanent teeth are concentrated in 25 percent of the most vulnerable children and adolescents (U.S. Department of Health and Human Services, 2000b). The National Institute of Dental and Craniofacial Research (NIDCR) estimates that 80 percent of American adults currently have some form of periodontal disease (National Institute of Dental and Craniofacial Research, 2009). Both dental caries and periodontal disease are infectious diseases that require treatment by dental professionals. Preventing them requires continuous monitoring and maintenance. Other oral conditions such as cleft lip and palate, oral cancer, and reduced salivary flow can also be prevented or treated.

As knowledge about etiology, prevention, and treatment of dental diseases has progressed, there has also been a recognition that more needs to be done to translate this knowledge into an improvement in people's oral and general health. While some people may not be aware that oral health is essential to general health, or that oral diseases can be prevented or controlled, many know these facts, but are simply not able to access or afford needed services to maintain or restore oral health.

In spite of improvements in American's oral health status, striking disparities persist, especially among the poor and among racial/ethnic minorities. Oral health status and access to services vary significantly by race/ethnicity, family income, and level of education (Edelstein, 2002). Adults and children residing in rural areas are also at a disadvantage since they are more likely to be uninsured for dental care, report more unmet dental needs, are less likely to have visited a dentist in the past year, and are less likely to be regular users of dental care, compared to their urban counterparts (Vargas, Dye, & Hayes, 2002; Vargas, Ronzio, & Hayes, 2003).

These underserved populations make up a considerable portion of Indiana residents.

It is undisputable that the infrastructure for oral healthcare delivery is limited, and a substantial obstacle to progress is the lack of adequate and comprehensive data on oral health and care for the U.S. population and its diverse subgroups. This hinders development of better measures of disease and health outcomes. Also hampered are the design of new approaches to eliminate health disparities and evaluation of existing programs. Data on state and local populations are lacking or rare, as is health services research (U.S. Department of Health and Human Services, 2000b). The state of Indiana is no exception regarding the unavailability of recent data and the lack of a surveillance system to record oral health information.

Promotion of oral health requires self-care, professional care, and population-based initiatives. The U.S. Department of Health and Human Services' prevention initiative Healthy People 2010 recognizes the public health impact of oral health conditions. Its goals are to prevent and control oral and craniofacial diseases, conditions, and injuries and to improve access to related services (U.S. Department of Health and Human Services, 2000a). A concerted effort from dental services providers, dental educators, oral health researchers, policy makers, communities and individuals, will be needed to accomplish these goals.

The purpose of this report is to provide a baseline measure of Indiana's oral health status and to identify critical needs and prevention priorities in the underserved. Information was collected on various oral health indicators for which data were available. The results are presented in the following categories:

- Indiana's demographic profile and vulnerable populations
- Oral disease prevalence
- Access to and utilization of oral healthcare services
- Oral health infrastructure (existing oral health programs, services, and resources)
- Oral health workforce

INDIANA'S DEMOGRAPHIC PROFILE AND VULNERABLE POPULATIONS

Indiana, which is located in the Midwestern region of the United States, is bordered by Michigan in the north, Ohio in the east, Kentucky in the south, and Illinois in the west. With over 6.3 million residents, Indiana ranked 15th in population size among U.S. states in 2007. The majority of the population is non-Hispanic white (88.1%) and non-Hispanic black (9.0%); five percent (5.0%) are Hispanic (including all races). Almost 90 percent (88.2%) of Indiana residents are high school graduates (or higher), and 21.9 percent attained at least a bachelor's degree. The annual per capita personal income in 2007 was $33,215 and the median household income was $47,422. The statewide unemployment rate was 5.9 percent in 2008 (Indiana Business Research Center, n.d.).

Across the country, researchers have found that certain population groups are at a higher risk for developing oral diseases than others. The Surgeon General's report on oral health in America (U.S. Department of Health and Human Services, 2000b) states:

> *"Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable. Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems. Individuals who are medically compromised or who have disabilities are at greater risk for oral diseases, and, in turn, oral diseases further jeopardize their health."*

Indiana ranked as the 24th poorest state in the country in 2007. An estimated 760,606 Hoosiers were classified as poor (12%).[1] Of these, 522,530 (10%) were non-Hispanic white; 140,816 (27%) were black; 65,858 (23%) were Hispanic or Latino; 10,739 (14%) were Asian; and 34,756 (23%) reported "some other race" (U.S. Census Bureau, n.d.).

Another indicator of a population's poverty level is use of the National School Lunch Program. Children from families with incomes at 130 percent or below the federal poverty level (FPL) are eligible for free meals, and children from households with incomes between 130 percent and 185 percent FPL qualify for reduced-price meals (U.S. Department of Agriculture, 2008). Therefore, the number of children on free or reduced-price meals is a proxy indicator of poverty.

On average, for the 2007-2008 school year, 328,401 Hoosier children received free school lunches and 88,295 children received reduced-price lunches. This constituted more than one-third (36.1%) of the student population (Indiana Department of Education, 2008). According to the American Dental Association, children from households that are under 200 percent FPL are less likely to utilize dental services (American Dental Association, 2004).

Adults on Medicaid are another vulnerable group, since coverage of dental services in Indiana is limited to $600 per year for individuals ages 21 and older (Health Resources and Services Administration, n.d.). [For the number of dental services covered in Medicaid adult beneficiaries, see Appendix A; for adult Medicaid payment rates on selected dental procedures, see Appendix B.]

In 2008, a total of 732,000 Hoosiers were covered by Medicaid, representing 11.7 percent of Indiana's population. The majority of Medicaid enrollees were white (511,000 or 65%) or black (195,000 or 25%); 10 percent (76,000) were of Hispanic origin. Most of the Hoosiers enrolled in Medicaid were children ages 0

to 17 (466,000 or 64%), followed by adults ages 18 to 64 (235,000 or 32%); only 31,000 of enrollees (4%) were 65 years or older (U.S. Census Bureau, n.d.).

Most Medicaid-eligible children are enrolled in Hoosier Healthwise, a statewide managed care program.[2] Package A covers low-income families from households with incomes up to 25 percent FPL and children ages 0 to 18 years old living in households with incomes up to 150 percent FPL. Package B covers pregnant women with incomes up to 150 percent FPL. Package B enrollees receive health benefits, including dental benefits, for services related to prenatal care and 60 days postpartum care, as well as treatment of conditions that might complicate pregnancy or delivery.

As part of the Federal Balanced Budget Act of 1997, Congress created the Children's Health Insurance Program (CHIP) to improve low-income uninsured children's access to care. The program is intended for children in families with incomes above the threshold for Medicaid eligibility and is funded in part by the federal government and by each state. In Indiana, CHIP is part of Hoosier Healthwise, and constitutes Package C, which covers children from birth to age 18 from families with incomes between 150 percent and 200 percent FPL. Both Package A and C offer the same dental benefits that include diagnostic, preventive, restorative, and endodontic services, as well as oral and maxillofacial surgery and adjunctive general services.

[For a list of dental services in children, procedure codes, and Medicaid reimbursement rate, see Appendix C, and for Indiana's Medicaid payment rates compared to claims for the same procedures in other states in the region, see Appendix D.]

Eligible blind or disabled children, and children in foster care who are wards of the state are enrolled in Care Select, an enhanced primary care management program (Family and Social Services Administration, Office of Medicaid Policy and Planning, n.d.; American Dental Association, 2005).

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for people under the age of 21. Each state must report EPSDT performance annually using the Centers for Medicare and Medicaid Services (CMS) Form-416, which provides basic information on participation in Medicaid child health programs. This report is the most common source of data on children's use of dental services. (U.S. Dept. of Health & Human Services, Center for Medicare & Medicaid Services, n.d.)

According to CMS-416 report information, from 1999 to 2006 there was an increase in the number of Indiana children enrolled in Medicaid, and in the percentage of children who received dental services, as can be seen in Table 1 (American Dental Association, 2008a).

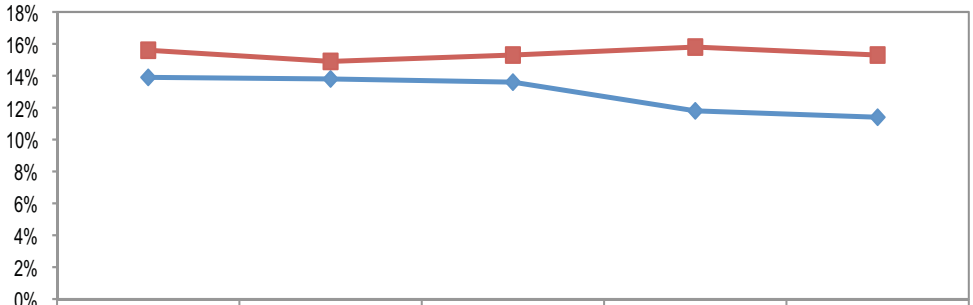
Table 1 Annual Dental Services[3] Provided to Medicaid Child Beneficiaries in Indiana

	1999	2000	2005	2006
Number Enrolled	391,954	451,535	589,857	607,230
Number with any dental service	104,111	132,563	233,839	251,647
Percent with any dental service	26.6%	29.4%	39.6%	41.4%
Number with any preventive dental service	89,086	113,272	206,283	224,456
Percent with any preventive dental service	22.7%	25.1%	35%	37%
Number with any dental treatment service	55,128	71,488	123,968	134,480
Percent with any dental treatment service	14.1%	15.8%	21%	22.1%

Source: American Dental Association, 2008a

The most vulnerable group of Hoosiers is the uninsured. The number of Americans without dental insurance is three times higher than the number of people without medical coverage (U.S. Department of Health and Human Services, 2003). In 2007, over 700,000 Indiana residents were not covered by health insurance, and 83,000 of them were under the age of 18. The percentage of Hoosiers without health insurance decreased from 13.9 percent in 2003 to 11.4 percent in 2007 (see Figure 1). Even though Indiana's rates of the uninsured have been consistently lower than the national rates for the years reviewed, and the percentage of Hoosiers without insurance decreased in that time period, it is important to note that there is still a large share of Indiana residents without health insurance coverage (U.S. Census Bureau, n.d.). The number of people without dental insurance is certainly higher.

Figure 1 Percentage of Indiana and U.S. Population without Health Insurance, 2003-2007



	2003	2004	2005	2006	2007
Indiana	13.9%	13.8%	13.6%	11.8%	11.4%
US	15.6%	14.9%	15.3%	15.8%	15.3%

Source: U.S. Census Bureau, n.d.

Among the uninsured, undocumented immigrant children face some of the highest obstacles to obtaining medical and dental care. They come from very low-income families who lack employer-sponsored health coverage, and federal law limits eligibility for federally-funded health benefits to qualified immigrants with permanent legal residency. In Indiana, undocumented immigrant

children qualify only for emergency medical and dental services, and are ineligible for full coverage through Hoosier Healthwise (Family and Social Services Administration, Office of Medicaid Policy and Planning, n.d.).

People with disabilities face numerous difficulties accessing dental services and have many unmet dental health needs. Deinstitutionalization, an increase in life span of disabled individuals, the lack of adequately trained dental providers, and limited or inadequate financing to cover dental services all contribute to reported disparities (Fenton, S.J., H. Hood, M. Holder, P.B. May Jr. & W.E. Mouradian, 2003). In Indiana, among the population ages 5 years and older, 898,900 reported one or more types of disabilities (15%). The likelihood of having a disability increased with age, from seven percent of people 5-15 years old (66,521), to 13 percent of people 16-64 years old (529,621), and 41 percent of people 65 years old and older (302,758) (U.S. Census Bureau, n.d.).

Populations living in rural areas are also more likely to suffer from untreated oral disease, as there are fewer dental providers in these areas. These providers may be overburdened or may only accept patients with dental insurance. Fifty percent of Indiana counties are designated as rural (Yoder, 2007). As of 2008, it was estimated that the population for rural Indiana was 1,387,419, or 22 percent of the total state population (Economic Research Service and U.S. Department of Agriculture, 2009).

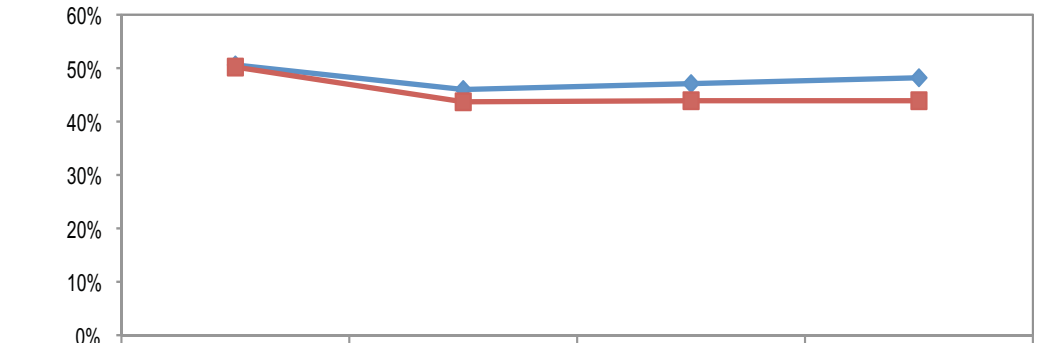
ORAL DISEASE PREVALENCE

Although there is no formal and continuous surveillance system on oral health in Indiana, some state-level information is available from the Behavioral Risk Factor Surveillance System (BRFSS), a random telephone survey of state residents ages 18 and older in households with a telephone. The BRFSS, established in 1984 by the CDC, is a state-based monitoring system of health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. Oral health items were first added to the survey instrument in 1999. Results from the survey provide a glimpse of the nation's oral health status and allow us to compare Indiana with other states as well as the entire nation. The most recent BRFSS oral health results available for Indiana are from 2008 and include information on visits to the dentist, prevalence of tooth extractions, prevalence of extraction of all natural teeth, and prevalence of tobacco use (Centers for Disease Control and Prevention, 2009).

Additionally, the Indiana State Department of Health (ISDH) collects information on the prevalence of cleft lip and palate and on hospital discharges with oral health diagnoses. The CDC also collects information on oral health-related mortality.

Dental Extractions—According to 2008 BRFSS results, 48.2 percent of Indiana adults (95% Confidence Interval [CI]: 46.0–50.3) have had any permanent teeth extracted. This percentage was significantly higher than the national median of 43.9 percent. Statistically, Indiana's prevalence has remained stable from 1999 to 2008 (see Figure 2). Groups with the highest prevalence of tooth extractions included blacks, individuals with an annual household income of less than $35,000, and individuals with lower educational attainment. Also, prevalence was strongly associated with age; as age increased, so did the percentage of Hoosiers who reported having had any permanent teeth extracted (Centers for Disease Control and Prevention, 2009). [For 2008 prevalence rates and 95 percent confidence intervals by gender, race/ethnicity, age group, income level, and educational attainment, see Appendix E.]

Figure 2 Prevalence Rates of Indiana and U.S. Adults Who Have Had Any Permanent Teeth Extracted (Behavioral Risk Factor Surveillance System, 1999–2008)

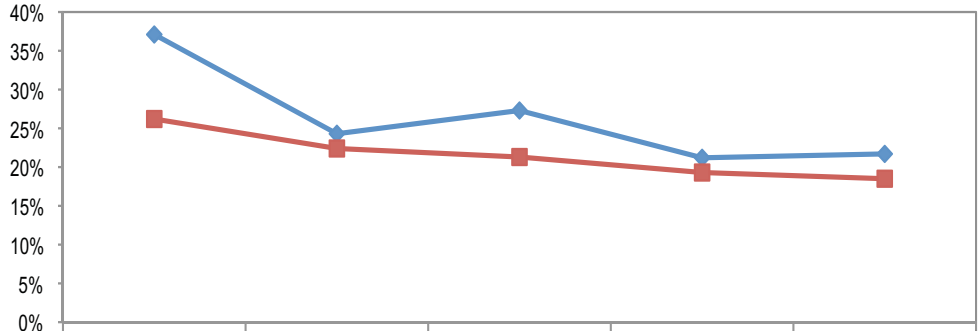


	1999	2004	2006	2008
Indiana	50.6%	46.0%	47.1%	48.2%
U.S.	50.2%	43.7%	43.9%	43.9%

Source: Centers for Disease Control and Prevention, 2009

Roughly one-fifth of Hoosiers 65 years and older (21.7%; 95% CI: 19.1-24.4) have had all their natural teeth extracted. This is a significant decrease from 1999, when 37.1 percent of Indiana residents in that age group (95% CI: 28.9–45.3) were reported to have had all their natural teeth extracted. However, Indiana's prevalence rate is higher than the U.S. rate of 18.5 percent (see Figure 3). Elderly Hoosiers who were affected the most included individuals with an annual household income of less than $15,000 and those with lower educational attainment (Centers for Disease Control and Prevention, 2009). [For 2008 prevalence rates and 95 percent confidence intervals by gender, race/ethnicity, age group, income level, and educational attainment, see Appendix F.]

Figure 3 Prevalence Rates of Indiana and U.S. Adults Ages 65 and Older Who Have Had All Their Natural Teeth Extracted (Behavioral Risk Factor Surveillance System, 1999–2008)



	1999	2002	2004	2006	2008
Indiana	37.1%	24.3%	27.3%	21.2%	21.7%
U.S.	26.2%	22.4%	21.3%	19.3%	18.5%

Source: Centers for Disease Control and Prevention, 2009

Elderly, minority, and low-income residents often face the unfortunate need to have some or all of their teeth extracted. After teeth are extracted, more complicated and expensive dental treatment will be needed to restore oral function. As life expectancy for adults continues to increase, there is clearly an urgent need to increase the life expectancy of the natural dentition, too. This is especially important in population subgroups with limited resources for further or more complex dental treatments.

Cleft Lip and Cleft Palate—The National Birth Defects Prevention Network (NBDPN) is a group of individuals involved in birth defects surveillance, research, and prevention. It was created to establish and maintain a national network of state- and population-based programs for birth defects surveillance and research. ISDH collects this information in Indiana and submits the data to NBDPN.

According to an ISDH report, the number of children born in Indiana with a cleft lip and/or cleft palate declined from 79 in 2003 to 60 in 2005. The rate per 10,000 live births, however, did not change significantly within these three years (see Table 2) (Indiana State

Department of Health, 2008). Cleft lip/palate is one of the most common birth defects. At the national level, it is estimated to affect one out of 600 live births for whites, and one out of 1,850 live births for blacks (U.S. Department of Health and Human Services, 2003).

Table 2 Number and Rate (per 10,000 Live Births) of Indiana Children Born with Cleft Lip and/or Cleft Palate, by Birth Year, 2003-2005 (National Birth Defects Prevention Network)

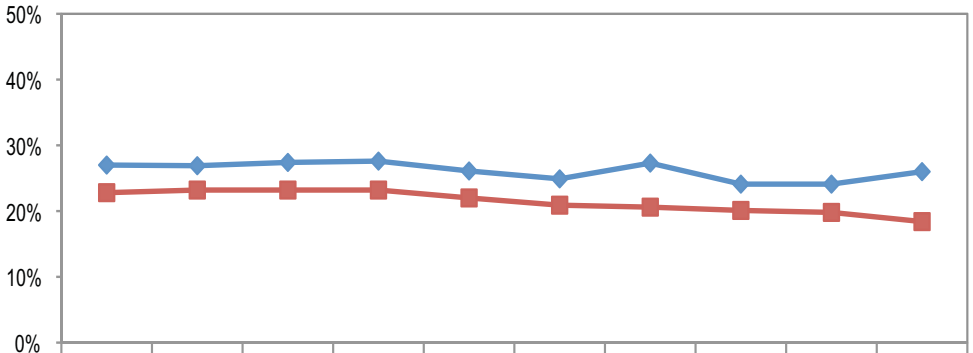
	Number of Children with Cleft Lip and/or Palate	Live Births	Rate per 10,000 (95% CI)
2003	79	86,382	9.15 (7.13-11.16)
2004	93	87,125	10.68 (8.51-12.84)
2005	60	87,088	6.89 (5.15-8.63)

Note: CI = confidence interval

Source: Indiana State Department of Health, 2008

Smoking—Smoking constitutes a grave risk for oral health. Tobacco products contain a variety of toxins that have been associated with cancers of the mouth, lip, tongue, and larynx; periodontal disease; and other oral health-related conditions (American Dental Association, n.d.). Adult smoking has consistently been more prevalent in Indiana than the United States for at least the past ten years. A significantly higher percentage of Hoosiers reported smoking in the past 30 days (26.0%; 95% CI: 24.0-28.1) compared to the nation (18.4%). Prevalence for daily smoking is also significantly higher in Indiana (19.7%; 95% CI: 17.8-21.7) than in the United States (13.4%) (Centers for Disease Control and Prevention, 2009). [See Figures 4 and 5 for smoking prevalence rates from 1999 through 2008.]

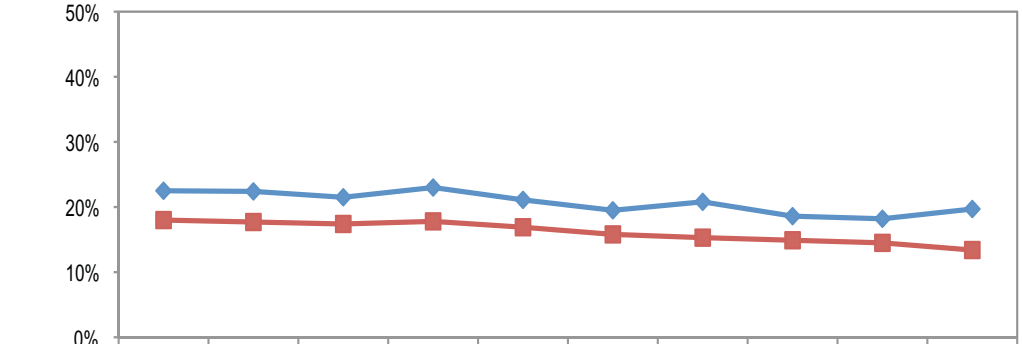
Figure 4 Percentage of Indiana and U.S. Adults Who Smoked in the Past 30 Days (Behavioral Risk Factor Surveillance System, 1999–2008)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Indiana	27.0%	26.9%	27.4%	27.6%	26.1%	24.9%	27.3%	24.1%	24.1%	26.0%
U.S.	22.8%	23.2%	23.2%	23.2%	22.0%	20.9%	20.6%	20.1%	19.8%	18.4%

Source: Centers for Disease Control and Prevention, 2009

Figure 5 Percentage of Indiana and U.S. Adults Who Smoke Every Day (Behavioral Risk Factor Surveillance System, 1999–2008)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Indiana	22.5%	22.4%	21.5%	23.0%	21.1%	19.5%	20.8%	18.6%	18.2%	19.7%
U.S.	18%	17.7%	17.4%	17.8%	16.9%	15.8%	15.3%	14.9%	14.5%	13.4%

Source: Centers for Disease Control and Prevention, 2009

Morbidity—Indiana's public hospital discharge data sets include, among other variables, discharge information and principal (primary) diagnosis of the patient. Data are provided in aggregate format. The rates of hospital discharges for patients with any type of oral health diagnosis remained statistically stable from 2003 through 2006, at 15.7 (95% CI: 14.7–16.7) and 14.3 (95% CI: 13.4–15.2), per 100,000 population, respectively (Indiana State Department of Health, n.d.). [See Table 3 for number of discharges due to specific oral health conditions.]

Table 3 Number of Hospital Discharges in Indiana by Oral Health Principal Diagnoses (Indiana Hospital Discharge Data Files, 2003–2006)

	2003	2004	2005	2006
Neoplasms of lip, oral cavity, and pharynx[4]	329	359	349	340
Diseases of oral cavity, salivary glands, and jaws[5]	530	518	546	465
Oral congenital anomalies (cleft lip/palate; anomalies of tongue, mouth, and pharynx)[6]	50	46	40	37
Injuries of lips, mouth, pharynx, and larynx[7]	62	54	65	59
Total	971	977	1,000	901

Source: Indiana State Department of Health, n.d.

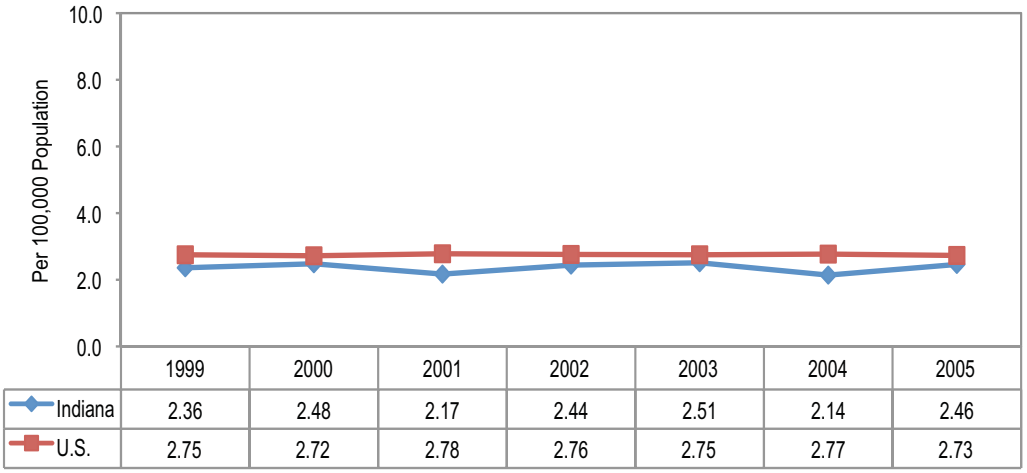
Mortality—The number of recorded deaths due to oral health diseases is very low. In 2005, a total of 154 Hoosiers died of oral health-related conditions, most of which were due to some form of cancer (see Table 4). This represents a mortality rate of 2.46 (95% CI: 2.07-2.85) per 100,000 population. The U.S. mortality rate for these oral health-related conditions remained stable from 1999 through 2005 and has been statistically similar to Indiana's except for 2001 and 2004, when the state's rate dipped slightly (see Figure 6) (Centers for Disease Control and Prevention, n.d.).

Table 4 Number of Deaths Attributable to Oral Health Diseases in Indiana (Mortality Data, 1999–2005)

	1999	2000	2001	2003	2003	2004	2005
Neoplasms of lip, oral cavity, and pharynx[8]	136	150	130	144	151	129	151
Diseases of oral cavity, salivary glands, and jaws[9]	4	1	3	6	4	4	2
Oral congenital malformations (cleft lip/palate and others)[10]	N/A	N/A	N/A	N/A	N/A	N/A	1
Total	140	151	133	150	155	133	154

Source: Indiana State Department of Health, n.d.

Figure 6 Indiana and U.S. Mortality Rate for Oral Health Diseases, per 100,000 Population (Mortality Data, 1999–2005)



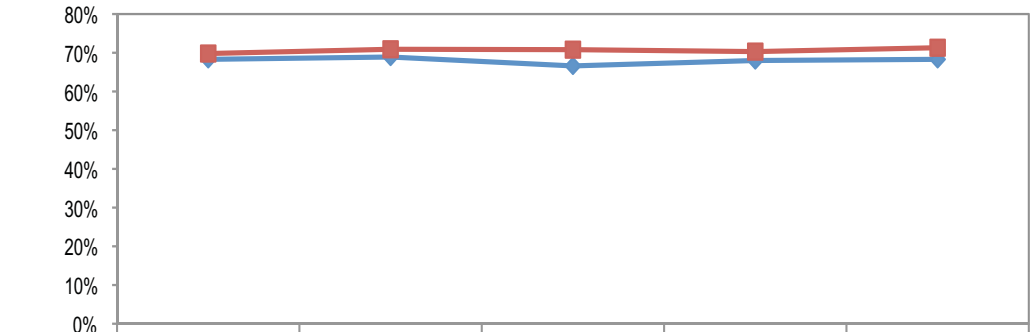
	1999	2000	2001	2002	2003	2004	2005
Indiana	2.36	2.48	2.17	2.44	2.51	2.14	2.46
U.S.	2.75	2.72	2.78	2.76	2.75	2.77	2.73

Source: Centers for Disease Control and Prevention, 2009

ACCESS TO AND UTILIZATION OF ORAL HEALTHCARE SERVICES

According to 2008 BRFSS results, 68.3 percent of people in Indiana (95% CI: 66.3–70.3) visited the dentist or dental clinic within the past year for any reason. The rate is lower than the U.S. median of 71.3 percent. Indiana's prevalence rate for past-year dental visits has remained stable from 1999 through 2008 (see Figure 7) (Centers for Disease Control and Prevention, 2009). [For 2008 prevalence rates and 95 percent confidence intervals by gender, race, age group, income level and educational attainment, see Appendix G.]

Figure 7 Percentage of Indiana and U.S. Population Who Visited the Dentist or Dental Clinic within the Past Year for Any Reason (Behavioral Risk Factor Surveillance System, 1999–2008)



	1999	2002	2004	2006	2008
Indiana	68.3%	68.9%	66.6%	68.0%	68.3%
U.S.	69.8%	70.9%	70.8%	70.3%	71.3%

Source: Centers for Disease Control and Prevention, 2009

Health Professional Shortage Areas (HPSAs), established under the U.S. Public Health Service Act, are federal designations of a geographic area (usually a county or a number of townships or census tracts) which meet the criteria of needing additional primary healthcare services. These designations are based on the availability of health professional resources within a rational service area. A rational service area can be defined as:

a) A county or a group of several contiguous counties whose population centers are within 40 minutes travel time of each other.

b) A portion of a county (or an area made up of portions of more than one county) whose population, because of topography, market or transportation patterns, distinctive population characteristics, or other factors, has limited access to contiguous area resources, as measured generally by a travel time of greater than 40 minutes to such resources.

c) Established neighborhoods and communities within metropolitan areas which display a strong self-identity (as indicated by a homogenous socioeconomic or demographic structure and/or a tradition of interaction or intradependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 20,000.

Primary care, dental, and mental health HPSAs also take into account practitioners within contiguous areas. Designations usually are geographic areas, but may apply to population groups and facilities (Health Resources and Services Administration, 2009). An

HPSA scoring system was developed by the National Health Service Corps to determine priorities for assignment of clinicians. Scoring criteria include: population-to-provider ratio, level of poverty within population, infant health index, and traveling distance to the nearest provider.

Scores for Dental Health Professional Shortage Areas (DHPSAs) range from 1 to 26[11], with higher scores representing greater priority or need. To be designated as a DHPSA, the geographic area must have a population to fulltime-equivalent dentist ratio of at least 5,000 to 1, or have a ratio between 4,000 to 1 and 5,000 to 1 and unusually high need for dental services.

An area of unusually high need is defined as an area where more than 20 percent of the population or of all households have incomes below the poverty level, or where the majority of the population does not have fluoridated water supply. In addition, dental professionals in contiguous areas must be excessively distant, inaccessible, or overutilized. Excessively distant, inaccessible, or overutilized means that

- dental professionals in contiguous areas are more than 40 minutes travel away;
- dentist-to-population ratios in contiguous areas are in excess of 1 to 3,000; or
- demographic or socioeconomic barriers prevent access to these providers and facilities.

Certain population groups within particular geographic areas will also be designated as having a shortage of dental care professionals. Members of federally recognized Native American tribes are automatically designated, as are federal and state correctional institutions and nonprofit medical facilities (Health Resources and Services Administration, 2009).

At the national level, as of March 31, 2009, there were 4,091 DHPSAs with 49 million inhabitants (Health Resources and Services Administration, 2009). Currently, there are 25 identified DHPSAs in Indiana, affecting 12 counties (see Table 5) (Health Resources and Services Administration, 2008). Based on the most recent information on provider-to-population ratios (see Oral Health Workforce section), further investigation is needed to determine whether more counties are eligible for a DHPSA designation.

Table 5 Dental Health Professional Shortage Areas (DHPSAs) Currently Designated in Indiana

	Service Area Name	Designation Type	Score
Allen	Central Fort Wayne	Low Income Population	14
	Neighborhood Health Clinics, Inc.	Comprehensive Health Center	8
Delaware	Open Door/BMH Health Center, Inc.	Comprehensive Health Center	10
	Center Township	Low Income Population	9
Lake	East Chicago Service Area	Geographical Area	15
	East Chicago Community Health Center	Comprehensive Health Center	10
Marion	Highland-Brookside (Indianapolis)	Geographical Area	19
	South Central Indianapolis	Geographical Area	15
	Near North Side (Indianapolis)	Geographical Area	10
	Indiana Health Centers	Comprehensive Health Center	9
	Health & Hospital Corp. of Marion Co.	Comprehensive Health Center	10
	Shalom Health Care Center, Inc.	Comprehensive Health Center	6
	Raphael Health Center	Comprehensive Health Center	10
	Healthnet	Comprehensive Health Center	4
Porter	North Shore Health Center	Comprehensive Health Center	8
	Valparaiso Service Area	Geographical Area	13
	Healthlinc, Inc.	Comprehensive Health Center	8
Randolph	Randolph County	Low Income Population	10
Rush	Rushville Township	Low Income Population	8
Saint Joseph	Southwest South Bend	Low Income Population	15
Switzerland	Switzerland	Low Income Population	11
Tippecanoe	Lafayette City	Low Income Population	25
	Tippecanoe Community Health Center	Comprehensive Health Center	11
Vanderburgh	Echo Community Health Care	Comprehensive Health Center	10
Vigo	U.S. Penitentiary Terre Haute	Correctional Facility	21

Source: Indiana State Department of Health, n.d.

ORAL HEALTH INFRASTRUCTURE

Indiana State Department of Health (ISDH)—The Oral Health Division of ISDH has a rich history of assisting various entities in improving the oral health of Hoosiers. The oral health staff and dental director assist local government and nongovernment entities, community health centers, private practitioners, professional organizations, and the residents of Indiana with the coordination of a wide range of issues related to improving oral health for residents. They are also the only entity recognized by CDC or Health Resources and Services Administration (HRSA) as eligible to apply for certain types of targeted federal funding available to states to improve oral health for residents.

The ISDH Executive Board authorized ISDH officials to work with local officials, groups, and water works personnel to implement community water fluoridation in late 1950. State dental director Chuck Gish's leadership helped establish the Riley Hospital Dental Clinic and regional campuses for dental hygiene and dental assisting education (Journal of the Indiana Dental Association, 2008). After ISDH authorized support for community water fluoridation on December 22, 1950, the first Indiana communities to begin community water fluoridation were Fort Wayne, Huntingburg, and Indianapolis, beginning in 1951. Currently, there are 397 Indiana public water supplies that adjust fluoride in their drinking water (253 municipalities, 118 consecutive systems, and 26 schools), plus 91 water systems with naturally occurring optimal fluoride levels (that serve about 328,000 Hoosiers), for a total of 488 Indiana water systems with optimal fluoride levels. In general, every city with a population of over 5,000 fluoridates its water, with the exception of Brazil, Rockville, the Tri-Township of Dearborne County (serving 8,370), Linton of Greene County (serving 11,748) and Jennings Water Inc. (serving 11,669). About 4.4 million residents receive optimally fluoridated water; i.e., over 95 percent of Indiana residents who are served by community water systems receive optimally fluoridated water (Smith, 2008).

The fluoridation program is managed and maintained by the chief of the fluoride unit and three fluoridation consultants. [See Table 6 for information on the historical and current oral health staffing at ISDH.]

Table 6 Oral Health-Related Staffing at the Indiana State Department of Health, 1975-2009

Position	1975	1985	1995	2005	2009
Dentist FTE	3.00	3.00	3.00	2.50	1.00
Hygienist FTE	4.00	4.00	4.00	1.00	1.00 (currently vacant)
Assistant FTE	2.00	2.00	2.00	3.00	0.25
Water Fluoridation Staff FTE	1.00	4.00	4.00	4.00	4.00
Total FTE	10.00	13.00	13.00	10.50	6.25

Note: FTE = Full-time employment

Source: Personal communication between current State Oral Health Director Dr. M. Kent Smith and previous directors, Drs. Chuck Smith and Mark Mallatt

Fluoride is a naturally occurring element needed regularly throughout life to protect teeth against tooth decay. In the United States, fluoridated community drinking water and fluoride toothpaste are the most common sources of fluoride. Fluoride can inhibit or reverse the initiation and progression of dental caries, by inhibiting the demineralization of sound tooth enamel and enhancing the remineralization of demineralized enamel throughout the lifetime of teeth. It also inhibits dental caries by affecting the activity of cariogenic (caries-causing) bacteria. Adults and children both benefit from its protective effect, especially those difficult to reach through other public health programs, or those with difficulties in accessing private dental care.

The Public Health Service recommends the use of an optimally adjusted concentration of fluoride in the community drinking water of 0.7 parts per million (ppm) to 1.2 ppm (depending on the average maximum daily air temperature of the area). This concentration can occur naturally or be attained through the controlled addition of fluoride to a public water supply. Community water fluoridation is a safe, equitable and cost-effective method of delivering fluoride to communities to aid in the prevention and control of dental caries. The CDC estimates that every dollar invested in community water fluoridation yields approximately $38 savings in dental treatment costs (Centers for Disease Control and Prevention, 2001).

ISDH has received federal funding from the Maternal and Child Health Services Title V Block Grant to support the following oral health programs:

- SEAL INDIANA ($90,000)
- Indiana Hemophilia and Thrombosis Center ($75,000 for the Indiana hemophilia Amish program)
- Donated Dental Services ($42,932 plus an additional $52,000 provided by the Indiana Family and Social Services Administration's Division of Aging) (Smith, 2008).

[For an overview of ISDH's historical activities dedicated to oral health, and state statutes that relate to oral health, see Appendices H and I.]

SEAL INDIANA—The SEAL INDIANA program is a not-for profit statewide mobile dental sealant program of Indiana University School of Dentistry (IUSD) that works in cooperation with Indiana dentists and the ISDH. The program is endorsed by the Indiana Dental Association and was initiated with matching funds from ISDH and Indiana University-Purdue University Indianapolis research investment funds. The program's goals are to:

- Locate rural and urban children from low-income families who are not receiving dental care
- Provide oral examination, with parental consent, and when indicated, apply sealants and fluoride varnish for prevention of dental caries
- Help to find local dental homes[12] to insure restorative services and continuity of care
- Provide service-learning experiences for dental and dental hygiene students to foster greater understanding of issues related to community oral health and access to dental care
- Engage in research that will promote optimal oral health and more equitable access to care

SEAL INDIANA serves:

- children from low-income families at Title I (lowest income) schools
- community health centers
- Head Start programs
- programs for children of migrant farm workers
- homeless shelters that house children

SEAL INDIANA has received grants from the ISDH, HRSA, Anthem Foundation, and Delta Dental Foundation. Medicaid fees are collected for services provided. Services are provided on a sliding fee schedule or at no charge for children from low-income families without Medicaid coverage.

Since establishment of the program in March 2003, more than 17,000 children have received a dental examination; more than 24,000 dental sealants have been applied; and more than 11,000 fluoride varnish treatments have been provided in more than 800 visits.

All of IUSD's fourth-year dental students are required to serve a three-day rotation with the SEAL INDIANA team at sites throughout the state. Second year dental hygiene students serve a one-day rotation on a voluntary basis. So far, more than 500 dental students and 200 dental hygiene students have participated (Yoder, 2008).

ORAL HEALTH WORKFORCE

Access to dental care depends heavily on available workforce. The Indiana University School of Dentistry (IUSD) is the only school in the state that trains future dentists. There are also six American Dental Association (ADA)-accredited institutions that train health professionals in dental hygiene and 11 institutions with dental assisting programs (see Table 7).

Dentists—A total of 498 dentists graduated from IUSD between 1994 and 1999, and 767 dentists graduated from 2000 to 2007 (Yoder, 2007; Lee, 2009). The availability of dental health professionals hinges on how many of them establish a practice in the state. About 70 percent of all 1994-1999 graduates remained in Indiana, and of graduates who were Indiana residents, 78 percent stayed to practice in the state. About 30 percent of out-of-state graduates also remained to practice in Indiana (Yoder, 2007). No data are available on how many graduates since the year 2000 are practicing in Indiana. According to the ADA, of the almost 180,000 dentists who were professionally active nationwide in 2006, 1.7 percent practiced in Indiana. The ADA does not propose an ideal dentist-to-patient ratio because of variability in economic environments from region to region, state to state, and urban vs. rural areas (ADA, 2008b). The number of dentists in the different geographic areas of the United States varies widely. The ADA Health Policy Resource Center and U.S. Census show that ratios range from around 74 dentists per 100,000 people for some states (New Jersey, Massachusetts, Hawaii, and New York), to 35-40 dentists per 100,000 people for other states (Mississippi, Arkansas, North Carolina, Nevada, and New Mexico). The overall national ratio is approximately 54 dentists per 100,000 population (Fox, 2006).

Indiana's ratio of dentist-to-population is low, and it has progressively worsened over the past 17 years. As the population of the state has increased, the number of dentists has decreased. In 1990, Indiana's population was over 5.5 million with almost 3,600 licensed dentists in the state, for a dentist-to-population

Table 7 ADA-Accredited Dental Programs in Indiana

	Doctoral Degree (DDS)	Dental Hygiene Degree	Dental Assisting Training
Indiana University School of Dentistry	X	X	X
Indiana University-Purdue University Fort Wayne		X	X
Indiana University Northwest		X	X
Indiana University South Bend		X	X
University of Southern Indiana		X	X
Ivy Tech Community College South Bend		X	
C4 Columbus Area Career Connection/Ivy Tech State			X
Ivy Tech Community College Lafayette			X
Ivy Tech Community College Anderson Campus			X
Ivy Tech Community College Kokomo			X
Professional Careers Institute			X
International Business College			X

Source: American Dental Association, Dental Schools and Programs, (n.d.)

ratio of 1 to 1,541 (Yoder, 2007). In 2007, almost 3,300 dentists practiced in Indiana, serving a population of 6.3 million Hoosiers (Indiana University Bowen Research Center, 2009). This represents a dentist-to-population ratio of 1 to 1,923. In other words, the number of active dentists in Indiana decreased from 1990 to 2007 by almost 300, while the population increased by over 0.8 million. It is also important to note that the dentist-to-population ratios vary considerably from one Indiana county to another. For example, in 2007, Newton County had one dentist per 14,014 residents, while Hamilton County had one dentist per 931 residents (Indiana University Bowen Research Center, 2009) (see Appendix J).

According to a recent report on dental provider expenditures for Medicaid populations in Indiana (including 590, ARCH, traditional Medicaid, and CHIP)[13], a total of 852,744 claims were submitted by Indiana counties in 2008. The counties of Benton, Brown, and Ohio had no claims submitted during that time period. The total amount billed was $246,706,446; and the total amount paid was $161,761,419. Marion County had the most claims submitted (189,669), followed by Lake (80,609), Allen (56,215) and St. Joseph (54,886). There were 7,213 claims submitted from facilities out-of-state, with a total amount paid of $1,167,644 (see Map 1 and Appendix K).

The numbers of underrepresented minorities in dentistry remain disproportionate to their representation in the United States population, especially now that minority populations are growing at a faster pace compared to the white population. Increasing the number of minority dental providers is a critical step toward addressing obstacles in access to care faced by minority populations. There is a high correlation between race/ethnicity of dentists and the majority of their patients. This may be due in part to the location of their practices or to a preference for a racially concordant dental provider (Fox, 2006; Patrick, Yin, Nucci, Grembowski, Zane Jolles & Milgrom, 2006). Minority providers tend to practice in inner-city or underserved communities; they have been reported to serve more minority patients and are twice as likely as white dentists to accept new Medicaid patients (Sinkford, J.C.,Valachovic, R.W. & Harrison, S.G., 2004; Weaver, Chmar, Haden & Valachovic, 2005; Okunseri, Bajorunaite, Abena, Self, Iacopino & Flores, 2008). Looking at provider-to-population ratios by race/ethnicity, it has been reported that for every 100,000 white residents, there are 55 white dentists. The ratios for blacks and Hispanics are not so favorable, with 15 and 12 dentists per 100,000 residents, respectively (Fox, 2006). No data are currently available on race and ethnicity of dentists practicing in Indiana. However, we know that few underrepresented minority students have graduated as dental health professionals from Indiana schools. At IUSD, only 3.6 percent of all graduates from 2000 to 2007 were underrepresented minorities, including 17 Hispanic/Latino graduates, nine African-Americans, and one American Indian (Adams-Wilson, 2008).

The number of female dental students has steadily increased in the United States over the years, from 1.4 percent of students enrolled in U.S. dental schools in 1970-1971, to 40.23 percent in 2002 (Sinkford, Valachovic & Harrison, 2003). At IUSD, the gender distribution of dental graduates from 2000 to 2007 was 65 percent male (496) and 35 percent female (271) (Lee, 2009).

Dental Hygienists—Six ADA-accredited institutions in Indiana offer a dental hygiene degree: Indiana University School of Dentistry, Indiana University-Purdue University Fort Wayne, Indiana University Northwest, Indiana University South Bend, Univer-sity of Southern Indiana, and Ivy Tech Community College South Bend. A seventh, Ivy Tech Community College Anderson Campus, recently received initial accreditation (Hudson, 2009).

At IUSD, 225 students graduated from the dental hygiene program from 2003 to 2007. Of the 250 students enrolled during those years, 246 were female and four were male. Most of them (233) were white. There were 10 blacks (nine female and one male), three Asian females, three Hispanic females, and one American Indian female student (Young, 2008).

From 2003 to 2007, 137 students graduated with a dental hygiene degree from Indiana University-Purdue University Fort Wayne. Most of them were female (133) and white (132), with two black and three Hispanic graduates (Valliere, 2009).

From 2003 to 2007, 120 graduated from the dental hygiene program at Indiana University Northwest. The vast majority were female (119) and white (108), with one African-American, one Asian and 10 Hispanic graduates (Robinson, 2008).

There have been 166 dental hygiene graduates from Indiana University South Bend from 2003 to 2007. All of them were female. The majority were white (160); two were black; two were American Indian; one was Asian; and one was Hispanic (Schafer, 2009).

At the University of Southern Indiana from 2003 to 2007, 117 students graduated from the dental hygiene program. All graduates were white and 115 of them were female (Carl, 2008).

The first dental hygiene class at Ivy Tech Community College South Bend will graduate in 2010. They currently have 15 female students. One student is black, one is part American Indian, and one is biracial (black/white) (MacMillan, 2008).

Ivy Tech Community College Anderson Campus will have 15 students in its first class starting in August 2009. No data on gender and race/ethnicity are available yet (Hudson, 2009).

In summary, 765 dental hygiene graduates have emerged from all Indiana accredited schools from 2003 to 2007. Only about 5 percent (40) were minorities, while the majority were white and female.

The ratios of dental hygienists to population are more favorable than those of dentists to population. In 2006, there were 3,661 registered dental hygienists statewide, for a hygienist-to-population ratio of 1 to 1,722. Ratios varied widely at the community level, ranging from 1 to 923 in Hamilton County to 1 to 10,892 in Crawford County (Yoder, 2007). (See Appendix L).

Even though the ratios were low in many counties, a positive development has been the steady increase in the dental hygienist labor pool over recent years. Hygienists constitute a segment of the dental workforce that could help bridge the gaps in access to dental care, if their scope of practice were expanded, as has been done in some states and is being considered in others.

In Indiana, dental hygienists require direct supervision from a dentist in dental offices, long-term facilities, state institutional facilities, state/federal funded community centers,

and depending on their function, in school-system settings (American Dental Association, 2007). The Indiana State Board of Dentistry (ISBD) recently released a proposed draft of rules that will change dental hygienists' scope of practice by allowing prescriptive supervision[14] of hygienists who practice in public health settings. The new rule draft is the result of House Enrolled Act (HEA) 1172-2008, a bill advocated jointly by the Indiana Dental Association and Indiana Dental Hygienists' Association and passed by the Indiana General Assembly during the 2008 legislative session. The process is expected to be completed by the end of summer 2009 (Indiana Dental Association, 2009).

Dental Assistants—The 11 ADA-accredited institutions that offer dental assisting education are: C4 Columbus Area Career Connection/Ivy Tech, Indiana University Northwest, Indiana University-Purdue University Fort Wayne, IUSD, Indiana University South Bend, Ivy Tech Community College, Ivy Tech Community College Anderson Campus, Ivy Tech Community College Kokomo, Professional Careers Institute, University of Southern Indiana, and International Business College. Graduates of dental assisting programs in Indiana have traditionally been mostly white and female.

From 2003 to 2008, 162 dental assistants have graduated from IUSD. Most of them were female (161). The majority were white (151), while six were black, one was Hispanic, one was of Asian/Pacific descent, one was multiracial (black/Hispanic), and two did not indicate race/ethnicity (Ford, 2009; Rossok, 2009).

From 2003 to 2007, 105 dental assistants graduated from Indiana University-Purdue University Fort Wayne. Most of them were white (94), seven of them were black, and four were Asian or Pacific Islander. Most graduates were female (104). Over 80 percent of them are practicing in Indiana (Kracher, 2009).

At Indiana University Northwest, 84 graduated from the dental assisting program from 2003 to 2007. All of them were female; 10 were black and seven were Hispanic (Robinson, 2008).

The dental assisting program at Indiana University South Bend produced 85 graduates from 2003 to 2007. All of them were female. The majority were white (79), five were black, and one was Hispanic (Schafer, 2009).

At the University of Southern Indiana from 2006 to 2008, 53 students graduated from the dental assisting program; all female, with only one black graduate (Bastin, 2009).

From 2003 to 2007, 83 dental assistants graduated from C4 Columbus Area Career Connection/Ivy Tech. The majority were female (81) and white (82), while one graduate was a black female (Ross, 2009).

At Ivy Tech Community College Lafayette, 114 dental assistants graduated from 2003 to 2007. Most graduates were female (113). The ethnicity breakdown of graduates from 2004 to 2007 was white (88), Hispanic (3), and black (1) (Ticen, 2009).

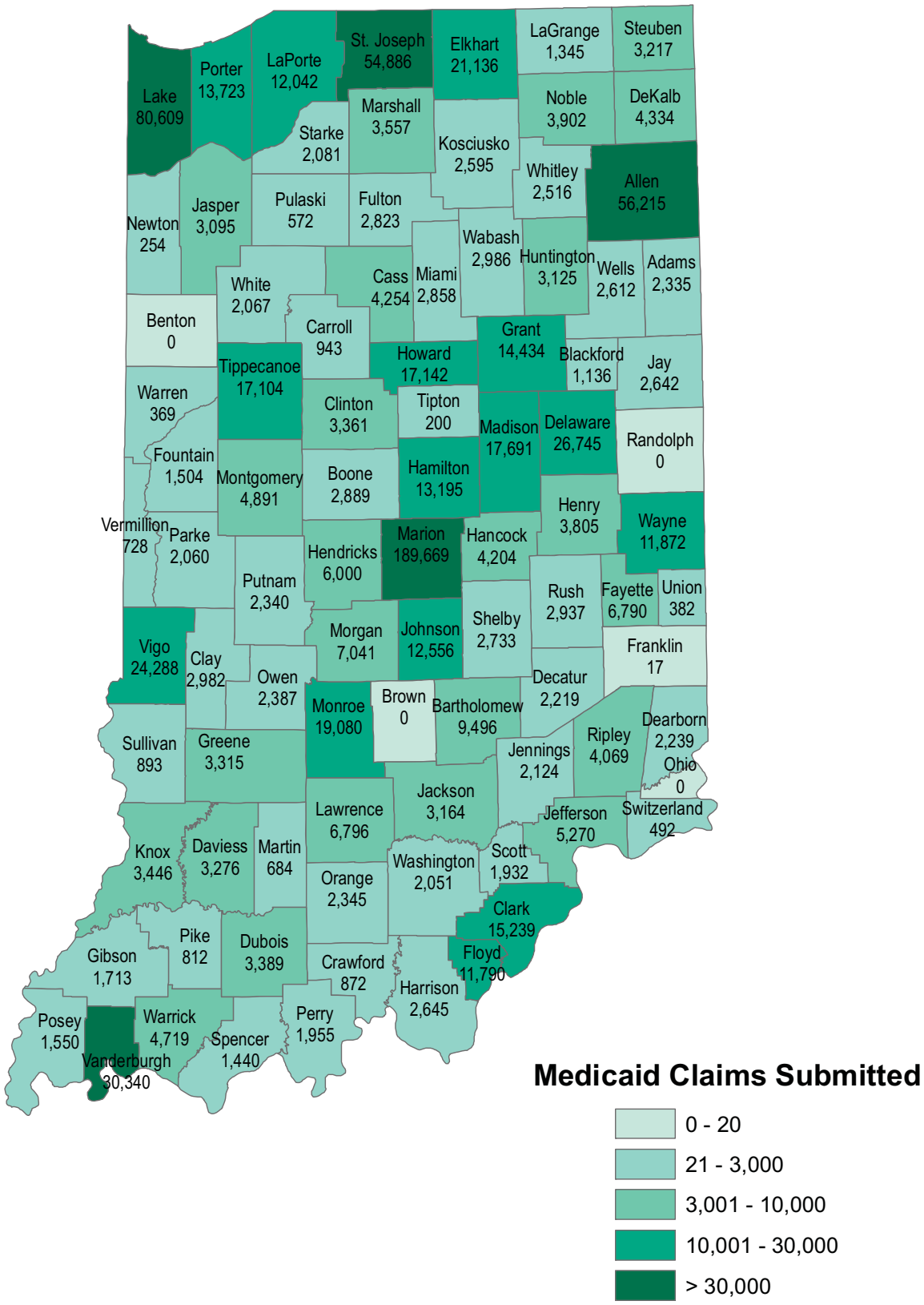
The first year for Ivy Tech Community College Anderson Campus' dental assisting program was 2005. Since then, 64 students have graduated. The majority were female (63) and white (60). There were three black (two females, one male) graduates and one multiracial female graduate (Macauley, 2008).

From 2006 to 2008, 47 dental assistants graduated from Ivy Tech Community College Kokomo. Two of them were Hispanic and the rest were white. They were all female (Riddick, 2009).

Professional Careers Institute has graduated 532 students from its dental assisting program from 2003 to 2007. Only two of them were male. Graduates were: 452 white, 68 black, four Hispanic, and one Asian. Seven declined to report (Loomis, 2009).

International Business College will have their first dental assistant graduating class in 2009. The class is made up of eight women and two men. There are one African-American and one Hispanic student (both female), while the rest are white (Brown, 2009).

Map 1: Number of Dental Claims Submitted to Medicaid in Indiana, by County, 2008



Note: Covered population includes 590, ARCH, Medicaid and CHIP (including Hoosier Healthwise, MCOs, and Medicaid Select)[13]

Source: MedInsight, 2009

APPENDIX A

Number of Dental Services Covered in Medicaid Adult Beneficiaries in Indiana, 2008

Category of Service (Codes)	Examples of Category Services	Number of Services Covered
Diagnostic (D0100-D0999)	Problem-focused oral evaluation; radiograph; lab test; oral pathology report	22
Preventive (D1000-D1999)	Prophylaxis; topical fluoride treatment; nutritional counseling; space maintenance	1
Restorative (D2000-D2999)	Amalgam or resin restoration; stainless steel crown; temporary crown; cast alloy crown	32
Endodontics (D3000-D3999)	Pulpal debridement for pain relief; pulpal therapy; complete root canal; apicoectomy	5
Periodontics (D4000-D4999)	Gingivectomy; periodontal surgery; teeth splinting; scaling and root planing	6
Prosthodontics (D5000-D5899)	Complete and partial denture; denture reline	26
Maxillofacial Prosthetics (D5900-D5999)	Facial prosthesis; obturator prosthesis; speech aid; feeding aid	0
Implant Services (D6000-D6199)	Surgical placement of implant; crown or denture supported by implant	0
Prosthodontics,fixed (D6200-D6999)	Alloy pontic; cast crown retainer (for bridge)	0
Oral and Maxillofacial Surgery (D7000-D7999)	Single tooth extraction; removal of impacted tooth; removal of tumor, cyst, neoplasm, reduction of fracture	0
Orthodontics (D8000-D8999)	Interceptive and comprehensive orthodontic treatment; replacement of lost retainer	0
Adjunctive General Services (D9000-D99999)	Palliative (emergency) treatment of dental pain; local anesthesia; conscious sedation; hospital call; antibiotic	7
Comments: For maxillofacial prosthetics, and oral and maxillofacial surgery, additional services may be provided as CPT codes. Many services need to be preauthorized. No orthodontics are provided except in cases of craniofacial deformity/cleft palate.		

Note: Population includes adults in traditional Medicaid, Hoosier Healthwise and Care Select.

Source: American Dental Association, 2008a

APPENDIX B

Indiana's Medicaid Reimbursement Rates for Selected Dental Procedures in Adults, 2008

ADA Procedure Code (CDT)	Procedure Description	2008 Medicaid Rate 6/1/2008
D0120	Periodical Oral Evaluation	$22.58
D1110	Prophylaxis (cleaning) Adult	$47.75
D4341	Periodontal scaling and root planing, per quadrant	$154.74
D5110	Complete denture, maxillary	$436.35
D7140	Extraction, Erupted Tooth or Exposed Root	$77.24

Source: American Dental Association, 2008a

APPENDIX C

Indiana's Medicaid Reimbursement Rates for Selected Dental Procedures in Children, 2008

ADA Procedure Code (CDT)	Procedure Description	2008 Medicaid Rate 6/1/2008
Diagnostic Services		
D0120	Periodic Oral Evaluation	$22.58
D0140	Limited Oral Evaluation, Problem Focused	$37.08
D0150	Comprehensive Oral Exam	$35.50
D0210	Intra-oral complete X rays, including Bitewings	$72.25
D0272	Bitewing X-rays- 2 Films	$24.81
D0330	Panoramic X-ray Film	$64.52
Preventive Services		
D1120	Prophylaxis (cleaning) - Child	$34.50
D1203	Topical Fluoride Application (excluding prophy) - Child	$22.25
D1206	Topical Fluoride Varnish	$0.00
D1351	Dental Sealant, per tooth	$29.35
Restorative Services		
D2150	Amalgam, 2 surfaces, primary or permanent tooth	$81.14
D2331	Resin-based Composite, 2 surfaces, anterior tooth	$96.47
D2751	Crown, porcelain fused to predominately base metal	$0.00
D2930	Prefabricated Resin Crown	$155.86
D2932	Prefabricated Resin	$138.75
Endodontic		
D3220	Therapeutic Pulpotomy	$105.11
D3310	Anterior Endodontic Therapy	$377.52
D3330	Molar Root Canal	$569.32
Oral and Maxillofacial Surgery		
D7140	Extraction, Erupted tooth or Exposed root	$77.24
Adjunctive General Services		
D9248	Conscious Sedation	$38.50
Comments: Topical fluoride applications are billable under D1203 (ages 1-12) or D1204 (ages 13-20).		

Note: Population includes all children in Hoosier Healthwise, traditional Medicaid and Care Select.

Source: American Dental Association, 2008a

APPENDIX D

Indiana's Medicaid Payment Rates for Selected Procedures Compared with Dentists' Claims for Insured Patients in the ADA East North Central Region, 2004

CDT4 Procedure Code	Procedure Description	IN Medicaid Payment Rate	ENC Region 50th Percentile	IN State 50th Percentile	IN State 75th Percentile	State Percentile Corresponding to IN Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	$20.25	$28.00	$26.00	$29.00	10th
D0150	Comprehensive Oral Exam	$35.50	$43.00	$40.00	$45.00	34th
D0210	Complete X-rays, with Bitewings	$72.25	$86.00	$85.00	$88.00	12th
D0272	Bitewing X-rays - 2 Films	$22.25	$27.00	$26.00	$28.00	21st
D0330	Panoramic X-ray Film	$61.00	$75.00	$72.00	$77.00	16th
Preventive						
D1120	Prophylaxis (cleaning)	$34.50	$40.00	$38.00	$40.00	24th
D1203	Topical Fluoride (excluding cleaning)	$22.25	$23.00	$20.00	$23.00	71st
D1351	Dental Sealant	$27.75	$33.00	$32.00	$35.00	15th
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	$72.75	$90.00	$87.00	$96.00	14th
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	$86.50	$109.00	$104.00	$116.00	16th
D2930	Prefabricated Steel Crown, Primary Tooth	$139.75	$175.00	$165.00	$175.00	10th
Endodontics						
D3220	Removal of Tooth Pulp	$94.25	$110.00	$103.00	$111.00	16th
D3310	Anterior Endodontic Therapy	$338.50	$460.00	$446.50	$551.00	8th
Oral Surgery						
D7140	Extraction, Single Tooth	$72.25	$85.00	$80.00	$90.00	33rd

Note: The East North Central Region is comprised of Indiana, Illinois, Michigan, Ohio, and Wisconsin.

Source: American Dental Association, 2005.

APPENDIX E

Percentage (95% Confidence Interval) of Indiana Adults Reporting in 2008 to Have Had Any Permanent Teeth Extracted (Behavioral Risk Factor Surveillance System, 2008)

		Percentage (95% CI)
Gender	Male	46.6% (43.3-49.9)
	Female	49.6% (46.9-52.4)
Race	White	47.1% (44.8-49.3)
	Black	59.7% (51.7-67.7)
	Hispanic	n/a
Age	18 - 24	22.3% (14.4-30.2)
	25 - 34	33.1% (27.5-38.6)
	35 - 44	32.8% (28.6-36.9)
	45 - 54	53.6% (49.7-57.6)
	55 - 64	67.9% (64.3-71.6)
	65 +	79.5% (76.8-82.3)
Income	Less than $15,000	61.1% (52.0-70.1)
	$15,000 - $24,999	60.1% (54.2-66.0)
	$25,000 - $34,999	61.6% (54.4-68.8)
	$35,000 - $44,999	52.7% (47.3-58.1)
	$50,000 +	36.4% (33.3-39.5)
Education	Less than H.S.	61.0% (52.5-69.4)
	H.S. or G.E.D.	60.9% (57.1-64.6)
	Some post-H.S.	46.1% (42.1-50.2)
	College graduate	29.7% (26.5-33.0)

Note: Population includes all children in Hoosier Healthwise, traditional Medicaid and Care Select.

Source: American Dental Association, 2008a

APPENDIX F

Percentage (95% Confidence Interval) of Indiana Adults Ages 65 Years and Older Reporting in 2008 to Have Had All Their Natural Teeth Extracted (Behavioral Risk Factor Surveillance System, 2008)

		Percentage (95% CI)
Gender	Male	20.3% (15.9-24.7)
	Female	22.7% (19.4-26.1)
Race	White	21.5% (18.7-24.3)
	Black	n/a
	Hispanic	n/a
Age	65 - 74 years	21.2% (17.7-24.7)
	75 and over	22.3% (18.3-26.3)
Income	Less than $15,000	47.8% (38.2-57.5)
	$15,000 - $24,999	28.4% (22.3-34.6)
	$25,000 - $34,999	21.7% (14.7-28.7)
	$35,000 - $44,999	16.6% (9.5-23.7)
	$50,000 +	7.3% (2.8-11.9)
Education	Less than H.S.	54.7% (45.8-63.6)
	H.S. or G.E.D.	23.1% (19.1-27.0)
	Some post-H.S.	14.1% (9.7-18.5)
	College graduate	5.9% (2.3-9.5)

Note:H.S. = High school; G.E.D. = General Educational Development certificate

Source: Centers for Disease Control and Prevention, 2009

APPENDIX G

Percentage (95% Confidence Interval) of Indiana Adults Reporting in 2008 to Have Visited the Dentist or Dental Clinic within the Past Year for Any Reason (Behavioral Risk Factor Surveillance System, 2008)

		Percentage (95% CI)
Gender	Male	65.1% (61.9-68.3)
	Female	71.3% (68.9-73.8)
Race	White	69.8% (67.7-71.9)
	Black	67.3% (60.4-74.1)
	Hispanic	n/a
Age	18 - 24	68.7% (59.7-77.7)
	25 - 34	63.4% (57.7-69.0)
	35 - 44	72.6% (68.5-76.6)
	45 - 54	70.5% (66.9-74.0)
	55 - 64	68.8% (65.1-72.6)
	65 +	65.6% (62.5-68.7)
Income	Less than $15,000	45.5% (36.7-54.3)
	$15,000 - $24,999	46.7% (41.1-52.3)
	$25,000 - $34,999	55% (48.2-61.9)
	$35,000 - $44,999	66.9% (61.4-72.3)
	$50,000 +	82% (79.2-84.7)
Education	Less than H.S.	43% (35.3-50.8)
	H.S. or G.E.D.	62.7% (59.1-66.2)
	Some post-H.S.	70.3% (66.6-74.1)
	College graduate	82.7% (79.8-85.5)

Note:H.S. = High school; G.E.D. = General Educational Development certificate

Source: Centers for Disease Control and Prevention, 2009

APPENDIX H

Historical Activities of the Indiana State Department of Health, Oral Health Division

The ISDH Oral Health Division has contributed to the improved oral health of Hoosiers in the following ways:

- Participated in school surveys and provided oral health education to elementary schools around the state. Collaborated with Indiana University School of Dentistry and Oral Health Research Institute on surveys of the oral health status of children in Indiana. Surveys were completed in 1958-1959, 1971-1972, 1981-1982, and 1992-1993.
- Provided technical expertise and education on the benefits of community water fluoridation and collaborated with ISDH community water fluoridation staff, local communities, and community water facilities to initiate and monitor community water fluoridation activities and ensure compliance with CDC recommendations.
- Collaborated with the Indiana University School of Dentistry, Indiana Dental Association, and other professional groups on oral health issues by serving on the Indiana Dental Association Councils on Dental Public Health and Dental Education and the Indiana University School of Dentistry Executive Council.
- Collaborated with the Indiana University School of Dentistry to establish a school-based sealant program called SEAL INDIANA. ISDH provided more than $100,000 as part of the initial funding for this program.
- Coordinated with the Indiana University School of Dentistry, Oral Health Research Institute, elementary schools, and dental professionals on a school-based oral health education and fluoride rinse program.
- Served as consultants on oral health matters to other ISDH programs, Head Start Programs, other state agencies such as Department of Corrections, Medicaid, Department of Mental Health, state hospitals, and facilities for the developmentally disabled. Oral Health staff provided oral health information to Hoosiers at community events such as Indiana Black Expo, Indiana State Fair, schools, and other events.
- Participated in clinical examinations that resulted in the development of Crest Toothpaste. Oral Health staff were also active in other dental research activities at the dental school.
- Served as adjunct faculty at the dental school and provided education to students on dental public health matters at the dental school, Indiana Soldiers and Sailors Children's Home, and other entities.
- Had a major role in establishing the rules relating to the state law governing Universal Precautions. After the Universal Precautions rule was passed, Oral Health staff monitored infection control compliance by conducting random audits of dental offices and investigation of Universal Precautions complaints.
- Contributed articles on relevant oral health matters for professional journals such as the *Journal of the Indiana Dental Association*, the *Journal of the American Dental Association, Oral Health Research Journal, Journal of Public Health Dentistry,* etc.
- Responded to inquires from the public and governmental entities on oral health matters.
- Participated in local, state, or national meetings related to oral health. These meetings were sponsored by the Indiana Dental Association, Association of State and Territorial Dental Directors, American Dental Association and the American Public Health Association.
- Provided continuing education related to dental public health, emergency preparedness and other relevant matters to professional groups.
- Provided training to dentists on the child abuse and neglect P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) program.

Additionally, ISDH Oral Health Director Chuck Gish obtained grant funding for Riley Hospital, which assisted ISDH in starting the Riley Dental Clinic and regional campuses for dental hygiene and dental assisting education. Dr. Gish also initiated a highly successful oral cancer biopsy program, which allowed Hoosier dentists to submit tissue sections to the dental school's Oral Pathology Department for diagnosis.

Source: Smith, M.K. Personal communication, April 16, 2009

APPENDIX I

Indiana Dental Statutes Relating to Oral Health

IC 16-19-3
Chapter 3. Powers and Duties of State Department of Health and Executive Board

IC 16-19-3-20
Dental public health
Sec. 20. The state department (Indiana State Department of Health) shall provide facilities and personnel for investigation, research, and dissemination of knowledge to the public concerning dental public health.
As added by P.L.2-1993, SEC.2. Amended by P.L.142-1995, SEC.5.

Note: Indiana Code, available at http://www.in.gov/legislative/ic/code/title16/ar19/ch3.html

Source: Smith, M.K. Personal communication, December 15, 2008

IC 12-13-15.2
Chapter 15.2. Dental Care Information for Indiana Children

IC 12-13-15.2-2
Collaboration in establishing programs
Sec. 2. The division (Division of Family Resources) shall collaborate with the office of Medicaid policy and planning established by IC 12-8-6-1 and the state department of health established by IC 16-19-1-1 to establish programs that facilitate children's access to oral health services.
As added by P.L.169-2001, SEC.1.

Note: Indiana Code, available at http://www.in.gov/legislative/ic/code/title12/ar13/ch15.2.html

Source: Smith, M.K. Personal communication, December 15, 2008

APPENDIX J

Number of Dentists and Ratio of Dentist-to-Population, per County, 2007

County	Population	Dentists	Ratio
Adams	33,644	13	1:2,588
Allen	349,488	176	1:1,986
Bartholomew	74,750	42	1:1,780
Benton	8,810	2	1:4,405
Blackford	13,189	4	1:3,297
Boone	54,137	42	1:1,289
Brown	14,670	3	1:4,890
Carroll	19,987	9	1:2,221
Cass	39,193	9	1:4,355
Clark	105,035	37	1:2,839
Clay	26,648	5	1:5,330
Clinton	33,795	9	1:3,755
Crawford	10,782	2	1:5,391
Daviess	30,035	6	1:5,006
Dearborn	49,759	7	1:7,108
Decatur	24,959	5	1:4,992
DeKalb	41,796	20	1:2,090
Delaware	115,419	54	1:2,137
Dubois	41,225	22	1:1,874
Elkhart	197,942	60	1:3,299
Fayette	24,273	6	1:4,046
Floyd	73,064	44	1:1,661
Fountain	17,143	4	1:4,286
Franklin	23,234	8	1:2,904
Fulton	20,308	7	1:2,901
Gibson	32,754	12	1:2,730
Grant	68,847	30	1:2,295
Greene	32,692	12	1:2,724
Hamilton	261,661	281	1:931
Hancock	66,305	29	1:2,286
Harrison	36,810	17	1:2,165
Hendricks	134,558	87	1:1,547
Henry	47,181	12	1:3,932
Howard	83,776	48	1:1,745
Huntington	37,743	11	1:3,431
Jackson	42,184	16	1:2,637
Jasper	32,275	10	1:3,228
Jay	21,514	6	1:3,586
Jefferson	32,704	19	1:1,721
Jennings	28,106	4	1:7,027
Johnson	135,951	79	1:1,721
Knox	37,949	18	1:2,108
Kosciusko	76,115	24	1:3,171
LaGrange	37,032	6	1:6,172
Lake	492,104	230	1:2,140
LaPorte	109,787	47	1:2,336
Lawrence	46,033	15	1:3,069
Madison	131,312	53	1:2,478
Marion	876,804	837	1:1,048
Marshall	46,698	15	1:3,113
Martin	10,058	2	1:5,029
Miami	36,641	6	1:6,107
Monroe	128,643	63	1:2,042
Montgomery	37,881	14	1:2,706
Morgan	69,874	27	1:2,588
Newton	14,014	1	1:14,014
Noble	47,526	12	1:3,961
Ohio	5,772	2	1:2,886
Orange	19,607	6	1:3,268
Owen	22,398	4	1:5,600
Parke	17,169	2	1:8,585
Perry	18,916	7	1:2,702
Pike	12,605	3	1:4,202
Porter	160,578	83	1:1,935
Posey	26,262	6	1:4,377
Pulaski	13,778	5	1:2,756
Putnam	37,014	11	1:3,365
Randolph	25,859	6	1:4,310
Ripley	27,350	7	1:3,907
Rush	17,494	5	1:3,499
St. Joseph	266,088	132	1:2,016
Scott	23,679	6	1:3,947
Shelby	44,063	11	1:4,006
Spencer	20,334	4	1:5,084
Starke	23,542	2	1:11,771
Steuben	33,450	10	1:3,345
Sullivan	21,366	4	1:5,342
Switzerland	9,684	1	1:9,684
Tippecanoe	163,364	75	1:2,178
Tipton	16,069	7	1:2,296
Union	7,203	2	1:3,602
Vanderburgh	174,425	93	1:1,876
Vermillion	16,417	4	1:4,104
Vigo	104,915	52	1:2,018
Wabash	32,918	13	1:2,532
Warren	8,482	2	1:4,241
Warrick	57,090	28	1:2,039
Washington	27,920	7	1:3,989
Wayne	68,260	34	1:2,008
Wells	27,927	9	1:3,103
White	23,819	8	1:2,977
Whitley	32,655	9	1:3,628
Indiana	6,345,289	3,299	1:1,923

Population data source: U.S. Census Bureau

Dentist data: IU Bowen Research Center

APPENDIX K

Number of Dental Claims Submitted to Medicaid, Total Amount Billed to Medicaid, and Total Amount Paid by Medicaid in Indiana, by County, 2008

County	Claims Submitted	Total Billed	Total Paid
Adams	2,335	$544,652	$343,748
Allen	56,215	$17,173,241	$11,630,349
Bartholomew	9,496	$2,640,426	$1,698,363
Blackford	1,136	$156,061	$113,880
Boone	2,889	$1,299,914	$955,973
Carroll	943	$124,526	$109,969
Cass	4,254	$1,093,885	$625,057
Clark	15,239	$4,195,125	$2,736,070
Clay	2,982	$448,044	$364,946
Clinton	3,361	$678,253	$482,091
Crawford	872	$108,295	$87,182
Daviess	3,276	$685,230	$510,398
Dearborn	2,239	$426,481	$327,297
Decatur	2,219	$486,013	$325,032
Dekalb	4,334	$991,842	$645,675
Delaware	26,745	$7,256,220	$5,149,558
Dubois	3,389	$1,061,420	$733,904
Elkhart	21,136	$4,547,777	$3,656,782
Fayette	6,790	$1,251,641	$1,171,249
Floyd	11,790	$3,221,444	$2,449,632
Fountain	1,504	$275,778	$205,448
Franklin	17	$2,048	$1,342
Fulton	2,823	$683,282	$444,164
Gibson	1,713	$275,647	$203,258
Grant	14,434	$4,859,850	$2,902,293
Greene	3,315	$512,251	$408,270
Hamilton	13,195	$3,693,149	$2,375,907
Hancock	4,204	$1,110,249	$642,658
Harrison	2,645	$538,042	$405,725
Hendricks	6,000	$2,311,734	$1,397,676
Henry	3,805	$761,354	$549,191
Howard	17,142	$5,623,034	$3,716,280
Huntington	3,125	$558,908	$390,148
Jackson	3,164	$982,476	$730,079
Jasper	3,095	$1,078,809	$621,376
Jay	2,642	$565,849	$407,124
Jefferson	5,270	$1,542,219	$1,098,825
Jennings	2,124	$534,830	$435,697
Johnson	12,556	$4,009,891	$2,706,220
Knox	3,446	$489,140	$448,794
Kosciusko	2,595	$428,892	$314,179
Lagrange	1,345	$200,067	$152,605
Lake	80,609	$22,257,928	$15,073,446
Laporte	12,042	$3,153,443	$2,289,839
Lawrence	6,796	$1,236,171	$989,420
Madison	17,691	$4,997,425	$3,652,592
Marion	189,669	$57,192,955	$38,252,272
Marshall	3,557	$606,747	$568,472
Martin	684	$90,294	$84,627
Miami	2,858	$461,128	$366,609
Monroe	19,080	$5,168,401	$3,616,652
Montgomery	4,891	$1,193,511	$815,442
Morgan	7,041	$1,643,479	$1,153,870
Newton	254	$29,117	$29,082
Noble	3,902	$736,300	$635,186
Orange	2,345	$381,639	$302,488
Owen	2,387	$636,336	$511,745
Parke	2,060	$531,337	$391,137
Perry	1,955	$439,091	$410,865
Pike	812	$105,217	$94,716
Porter	13,723	$4,417,360	$2,883,014
Posey	1,550	$234,403	$213,616
Pulaski	572	$89,299	$68,331
Putnam	2,340	$497,351	$297,828
Ripley	4,069	$1,088,715	$593,367
Rush	2,937	$800,557	$474,113
Saint Joseph	54,886	$29,061,956	$11,558,335
Scott	1,932	$463,061	$343,721
Shelby	2,733	$658,615	$436,789
Spencer	1,440	$176,030	$148,528
Starke	2,081	$269,295	$220,663
Steuben	3,217	$587,969	$425,899
Sullivan	893	$115,903	$99,853
Switzerland	492	$67,458	$50,258
Tippecanoe	17,104	$4,930,725	$3,527,920
Tipton	200	$45,394	$33,335
Union	382	$58,243	$40,751
Vanderburgh	30,340	$7,970,623	$5,530,914
Vermillion	728	$151,817	$98,104
Vigo	24,288	$5,625,886	$4,271,190
Wabash	2,986	$499,177	$420,360
Warren	369	$33,395	$28,555
Warrick	4,719	$1,043,709	$703,158
Washington	2,051	$698,650	$548,423
Wayne	11,872	$3,990,367	$2,710,905
Wells	2,612	$511,589	$338,152
White	2,067	$449,956	$330,549
Whitley	2,516	$386,173	$284,270
Out-of-state	7,213	$1,494,259	$1,167,644
TOTAL	852,744	$246,706,446	$161,761,419

Note: Covered population includes 590, ARCH, Medicaid and CHIP (including Hoosier Healthwise, MCOs, and Medicaid Select)13

Source: MedInsight, 2009

APPENDIX L

Number of Registered Dental Hygienists (RDH) and Ratio of RDH-to-Population, per County, 2006

County	Population	RDH	Ratio
Adams	33,623	31	1:1,085
Allen	346,144	309	1:1,120
Bartholomew	73,999	39	1:1,897
Benton	8,860	3	1:2,953
Blackford	13,281	4	1:3,320
Boone	52,938	54	1:980
Brown	14,825	4	1:3,706
Carroll	20,017	5	1:4,003
Cass	39,459	28	1:1,409
Clark	103,692	43	1:2,411
Clay	26,738	10	1:2,674
Clinton	33,795	11	1:3,072
Crawford	10,892	1	1:10,892
Daviess	29,899	12	1:2,492
Dearborn	49,199	12	1:4,100
Decatur	25,003	9	1:2,778
DeKalb	41,540	29	1:1,432
Delaware	115,680	36	1:3,213
Dubois	41,050	21	1:1,955
Elkhart	196,466	98	1:2,005
Fayette	24,384	7	1:3,483
Floyd	72,383	40	1:1,810
Fountain	17,225	5	1:3,445
Franklin	23,059	22	1:1,048
Fulton	20,281	12	1:1,690
Gibson	32,974	20	1:1,649
Grant	69,501	25	1:2,780
Greene	32,934	13	1:2,533
Hamilton	251,980	273	1:923
Hancock	64,551	55	1:1,174
Harrison	36,624	19	1:1,928
Hendricks	130,325	107	1:1,218
Henry	47,492	21	1:2,262
Howard	83,874	46	1:1,823
Huntington	37,875	25	1:1,515
Jackson	42,052	18	1:2,336
Jasper	31,844	25	1:1,274
Jay	21,457	9	1:2,384
Jefferson	32,720	10	1:3,272
Jennings	27,971	22	1:1,271
Johnson	132,597	104	1:1,275
Knox	38,066	20	1:1,903
Kosciusko	75,811	37	1:2,049
LaGrange	36,693	14	1:2,621
Lake	489,925	243	1:2,016
LaPorte	109,278	75	1:1,457
Lawrence	45,892	22	1:2,086
Madison	131,195	64	1:2,050
Marion	872,986	436	1:2,002
Marshall	46,648	36	1:1,296
Martin	10,153	6	1:1,692
Miami	36,954	10	1:3,695
Monroe	127,306	38	1:3,350
Montgomery	37,718	19	1:1,985
Morgan	69,605	35	1:1,989
Newton	14,009	4	1:3,502
Noble	47,518	25	1:1,901
Ohio	5,836	1	1:5,836
Orange	19,483	2	1:9,742
Owen	22,323	8	1:2,790
Parke	17,154	10	1:1,715
Perry	18,824	4	1:4,706
Pike	12,639	4	1:3,160
Porter	158,189	154	1:1,027
Posey	26,372	10	1:2,637
Pulaski	13,775	6	1:2,296
Putnam	36,813	18	1:2,045
Randolph	26,110	9	1:2,901
Ripley	27,431	6	1:4,572
Rush	17,554	5	1:3,511
St. Joseph	265,505	231	1:1,149
Scott	23,617	5	1:4,723
Shelby	43,712	13	1:3,362
Spencer	20,335	12	1:1,695
Starke	23,522	12	1:1,960
Steuben	33,555	17	1:1,974
Sullivan	21,367	9	1:2,374
Switzerland	9,634	4	1:2,409
Tippecanoe	160,458	65	1:2,469
Tipton	16,151	9	1:1,795
Union	7,176	2	1:3,588
Vanderburgh	174,087	119	1:1,463
Vermillion	16,458	9	1:1,829
Vigo	104,899	36	1:2,914
Wabash	33,291	21	1:1,585
Warren	8,581	2	1:4,291
Warrick	56,165	52	1:1,080
Washington	27,846	7	1:3,978
Wayne	68,559	23	1:2,981
Wells	27,895	19	1:1,468
White	23,980	8	1:2,998
Whitley	32,390	28	1:1,157
Indiana	6,302,646	3,661	1:1,722

Population source: U.S. Census Bureau

Dental Hygienists data: Yoder, 2007

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END NOTES

1. The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. Poverty thresholds can be viewed at the Census website at http://www.census.gov/hhes/www/poverty/threshld.html.

2. In 1994, Indiana implemented Hoosier Healthwise, a mandatory managed care program for eligible Medicaid recipients, including children, low-income families and pregnant women. The Office of Medicaid Policy & Planning phased in the program, so that by July 1997, it became statewide. Since January 2000, the Indiana Medical Assistance Programs have been known as the Indiana Health Coverage Programs (IHCP). Hoosier Healthwise is one part of the IHCP (Family & Social Services Administration, Office of Medicaid Policy & Planning, n.d.).

3. Any dental service refers to diagnostic services, including clinical oral evaluations, radiographs/diagnostic imaging, tests and examinations (such as caries susceptibility tests and pulp vitality tests), and oral pathology laboratory, as defined by the CMS's Healthcare Common Procedures Coding (HCPC) system codes D0100 -D9999 (ADA codes 00100 - 09999). Preventive dental services include dental prophylaxis, topical fluoride treatment, and other preventive services such as nutritional counseling, oral hygiene instruction, sealants and space maintainers, as defined by HCPC codes D1000 - D1999 (ADA codes 01000 - 01999). Dental treatment services include restorative procedures (such as amalgam restorations, resin-based composite restorations, and crowns); endodontic, periodontic and prosthodontic procedures; maxillofacial prosthetics; implant services; oral and maxillofacial surgery; orthodontics; and adjunctive general services (such as anesthesia and professional consultation services), as defined by HCPC codes D2000 -D9999 (ADA codes 02000 - 09999). The list of valid ADA procedure codes can be found at http://www.deltadentalwa.com/Dentist/Public/ResourceCenter/CDT%20Procedure%20Codes.aspx.

4. ICD-9 codes for neoplasms of lip, oral cavity, and pharynx: 140-149 Malignant neoplasm of lip, oral cavity, and pharynx; 210 Benign neoplasm of lip, oral cavity, and pharynx; 230.0 Carcinoma in situ of lip, oral cavity, and pharynx.

5. ICD-9 codes for diseases of oral cavity, salivary glands, and jaws: 520-529 Diseases of oral cavity, salivary glands, and jaws.

6. ICD-9 codes for congenital anomalies: 749 Cleft palate and cleft lip; 750.0-750.2 Other congenital anomalies of upper alimentary tract (tongue, mouth, pharynx).

7. ICD-9 codes for injuries of lips, mouth, pharynx, and larynx: 933 Foreign body in pharynx and larynx; 935.0 Foreign body in mouth; 941.03/941.13/941.23/941.33/941.43/941.53 Burns of lips; 947.0 Burn of mouth and pharynx.

8. ICD-10 codes for neoplasms of lip, oral cavity, pharynx: C00-C14 Malignant neoplasms of lip, oral cavity and pharynx; C43.0 Malignant melanoma of lip; C44.0 Basal cell carcinoma of lip; D00.0 Carcinoma in situ of lip, oral cavity and pharynx; D03.0 Melanoma in situ of lip; D04.0 Carcinoma in situ/skin of lip; D10 Benign neoplasm of mouth and pharynx; D11 Benign neoplasm of major salivary glands; D37.0 Neoplasm of uncertain or unknown behavior/Lip, oral cavity and pharynx.

9. ICD-10 codes for diseases of oral cavity, salivary glands, and jaws: K00-K14 Diseases of oral cavity, salivary glands and jaws.

10. ICD-10 codes for oral congenital malformations: Q35-Q37 Cleft palate and cleft lip; Q38 Other congenital malformations of tongue, mouth and pharynx.

11. HPSA scores range from 1 to 25 for primary care and mental health and from 1 to 26 for DHPSAs.

12. A dental home refers to the ongoing relationship between a primary dental care provider and the patient, which includes comprehensive oral health care (ADA, 2008a).

13. The Medicaid program 590 is part of Indiana Health Coverage Programs (IHCP) but not of Hoosier Healthwise. This program benefits residents of state-owned facilities under the direction of the Indiana Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA), and the Indiana State Department of Health (ISDH). Members are eligible for full Medicaid benefits. Medicaid Select was an IHCP program until 2008 when it became a Care Select provider. Care Select is a managed care program created by the FSSA to provide healthcare to the aged, blind and disabled, those receiving adoption assistance, members of the Medicaid Waiver Program, M.E.D. Works (Medicaid for Employees with Disabilities), and wards and foster children. The Assistance for Residents of County Homes (ARCH) program benefits members who need assistance paying for healthcare and other expenses (Family & Social Services Administration, Office of Medicaid Policy & Planning, n.d.), (Electronic Data Systems, 2007), (Family & Social Services Administration, Division of Disability & Rehabilitative Services, n.d.).

14. "Prescriptive supervision" means that a licensed dentist is not required to be physically present in the facility when patient care is provided, if a licensed dentist has examined the patient and has prescribed the patient care within the previous 45 days. "Direct supervision" means that a licensed dentist is physically present in the facility when patient care is provided (Indiana Code, IC 25-13-1-2, available at http://www.in.gov/legislative/ic/code/title25/ar13/ch1.html).

INDIANA'S STRATEGIC ORAL HEALTH PLAN

Indiana Strategic Oral Health Initiative (SOHI)

The Health Resources and Services Administration (HRSA), part of the U.S. Department of Health and Human Services, awarded a one-year workforce development grant to the Indiana State Department of Health (ISDH). ISDH contracted with the Indiana University School of Dentistry (IUSD) and the Indiana University Center for Health Policy (CHP) to develop a strategic plan designed to improve the State's oral health workforce and service delivery infrastructure for the underserved. To execute the grant, selected members of the three organizations and the Indiana Dental Association (IDA) formed a steering committee (called the Coordinating Committee, or CC), which coordinated all processes involved in developing Indiana's Strategic Oral Health Plan. The CC met regularly, at least once a month.

We, the CC, required the strategic plan to follow a public health model, be data-driven, and strive to be evidence-based, using best available scientific evidence and guidelines endorsed by federal agencies and professional organizations. Indiana's most important oral health needs and priorities that are being addressed in this plan were identified using a two-fold process that included:

a) ***Statewide needs assessment***
The Data Group, a subgroup of the CC, guided the completion of the needs assessment. Unfortunately, only limited oral health data are currently available in Indiana.

b) ***Community-based participatory research***
At the heart of the effort was the establishment of the Statewide Planning Council (SPC), a group of key stakeholders from oral health, primary care, and minority health communities as well as other community leaders interested in improving the oral health of Indiana's residents. The SPC met four times (January, March, May, and August of 2009) to discuss and identify oral health needs, goals, and strategies to be included in the plan. Additionally, we conducted five focus groups in various regions of the State (Evansville, New Albany, Gary, Fort Wayne, and Indianapolis) to receive feedback on preliminary goals. The comments we received were incorporated and the goals revised.

We realize that the development of a strategic plan is only the first step in the process of building an adequate workforce, increasing capacity, and improving access to care for the underserved. The next step is the implementation of the plan. In the current economic climate, finding the necessary resources to implement a program or build service-delivery infrastructure is difficult, at best. But we believe that addressing the goals outlined in the strategic plan is crucial to ensure that Indiana is preparing to meet the current and future oral health needs of its residents.

We recommend that the implementation of the strategic plan shall be overseen by a coordinating body. Considering economic challenges and to encourage sustainability, the process of implementation shall be governed by a group that is already in existence, the Oral Health Task Force (OHTF). The OHTF's new mission shall include taking on a stronger, more committed leadership role in furthering oral health for all Indiana residents. To better address the new mission, it is recommended that ISDH shall do the following:

- Re-assemble the OHTF to include committed members from the State and local health departments; IUSD; Indiana Dental Association (IDA); Indiana Dental Hygienists' Association (IDHA); Indiana Dental Assistants Association (IDAA); and other potential stakeholders. The process of reformation shall begin no later than January 2010 and be accomplished by March 2010.
- Establish co-chairs (State Oral Health Director and IUSD faculty member). This shall be accomplished by March 2010.
- The OHTF shall serve as the "keeper" of Indiana's Strategic Oral Health Plan. The OHTF responsibilities shall include overseeing implementation of the plan and review/update of the plan every 2 years. The next review/update of the plan shall occur no later than January 2012.
- The OHTF shall appoint committees to implement recommended goals and others as they are developed. The committees may consist of OHTF members, members of the Oral Health Coalition and other experts or interested parties. These committees shall be appointed in a timely manner, depending on the deadlines of the recommended goals.
- The OHTF shall assure that the best available scientific evidence and guidelines endorsed by federal agencies and professional organizations are applied in the implementation of its charge.
- Build an oral health coalition (from here on referred to as 'Oral Health Coalition' or 'OHC'). We recommend turning the SPC, which consists of over 300 members (approximately 80 of which were consistently involved in developing the key goals for the strategic plan), into a formal oral health coalition. The process of building a formal oral health coalition shall begin no later than May 2010.

Strategic Oral Health Plan

The Strategic Oral Health Plan consists of eleven goals. These goals broadly state what we hope to accomplish. Each goal contains at least one strategy and various sub-strategies, which identify specific actions, key players, and the time period by which the action shall be initiated and/or completed. Outcome objectives describe the anticipated measurable results. The outcome objectives, as they are currently written, do not contain specific information on the amount of change that is expected. We recommend that the OHTF and appointed committees shall specify the predicted amount of change, and conduct, after program implementation, an evaluation to measure its effectiveness.

The CC and SPC recommend for the State of Indiana to address the following goals to support the development of a diverse and effective oral health workforce; to increase access to oral health care among the underserved; and to improve the oral health of all Hoosiers. [Listing of goals is arbitrary / not ranked by importance.]

GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents.

Strategy 1.1: The Committee shall inform and raise awareness on oral health issues among Indiana policy makers. It shall encourage the Indiana Legislature to hold informational hearings. Results of these hearings shall be shared with the Oral Health Task Force (OHTF) and Oral Health Coalition (OHC). The informational hearings shall include:

1.1.a Discussion of resources and infrastructure necessary to educate the next generation of oral health providers;

1.1.b Discussion of demographics (such as gender, race, and ethnicity) of the current oral health workforce and strategies to increase its diversity;

1.1.c Discussion of the oral health needs of rural Indiana and strategies to increase availability of the oral health workforce in these areas;

1.1.d Discussion of additional resources needed to meet the oral health needs of Indiana's underserved populations, including individuals who are un- and under-insured, low-income, unemployed, aging, and/or have intellectual/developmental disabilities and other special healthcare needs.

This process shall begin no later than May 2010 and continue annually.

Outcome Objectives:

1.i Increase in the dentist-to-population ratio in underserved counties

1.ii Increase in the number and wider geographic distribution of community health centers with dental clinics

1.iii Increase in the number of dentists who accept patients covered by Medicaid

1.iv Increase in recruitment and retention of ethnic and racially underrepresented dental students

1.v Increase in use of dental hygienists' workforce and their broadened scope of practice in public health settings to provide preventive services for underserved populations, especially school-based dental sealant programs for children from low-income families

GOAL 2—Obtain additional Dental Health Professional Shortage Area (DHPSA) designations in areas of unmet need.

Strategy 2.1: The Committee shall work with communities and the Indiana Primary Health Care Association (IPHCA) to identify areas with unmet oral health needs.

2.1.a The Committee shall help communities with the process of establishing a DHPSA, as defined by federal guidelines from the Health Resources and Services Administration. This process shall begin by June 2010.

Outcome Objectives:

2.i Increase in opportunities for recent dental and dental hygiene graduates to earn student loan repayment while practicing in underserved areas of Indiana

2.ii Increase in number of dentists and dental hygienists working in rural and inner city locations

GOAL 3— Increase dental students' involvement in working in underserved areas.

Strategy 3.1: The Committee shall collaborate with dental directors of safety net clinics[1] to provide service learning opportunities for dental students in underserved areas and/or populations.

3.1.a The Committee shall contact/meet with dental directors (or their representatives) of safety net clinics to identify facilities interested in working with dental students. This process shall begin by August 2010.

3.1.b The Committee together with the dental directors shall develop recommendations for service learning opportunities for Indiana University dental students at safety net clinics. Recommendations shall be developed by January 2011.

3.1.c The Committee shall present recommendations to the Dean of Indiana University School of Dentistry and to the Heads of Indiana's safety net clinics. Recommendations shall be presented by March 2011.

[1]The Institute of Medicine defined safety net clinics as, "Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients" (2000).

Outcome Objectives:

3.i Increase in recruitment of dental students from rural and other dental health professional shortage areas (drawing on dental students as role models)

3.ii Increase in recruitment and retention of dental professionals in underserved areas and populations

3.iii Increase in delivery of oral health care and services to vulnerable populations by helping staff safety clinics with dental students

3.iv Greater sense of community engagement and civic responsibility in future oral health professionals

GOAL 4—Educate the public and raise awareness of oral health issues.

Strategy 4.1: The Committee shall develop a Public Service Announcement (PSA) and Reference Tool to promote oral health throughout Indiana.

4.1.a The Committee shall identify a theme and target population, and develop an appropriate PSA, by February 2011.

4.1.b Together with the PSA, a reference tool (website, brochure, and/or 'hot line') shall be established to provide information on oral health issues, a referral list of oral health professionals who accept Medicaid patients, and safety net dental clinics. This shall be accomplished by February 2011. The Committee shall review and update the reference tool annually.

Strategy 4.2: The Committee shall, in collaboration with the Indiana Department of Education (IDOE), work with assigned school staff (e.g., school nurse, social worker, health educator, or dental hygienist) to encourage and assist schools (public, private, charter, and parochial) in providing oral health education and promotion for K-12 students and their families.

4.2.a The Committee shall assist school staff in organizing an oral health promotion per school district. The planning shall start August 2010.

4.2.b The Committee shall present oral health information at a symposium targeting school staff (e.g., Head Start Training Conference, School Nurse Conference, IDOE Conference, etc.). At least one workshop shall be presented annually, starting in 2010.

4.2.c The Committee shall provide annual updates to the OHTF and OHC, starting in 2010.

4.2.d The Committee shall work in collaboration with the Bureau of Child Development to provide oral health education for child care providers, child care attendees and their families. The planning shall start by August 2011.

Strategy 4.3: The Committee shall partner with state and local agencies and organizations, such as ISDH's Nutrition and Physical Activity Division and Diabetes Prevention and Control Program, community health centers and other safety net clinics, healthcare professionals, WIC[2] offices, and other community-based and/or faith-based entities to develop a community-based promotion campaign on diet and nutrition and its consequences for oral health.

4.3.a The Committee shall work with state and local agencies that provide food and nutrition counseling to encourage them (the agencies) to educate on oral health consequences of food choices. The process of identifying state/local agencies and initiating collaborative work shall begin no later than January 2011.

[2]WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) is a food and nutrition program for pregnant women, infants and children up to age 5 who are at nutritional risk which provides nutritious foods to supplement diets, information on healthy eating, and referrals to health care. The program is sponsored by the U.S. Department of Agriculture.

4.3.b The Committee shall develop, in collaboration with these state/local agencies, a campaign for local health fairs. The campaign shall be developed by July 2011.

4.3.c The Committee shall develop, in collaboration with these state/local agencies, a mechanism to bring schools together for an oral health promotion/campaign that would educate families on issues of diet, nutrition, and oral health. The mechanism shall be identified/developed by October 2011.

Outcome Objectives:

4.i Increase in oral health awareness among K-12 school system and general public

4.ii Increase in knowledge of nutrition and its consequences for oral health

4.iii Greater utilization of oral health services by low-income populations including those who are enrolled in Medicaid

GOAL 5—Assist communities with Water Fluoridation Program.

Strategy 5.1: The Committee shall educate communities on the benefits of public water fluoridation, and assist them in implementing, improving, and/or maintaining their water fluoridation program.

5.1.a The Committee shall educate communities on the importance and benefits of water fluoridation. This process shall begin by June 2010.

5.1.b The Committee shall help communities identify funding to maintain/improve infrastructure for public fluoridation programs and develop a community fluoridation plan by December 2010.

5.1.c It is recommended that ISDH shall add an additional staff position to support implementation of the community fluoridation plan.

Outcome Objectives:

5.i At a minimum, maintain the proportion of Indiana residents on communal water supplies who receive optimally fluoridated water (95%)

GOAL 6—Increase community-based oral disease prevention programs.

Strategy 6.1: The Committee shall provide guidance to communities to identify funding, develop, and/or implement community-based/school-based oral disease prevention programs (e.g., sealant programs).

6.1.a The Committee shall help communities identify funding to maintain and expand current preventive programs. This collaborative process shall begin by September 2010.

6.1.b The Committee shall help communities establish new local/regional preventive programs. This collaborative process shall begin by November 2010.

6.1.c The Committee shall help communities develop a referral system to connect people to treatment. This collaborative process shall begin by January 2011.

Outcome Objectives:

6.i Increase in number of local and regional school-based or school-linked dental sealant programs

6.ii Assurance of follow-up treatment and continuity of care in a local dental home

GOAL 7—Educate pregnant women on oral health issues and increase their access to oral health care.

Strategy 7.1: The Committee shall create partnerships with maternal health clinics, OB/GYNs, physicians' offices, safety net clinics, and WIC offices, to initiate health promotion strategies to educate expecting

mothers, focusing on preventive oral health care, and providing resources to help them access oral health services.

7.1.a ISDH and local health departments shall strive to provide access to oral health care and education for pregnant women, by June 2010.

7.1.b The Committee shall raise awareness in the above mentioned partnerships to stress the importance of establishing a dental home by age one. This process shall begin by July 2010.

7.1.c The Committee shall connect expecting mothers with the Born to Smile program. This process shall begin by July 2010.

Outcome Objectives:

7.i Greater awareness of oral health in pregnant women and young mothers

7.ii Improved oral health for pregnant women

7.iii Improved oral health for babies and young children

7.iv Increase in the number of children who have a dental home by age one

GOAL 8—Encourage pediatricians and family physicians' medical offices to provide oral screenings and counseling for children ages 0-3, who do not have a dental home, and fluoride varnish for those who are at risk for dental caries.

Strategy 8.1: Since most young children see a physician or nurse many times before seeing a dentist, the Committee shall encourage the Office of Medicaid Policy and Planning (OMPP) to establish a medical code to reimburse appropriately trained healthcare providers for performing oral assessments, applying fluoride varnish for those who are at risk for dental caries, and making referrals for young children ages 0-3.

8.1.a The Committee shall work with OMPP and private insurers to support fluoride varnish as a specific component of oral health promotion in medical offices. This process shall begin by October 2010.

8.1.b The Committee shall work with physicians and nurses to include fluoride varnish as part of an overall health mission. This process shall begin by October 2010.

8.1.c The Committee shall link healthcare providers to training opportunities for proper oral health assessment, application of fluoride varnish, and referral to oral health providers. This process shall begin by January 2011.

Outcome Objectives:

8.i Increase in physicians and nurses who promote oral health maintenance and regular dental visits for their patients

8.ii. Increase in physicians and nurses who provide fluoride varnish to young children

8.ii Improvement of oral health of babies and toddlers who have not received their first appointment in a dental office

GOAL 9—Engage the Office of Medicaid Policy and Planning (OMPP) in discussions on dental reimbursement and payment policies.

Strategy 9.1: The Committee shall start discussions with OMPP representatives for better utilization of Medicaid funds and more effective reimbursement and payment policies.

9.1.a The Committee shall meet regularly with OMPP representatives to encourage utilization of school-based dental clinics, private practices, or community health center dental clinics to promote the "dental home" model for continuity of care. These meetings shall begin by November 2010.

9.1.b The Committee shall meet regularly with appropriate program directors to discuss utilization of Medicaid funds for more efficient financing, with emphasis on dental health education and prevention based on clinical outcomes, and problems associated with the $600 cap for dental treatment in adults. These meetings shall begin by November 2010.

Outcome Objectives:

9.i Improved access to continuity of primary care dental services

9.ii Improved access to dental services for adults, especially those with intellectual/developmental disabilities and other special needs

GOAL 10—Educate on the benefits of dental coverage through the Healthy Indiana Plan (HIP).

Strategy 10.1: The Committee shall encourage the state to provide dental coverage to adults through HIP.

10.1.a The Committee shall identify funds to provide dental coverage to adults through the Healthy Indiana Plan. This process shall begin by January 2011.

10.1.b The Committee shall ask State Legislators to add dental care to the Healthy Indiana Plan. This process shall begin by January 2011.

Outcome Objectives:

10.i Improved access to dental services for Indiana's uninsured or underinsured adults

GOAL 11— Establish an oral health surveillance system[3] in Indiana.

Strategy 11.1: The Committee shall provide assistance to ISDH in setting up an oral health surveillance system.

11.1.a The Committee shall identify existing and accessible data sources to assess oral health needs; barriers to accessing care; and the state's resources and capacity to deliver adequate oral health care. This process shall be completed no later than December 2010.

11.1.b The Committee shall identify additional data required to quantify, by county, the numbers and groups of people (subpopulations) with unmet dental needs. This process shall be completed no later than February 2011.

11.1.c The Committee shall assist ISDH in setting up and executing an oral health data collection system. This process shall begin no later than June 2011.

11.1.d The committee shall review data at least biannually, and update the data-driven strategic plan accordingly. This process shall be continued every 2 years.

Outcome Objectives:

11.i Monitor oral health trends and needs among Indiana residents

11.ii Support data-based decision-making

11.iii The State of Indiana will have appropriate data resources for planning, implementing and evaluating oral health services for its residents

[3]The term 'surveillance system' in this context refers to a system for collecting, analyzing, interpreting and disseminating health data on an ongoing basis.

Indiana Strategic Oral Health Initiative (SOHI)

Process Evaluation

PROCESS EVALUATION

The Health Resources and Services Administration, part of the U.S. Department of Health and Human Services, awarded a one-year workforce development grant to the Indiana State Department of Health (ISDH). ISDH contracted with the Indiana University School of Dentistry and the Indiana University Center for Health Policy to develop a strategic plan designed to improve the State's oral health workforce and service delivery infrastructure for the underserved. To execute the grant, selected members of the three organizations formed a steering committee (called the Coordinating Committee), which coordinated all processes involved in developing Indiana's Strategic Oral Health Plan.

Conducting a process evaluation at the end of the project was one of the grant requirements. This critical step is necessary to assess whether all benchmarks were achieved and deliverables provided. This report is divided into individual components:

- The Coordinating Committee
- Statewide Planning Council
- Focus Groups
- Needs Assessment Report
- Strategic Oral Health Plan
- Evaluation

The Coordinating Committee (CC)

The proposal stated: To coordinate the individual steps of the project, assist in the development of the strategic plan, and conduct the progress evaluation, a Coordinating Committee will be established consisting of designated staff from the Indiana State Department of Health, Indiana University School of Dentistry, Center for Health Policy, and the Indiana Dental Association. The Committee will be responsible for (a) setting up the Statewide Planning Council, (b) conducting a statewide oral health needs assessment, (c) identifying priority needs and developing a preliminary strategic oral health plan, and (d) finalizing the strategic plan (after receiving feedback from stakeholders throughout Indiana) and beginning implementation of the plan. The Coordinating Committee will convene on a regular basis. Especially, during the time of the needs assessment, members of the Coordinating Committee will meet at least biweekly to discuss the issues at hand.

Response: The Coordinating Committee consisted of 13 representatives from the Indiana State Department of Health, Indiana University School of Dentistry, Indiana University Center for Health Policy, and Indiana Dental Association. The members were:

Kent Smith, DDS, RPh
Karen Yoder, MSD, PhD
Eric Wright, PhD
Judith Ganser, MD
Domenick Zero, DDS, MS
Gerardo Maupome, MSc, DDPHRCS, PhD
E. Angeles Martinez-Mier, DDS, MSD, PhD
Nancy Young, MEd
Ed Popcheff, BSPA
Stephen Towns, DDS
Odette Aguirre-Zero, DDS, MS
Pinkie Evans, MBA
Marion Greene, MPH

The CC coordinated all steps of the project, including (a) assembling and coordinating the Statewide Planning Council; (b) completing a statewide oral health needs assessment; (c) identifying priority oral health needs and developing a preliminary strategic oral health

plan; and (d) facilitating focus groups, finalizing strategic oral health plan, and starting implementation of the plan. Furthermore, the CC is conducting the process evaluation for the project.

A subcommittee of the CC was established, the Data Group, to guide and oversee the needs assessment. During the grant period, the CC met eleven times, and communicated via email and/or phone numerous times (see Appendix I for meeting minutes).

The Statewide Planning Council (SPC)

The proposal stated: The SPC is designed to be the planning body that oversees the individual process steps and develops the strategic plan. Next to members from the oral health community, the SPC shall include (a) primary care providers to denote the importance of connecting primary and oral health care and to acknowledge the overlapping issues both systems face, and (b) minority health representatives to address matters of cultural competence. Key organizations that shall be included, at a minimum, are: Indiana State Department of Health, Indiana State Health Commissioner, Indiana State Oral Health Director, Indiana University School of Dentistry (IUSD), IUSD Oral Epidemiologist, Oral Health Research Institute, Indiana University Center for Health Policy, Indiana Dental Association, Indiana Dental Hygienists' Association, private dental practitioners, Indiana Primary Health Care Association, Indiana School Health Program, Indiana Head Start Association, Office of Medicaid Policy and Planning, local health departments, James Whitcomb Riley Hospital for Children (pediatricians, pediatric dentists, or administrators), Indiana Minority Health Coalition, Indiana Latino Institute, Indiana Coalition on Housing and Homeless Issues, and ARC of Indiana (representing people who are developmentally disabled).

The SPC will convene at least five times during the one-year cycle; more often if needed. All meetings will be held at the Indiana Government Center or the Indiana State Department of Health in Indianapolis. The first meeting will occur approximately four months after the project has started (Phase I). Members will be welcomed and introduced to each other; purpose and details of the project will be discussed; and preliminary results of the needs assessment will be presented. SPC members will have the opportunity to comment on the needs assessment and provide ideas for further research and additional data sources. Dr. Edelstein, nationally renowned founding director of the Children's Dental Health Project, and his assistant/colleague Marcie Frosh will facilitate the first meeting and set-up the strategic framework of the project. The second meeting will be scheduled during the sixth month (Phase II). The focus of the meeting will be data-driven identification of need priorities based on the completed needs assessment. The SPC will specify the priorities that will be addressed in the strategic plan. The third and fourth meetings will take place during the eighth and ninth months (Phase II); the development of a strategic plan targeting the identified priorities will be the focal point of both meetings. The last meeting will occur during the eleventh month (Phase III). After focus groups have been conducted and feedback on the initial strategic plan has been received, the SPC will meet to discuss implications and update/finalize the strategic oral health plan. Furthermore, members will identify

resources and the capacity of the state to implement the plan and address sustainability issues.

Response: For the Statewide Planning Council, a total of 348 stakeholders from oral health, primary healthcare, and minority health communities, as well as representatives from Indiana's Family and Social Services Administration and other key players interested in the oral health of Indiana's residents were identified. All groups and individuals listed in the proposal were invited to join the SPC, and most of them sent representation. Approximately 80 SPC members were consistently involved in the project.

Because of the difficulty aligning busy schedules for such a large group, instead of the proposed five times, the SPC met four times (January, March, May, and August of 2009), which seemed sufficient. All meetings were held in Indianapolis, two were held at the Pecar Health Center and two were held at the IUPUI Campus Center. These locations provided more flexibility regarding room size and parking availability compared to the Indiana State Department of Health and the Indiana Government Center.

The proposal indicated that Dr. Burton Edelstein and his assistant Marcie Frosh facilitate the initial SPC meeting. Due to a serious health condition, Dr. Edelstein had to cancel, and we engaged Wendy Frosh from Healthcare Management Strategies for the meeting. Ms. Frosh had previously worked with Dr. Edelstein and came highly recommended.

During the first three meetings, the SPC was charged with identifying oral health needs in Indiana and discussing the goals and objectives to be addressed in the strategic plan (see Appendix II for meeting agendas). The discussions, which were guided by facilitators, fell into five content areas: workforce and diversity, safety net, prevention, finance, and data. During these meetings, a draft of the needs assessment report and an issue brief on oral health needs in Indiana were handed out and discussed. At the fourth meeting, the final oral health goals were presented to the group.

Meeting minutes were not taken because the group discussions resulted in written documents (including notes, forms, lists/matrices, etc.) that provided the basis for the strategic oral health plan.

After each meeting, participants were encouraged to complete an online meeting evaluation and provide additional feedback (see Appendix III for surveys and results). Furthermore, after presentation of the final oral health goals, all SPC members, including members who did not participate in the meetings as well as focus group participants, received an invitation to rate their overall satisfaction with the strategic planning process and the final goals (see Appendix IV).

Focus Groups

The proposal stated: The Coordinating Committee will conduct five focus groups: one in each corner of Indiana, (northwest, northeast, southwest, and southeast) and one in Central Indiana. The information obtained during these focus groups will allow the SPC to adjust planning and prioritization as needed. Those invited to the focus groups will represent a broad spectrum of oral health stakeholders as identified by the Statewide Planning Council, as suggested by interested persons, or as self-identified.

Response: The CC conducted five focus groups throughout Indiana (Evansville, New Albany, Gary, Fort

Wayne, and Indianapolis), as proposed. Altogether, 147 key informants from these regions were invited, and a total of 28 respondents participated in the groups. Facilitators presented the preliminary oral health goals identified by the SPC, and focus group participants provided comments. Their feedback was incorporated into the strategic oral health plan.

Needs Assessment Report

The proposal stated: During the first phase of the project, the Coordinating Committee will conduct a detailed oral health needs assessment for the state of Indiana. This comprehensive statewide epidemiological profile will provide information on oral health status, access to oral health services, and critical needs and disparities thereof. Additionally, information will be gathered to measure Indiana's capacity to deliver services and respond to the population's oral health needs. The Committee will identify all available data sources, giving special interest to datasets that supply demographic (e.g., age, gender, race/ethnicity, educational attainment, family income) and geographic information (e.g., county, region, level of urbanization). Furthermore, members of the Statewide Planning Council will be asked to provide additional data sources – if available. Secondary data sets that shall be examined include, at a minimum, the Behavioral Risk Factor Surveillance System, Synopses of State Dental Public Health Programs data, and Medicaid data. Next to secondary sources, primary data will be collected and analyzed. The Committee will develop and administer surveys and/or conduct focus groups and key informant interviews to gain the necessary information. The needs assessment will provide a baseline measure from which subsequent interventions can be evaluated. The purpose of this project is to improve the accessibility of the oral health workforce for underserved geographic areas and populations in the state. Much of the current data address the critical need for dental services among children. The proposed needs assessment will use available data to identify priority needs among the underserved statewide. Using a highest need/highest contributor model, "hot spots", i.e., critical dental needs by population and/or geographic area, will be identified. The hot-spot-analysis will be helpful in pinpointing need priorities to address them in the strategic plan. We estimate the start-up (pre-phase) and Phase I to last five months.

Response: The CC conducted a statewide needs assessment, using secondary data sources, as proposed. Furthermore, we contacted directors/administrators of oral health programs in Indiana to receive available data on enrollment and graduation for these programs to assess future workforce trends. The needs assessment report includes information on:

- Indiana's demographic profile and vulnerable populations
- Oral disease prevalence
- Access to and utilization of oral healthcare services
- Oral health infrastructure
- Oral health workforce

Local (county-level) data availability was limited, so a "hot spot" analysis could not be performed. In addition to the needs assessment report, we also developed an issue brief on oral health needs in Indiana, which was distributed to all SPC members and Indiana's decision-/policy-makers (see Appendix V for oral health issue brief).

Strategic Oral Health Plan

The proposal stated: Based on needs assessment data, the Statewide Planning Council (SPC) will identify oral health priorities, i.e., the most critical needs by population and/or geographic area that shall be addressed in the strategic plan. These priorities will have to be specific, culturally competent, and measurable. Indiana's strategic oral health plan will address these priority needs.

Response: Indiana's finalized strategic plan follows a public health model, is data-driven, and strives to be evidence-based, using the best available scientific evidence and guidelines endorsed by federal agencies and professional organizations. As proposed, Indiana's most critical oral health needs and priorities are being addressed by the plan. These were identified using the two-fold process below:

a) Statewide needs assessment
The Data Group, a subgroup of the CC, guided the completion of the needs assessment.

b) Community-based participatory research

At the heart of the effort was the establishment of the Statewide Planning Council (SPC). The SPC met four times to discuss and identify oral health needs, goals, and strategies to be included in the plan. Additionally, we conducted five focus groups to receive feedback on preliminary goals. The comments we received were incorporated and the goals revised.

The Strategic Oral Health Plan consists of eleven goals. These goals broadly state what we hope to accomplish. Each goal contains at least one strategy and various sub-strategies, which identify specific actions, key players, and the time period by which the action shall be initiated and/or completed. Outcome objectives describe the anticipated measurable results. The goals/objectives are written in the SMART format in order to be

S pecific,

M easurable,

A chievable,

R ealistic, and

T ime-bound.

Evaluation

The proposal stated: The progress of the project will be evaluated by the Coordinating Committee in three steps by assessing benchmarks associated with each phase:

Phase I

- Was the SPC established within the proposed timeline?
- Does the SPC include key players from oral health, primary care, and minority health communities?
- Did the SPC meet and discuss data from the needs assessment?
- Has the needs assessment been completed?

Phase II

- Did SPC meet and identify data-based priority needs?
- Did SPC meet and develop the initial strategic oral health plan based on identified priorities?

Phase III

- Were a sufficient number of focus groups conducted throughout Indiana?
- Was the feedback received during focus group meetings incorporated in the final strategic oral health plan?
- Did the SPC meet and (a) approve of final strategic oral health plan,

and (b) identify resources in Indiana to implement the strategic oral health plan and address issues of sustainability on state and local levels?

Additionally, members of the Statewide Planning Council (SPC) will complete a brief evaluation after each SPC meeting ("Meeting Evaluation").

Response:

Phase I—The SPC was established within the proposed timeline and included all major key players. A draft of the needs assessment had been provided to SPC members and was discussed during a meeting. The needs assessment has been completed.

Phase II—The SPC met four times to identify priority needs and to develop the initial/preliminary strategic oral health plan.

Phase III—Five focus groups were conducted throughout Indiana; feedback received from these groups was incorporated into the strategic oral health plan. The final strategic plan containing Indiana's oral health goals was emailed to all SPC members and presented at the last SPC meeting in August. Implementation and sustainability concerns were addressed: In light of economic and sustainability challenges a group that already exists, the Oral Health Task Force (OHTF), will govern implementation. SPC members who are not already members of the OHTF were encouraged to join and sign up for sub-committees to oversee implementation of individual oral health goals. An overall satisfaction survey was sent to all SPC members and focus group participants to assess satisfaction with the strategic planning process and agreement with final goals. The vast majority (88.3%) was either satisfied or very satisfied with the community-participatory process, and most respondents strongly agreed with the identified oral health goals (see Appendix IV).

Invitations to complete a brief online meeting evaluation (Survey Monkey™) were sent to all SPC participants after every meeting (see Appendix III).

All benchmarks have been achieved and all deliverables have been completed.

APPENDIX I

COORDINATING COMMITTEE (CC)

Initial Meeting: 9/9/2008

I. Welcome and introductions

People in attendance: Pinkie Evans, Judith Ganser, Marion Greene, E. Angeles Martinez Mier, Gerardo Maupome, Ed Popcheff, Kent Smith, Karen Yoder, Nancy Young, Sandra Walker, Eric Wright

II. Discussion of contract between ISDH and IUSD/CHP

Sandra will work on a draft of the contract, send it to Jude Wilkinson for comments, and forward it to ISDH. The deliverables to be included were discussed (see attachment, p. 2).

III. Layout of timeline

a. Pre-phase: Assembly of Statewide Planning Council (SPC)
b. Phase I: Needs assessment
c. Phase II: Identification of priorities and development of strategic oral health plan
d. Phase III: Feedback and finalization of strategic plan

IV. Schedule next meeting

The CC will meet every second and fourth Tuesday, from 2—3pm at the Center for Health Policy. The Data Group, a smaller part of the CC (consisting of Karen Yoder, Eric Wright, Gerardo Maupome, Kent Smith, Pinkie Evans, and Marion Greene) will meet additionally, from 3—3:30pm.

V. Other business

a. Oncourse (Eric will set up an Oncourse Project Site for communications among CC members)
b. PR (Pinkie will contact Hetrick, a marketing communications firm, to draft a press release; the Center for Health Policy will publish the HRSA initiative in one of its upcoming newsletters)
c. Workshop with Dr. Edelstein/first SPC (Statewide Planning Council) meeting (Marion will contact Dr. Edelstein for available dates, probably in January; and reserve a meeting room, e.g., Pecar Health Center)

The next meeting will be on Tuesday, 9/23/08, at 2pm, at the Center for Health Policy.

ATTACHMENT

HRSA Grant to Support Oral Health Workforce Activities (# HRSA-08-134 CFDA # 93.236)
Timetable and Deliverables

Phase	Timeline	Deliverables	Budget %
Pre-phase: Assembly of SPC	September 1 through October 31, 2008	• Biweekly meetings of CC • Identification of key agencies/ organizations in the fields of oral health; primary care; and minority health • Recruitment of representatives from identified organizations for the SPC ➔ **Brief report on activities in pre-phase and list of members from organizations/ agencies to be recruited**	25%
Phase I: Needs Assessment	November 1, 2008, through January 31, 2009	• Biweekly meetings of CC • Conduct oral health needs assessment • First meeting of SPC (2-day workshop with Dr. Edelstein) (Jan '09) ➔ **Oral Health Needs Assessment Report**	25%
Phase II: Identification of Priorities & Development of Strategic Oral Health Plan	February 1 through May 31, 2009	• Biweekly meetings of CC • Second SPC meeting (Feb '09) • Third SPC meeting (April '09) • Fourth SPC meeting (May '09) • Data-driven identification of oral health priorities • Draft of strategic oral health plan ➔ **Initial draft of Indiana's strategic oral health plan**	30%
Phase III: Feedback & Finalization of Strategic Plan	June 1 through August 31, 2009	• Biweekly meetings of CC • Focus groups to review initial strategic oral health plan • Fifth SPC meeting (July '09) • Identification of resources to implement/ sustain strategic oral health plan • Finalize strategic oral health plan • Submission of plan to HRSA ➔ **Final Recommendations for Indiana's Strategic Oral Health Plan**	20%

Notes:
CC = Coordinating Committee
SPC = Statewide Planning Council
The dates for SPC meetings are tentative.

COORDINATING COMMITTEE (CC)

Meeting Minutes, 9/23/2008

I. Welcome

Attendance: Pinkie Evans, Marion Greene, E. Angeles Martinez-Mier, Kent Smith, Sandra Walker, Karen Yoder (via telephone), Nancy Young, Domenick Zero, Odette Zero

II. Discussion of contract between ISDH and IUSD/CHP

Kent has received a draft of the contract from Sandra; ISDH seems to approve of the draft; so far, no amendments have been made.

III. Introduction of GA research assistant (Odette Zero)

Odette Zero will be the research assistant for the project. She is part-time faculty at IUSD/oral biology department and a grad student in bioethics. Odette will help coordinate meetings and events, and assist with the statewide needs assessment.

IV. Press release of Indiana's Strategic Oral Health Initiative

Kent has been contacted by Justin Ohlemiller and Ryan Heath from Hetrick Communications—they are currently working on the press release for the HRSA grant.

V. Oncourse

An Oncourse site has been established for the project. Kent is in the process of registering for an IUPUI email account; Marion will check with Dr. Ganser and Ed to see if accounts have already been set up for them.

VI. Update on Dr. Edelstein

Marion contacted Dr. Edelstein by email (9/12 and 9/22) to ask for available dates for the 2-day workshop. Dr. Edelstein is currently on vacation and will return after September 26.

VII. CC meeting schedule

The 10/28/08 meeting will be cancelled (Karen, Eric, and Marion will be at the APHA conference) – Marion will send out reminders

November 11 is a State Holiday (Veteran's Day) – the group decided to have the scheduled meeting.

VIII. Other business

Pinkie will check on conference call availability at the Center to give CC members the opportunity to attend the meeting by phone; Angeles will contact Dr. Towns about the CC meetings.

IX. Adjourn the meeting

The next meeting will be on Tuesday, 10/14/08, at 2pm, at the Center for Health Policy.

DATA GROUP MEETING

Attendance: Pinkie Evans, Marion Greene, Kent Smith, Eric Wright, Karen Yoder (via telephone), Odette Zero

Discussion of Statewide Oral Health Needs Assessment

HRSA Proposal: During the first phase of the project, the Coordinating Committee will conduct a detailed oral health needs assessment for the state of Indiana. This comprehensive statewide epidemiological profile will provide information on oral health status, access to oral health services, and critical needs and disparities thereof. Additionally, information will be gathered to measure Indiana's capacity to deliver services and respond to the population's oral health needs. The Committee will identify all available data sources, giving special interest to datasets that supply demographic (e.g., age, gender, race/ethnicity, educational attainment, family income) and geographic information (e.g., county, region, level of urbanization). Furthermore, members of the Statewide Planning Council will be asked to provide additional data sources – if available. Secondary data sets that shall be examined include, at a minimum, the **Behavioral Risk Factor Surveillance System, Synopses of State Dental Public Health Programs data, and Medicaid data.** Next to secondary sources, primary data will be collected and analyzed. The Committee will develop **and administer surveys and/or conduct focus groups and key informant interviews** to gain the necessary information. The needs assessment will provide a baseline measure from which subsequent interventions can be evaluated. The purpose of this project is to improve the accessibility of the oral health workforce for underserved geographic areas and populations in the state. Much of the current data address the critical need for dental services among children. The proposed needs assessment will use available data to identify priority needs among the underserved statewide. Using a highest need/highest contributor model, "hot spots", i.e., critical dental needs by population and/or geographic area, will be identified. The hot-spot-analysis will be helpful in pinpointing need priorities to address them in the strategic plan. This type of analysis has previously been used in assessing the severity of substance abuse and its consequences in communities in Indiana. The State's strategic plan to address and fund substance abuse prevention services, a part of the five-year federal infrastructure-building Strategic Prevention Framework State Incentive Grant, utilized the highest need/highest contributor model to identify high-risk communities and provide them with funding for prevention services. We estimate the start-up (pre-phase) and Phase I to last five months.

We identified the following data sets as sources of interest (only data sets that provide statewide coverage):

- Behavioral Risk Factor Surveillance System (oral health Indiana: 1999, 2002, 2004, and 2006) (http://apps.nccd.cdc.gov/brfss/years.asp?yr=2007&state=IN&cat=OH)
    - Adults aged 65+ who have had all their natural teeth extracted
    - Adults that have had any permanent teeth extracted
    - Visited the dentist or dental clinic within the past year for any reason
- Synopses of State Dental Public Health Programs (1998 – 2005; trend data available) (http://apps.nccd.cdc.gov/synopses/StateDataV.asp?StateID=IN&Year=2005)
    - Demographics

    - Infrastructure
    - Workforce
    - Administration
    - Programs
- National Oral Health Surveillance System (http://www.cdc.gov/nohss/)
    - For some oral health indicators, no Indiana data available (e.g., caries experience, untreated tooth decay, and dental sealants in 3rd grade students)
- SEAL INDIANA data (2003 – 2007)
    - Number of Indiana school and community sites where SEAL INDIANA services are provided
    - Number of children examined
    - Number of sealants placed
    - Number of fluoride varnish treatments applied
    - Percentage of children with untreated dental caries
- Medicaid data
    - Medicaid eligible children and adults
        - Number of persons receiving routine dental care
        - Number of persons receiving emergency dental care (including oral injuries)
        - Number of persons receiving emergency dental care **and** have follow-up
        - Number/ratio of OH[i] providers accepting Medicaid
    - CHIP children
- Census data
    - Population estimates
    - Children at or below the 200% FPL (without insurance)
- ISDH
    - Population served by community water fluoridation (Water Fluoridation Reporting System; also on CDC website http://apps.nccd.cdc.gov/MWF/index.asp)
    - Babies born with cleft lip and palate (Indiana Birth Defects and Problems Registry; http://www.in.gov/isdh/20425.htm)
    - Hospital discharges due to oral injuries
    - Mortality from oral cancers
- Others
    - Number of children on free and/or reduced price meal program (Dept. of Agriculture/Child Nutrition Division)

- Accredited Schools of Dentistry and Dental Hygiene (American Dental Association)[ii]
- Community Based Dental Clinics and Programs[iii]
- Mobile Dental Clinics Funded or Supported by State[iv]
- Other indicators from ASTDD's Synopses 2006 – 2007
- Data on oral health workforce (see Karen's publication)
- Check NHANES for OH indicators (Indiana data easily obtainable?)
- IDA's safety net survey

We also discussed the possibility of developing a brief online questionnaire to be sent to OHC[v] providers (e.g., have IDA promote the survey). Kent and Karen emphasized the importance of a public health perspective and the tie-in with *Healthy People 2010*. We decided to include the OH indicators from the *HP 2010* publication and try to obtain data to measure these indicators in Indiana.

Marion will create a work outline for members of the data group. She will identify OH indicators and match them with the data set(s) that provide the information; she'll then assign group members to specific data sources to collect and analyze the information.

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[i] OH = oral health
[ii] Collect for capacity/resource assessment.
[iii] Ibid.
[iv] Ibid.
[v] OHC = oral health care

COORDINATING COMMITTEE (CC)

Meeting Minutes, 11/11/2008

Attendance (in alphabetical order): Pinkie Evans, Marion Greene, Gerardo Maupome, Kent Smith, Stephen Towns, Eric Wright, Karen Yoder, Domenick Zero, Odette Zero

Contract Negotiations between ISDH and IU
General contract negotiations between ISDH and IU (not specific to this grant) have been resolved. Kent will check on status of contract and send the document—when approved—to Sandra, who will route it through the university system.

Updates from Kent
Press release: ISDH public relations is working with Hetrick communications on the press release. It is planned to publish the press release around the same time we are sending out invitations to the Statewide Planning Council (SPC) for its initial meeting in January. ISDH will print the invitations (signed by Dr. Monroe). The Center for Health Policy will print additional background information and instructions for SPC members, stuff the envelopes and send them out. Invitations should be sent out by beginning of December.

Dr. Siegal: The Ohio Department of Health approved Dr. Mark Siegal's appearance as key note speaker at Indiana's first SPC meeting.

SPC Meeting
Pecar Health Center: Kent reported that he reserved the Pecar Health Center for January 15th (full day) and 16th (morning/half day).

Initial SPC meeting: The CC decided to have the strategic planning session with all SPC members on January 15th. However, since some SPC members might be too busy to dedicate 2 days to the project, the ½-day workshop on the 16th will be used for follow-up discussions with Wendy Frosh (the facilitator) and the CC; SPC members are encouraged to attend the follow-up meeting as well.
Pinkie, Odette, and Marion will schedule a conference call with Wendy for the beginning of December to discuss details.
Breakfast, lunch, and an afternoon snack will be provided at the SPC meeting. Odette will contact Angeles for information on catering services.

Safety Net Survey
IDA has sent out a safety net survey to its members. Karen will find out if they need help with data entry and if we can get access to the data.

Oncourse
We will start using the Oncourse website. This is the easiest way to access the site:

- Go to the Oncourse page, https://oncourse.iu.edu/portal
- Click on "Login"
- Type in your username and passphrase
- Click on "HRSA Oral Health"

You can have your Oncourse messages forwarded to any other email system. To do this, go to "Messages", click on the "Settings" tab, click on "yes" to auto-forward messages, and enter the

email address you want the message to be sent to. The advantage of using Oncourse is, all messages related to this project are kept together in one location, and all documents related to the grant are available in the resource section.

Meeting Dates
The group decided that, at the time being, monthly CC meetings would be sufficient. If additional meetings are required, they'll be scheduled on a need-to-meet basis. Additionally, Odette and Marion will keep the group informed about the progress of the needs assessment and other activities. Marion will send an electronic message to automatically update Outlook calendars with the new meeting times.

The next meeting will be on Tuesday, 12/9/08, at 2pm, at the Center for Health Policy.

CC - DATA GROUP MEETING

Odette and Marion provided an initial draft of the needs assessment. The group discussed the document and discussed further data sources to include. The draft is attached (see next page).

Indiana Strategic Oral Health Initiative (SOHI)

Oral Health Needs Assessment

Oral health is an essential and integral component of health throughout life. No one can be truly healthy unless he or she is free from the burden of oral and craniofacial diseases and conditions.[i] Promotion of oral health requires self-care and professional care as well as population-based initiatives. Studies have shown that oral health status and access to services vary significantly by race/ethnicity, family income, and level of education.[ii] Furthermore, children residing in rural areas are more likely to be uninsured for dental care, report more unmet dental needs, are less likely to have visited a dentist in the past year, and are less likely to be regular users of dental care, compared to their urban counterparts.[iii]

Without a doubt, community water fluoridation constitutes one of the top achievements of public health in the last century. As a result of water fluoridation, populations experienced a ---% decrease in the prevalence of dental caries (ref). However, water fluoridation has not been enough to prevent dental caries, and there is some evidence that its prevalence may be increasing, especially in certain population subgroups. Even though there are effective measures and approaches to prevent and treat dental caries and periodontal disease, they continue to affect ---% and ---% of Americans respectively (ref).
As knowledge about etiology, prevention and treatment of dental diseases has progressed, there has also been a recognition that more need to be done. A "silent epidemic" of dental and oral diseases is affecting some population groups. This burden of disease restricts activities in school, work, and home, and often significantly diminishes the quality of life.[iv] There is an ever-present need to improve and maintain Americans' oral health.

In spite of improvements in overall oral health status, striking disparities exist within population groups; especially among the poor of all ages, racial and ethnic minorities, and rural populations. These underserved populations constitute a considerable portion of Indiana residents. A substantial obstacle to progress is the fact that there are no adequate and comprehensive data on oral health and care for the U.S. population and its diverse subgroups.[v] It has been recognized that the infrastructure for oral health care delivery is limited, but the development of better measures of disease and health, the design of new approaches to eliminate health disparities, and the evaluation of existing programs has been hindered by the lack or rarity of data on state and local populations. The U.S. Department of Health and Human Services' prevention initiative *Healthy People 2010* recognizes the public health impact of oral health conditions and set the goal to prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.[vi]

The purpose of this report is to provide a baseline measure of Indiana's oral health status, and to identify critical needs and prevention priorities in the underserved. Information on various oral health indicators for which data were available, was collected. The results are presented in the following categories:

- Indiana's demographic profile and vulnerable populations

- Oral disease prevalence
- Access to and utilization of oral health care services
- Oral health infrastructure (existing oral health programs, services, and resources)
- Oral health workforce

Indiana's Demographic Profile and Vulnerable Populations

In 2007, Indiana had an estimated population of 6,345,289, of which about number (49%) were male and number (51%) were female. The median age of the population was 36.5 years. A total of number (7%) of the population was under 5 years old; number (25%) of the population was under the age of 18; and number (12%) of the population was over 65 years old. The majority of Hoosiers (number; 98%) reported to be of one race only. Among those, number (86%) reported to be White, number (9%) reported to be Black, number (5%) reported to be Hispanic (of any race), and the rest (number) reported other races.

Indiana ranked as the 24th poorest state in the country. An estimated number (12%) of Hoosiers were classified poor [insert definition for poor]; and number (17%) of them were under the age of 18. The percentages of the poor according to race or ethnicity were as follows: number (10%) were White (with number (10%) under the age of 18); number (26%) were Black (with number (36%) of them under the age of 18); number (22%) were Hispanic or Latino (with number (29%) of them under the age of 18); [number] (16%) were Asian (with number (15%) of them under the age of 18); and number (23%) reported "some other race" (with number (31%) of them under the age of 18).[vii]

On average, for the 2008 school year, 343,523 Hoosier children received free school lunches, and 93,668 children received reduced-fee lunches. This constituted about 38% of the student population.[viii]

Among the population five years old or older, number (15%) reported a disability. The likelihood of having a disability increased with age, from 7% of people 5-15 years old (number), to 13% of people 16-64 years old (number), and 42% of people 65 years old and older (number).[ix]

- CHIP children
- Number/percentage without insurance
- Number/percentage on Medicaid

Oral Disease Prevalence

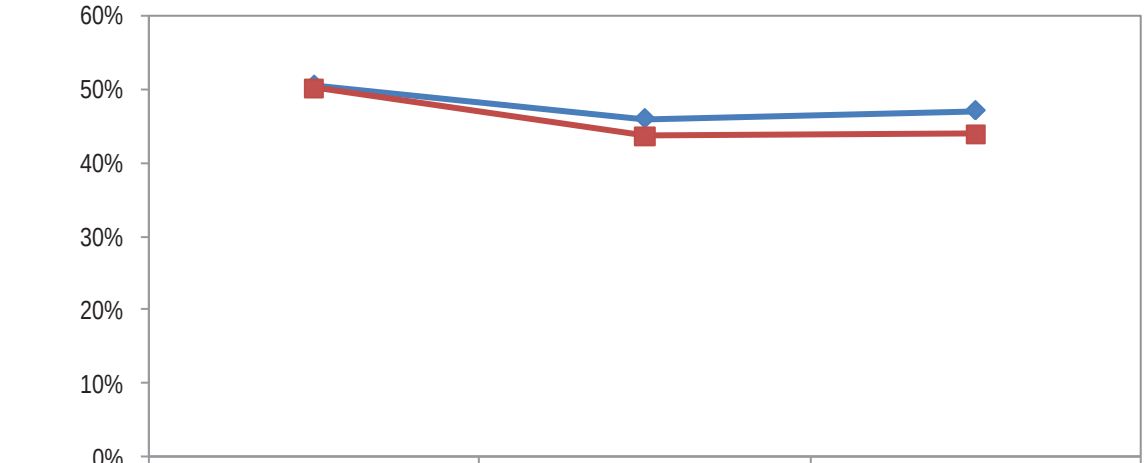
Prevalence of Tooth Extractions

The Behavioral Risk Factor Surveillance System (BRFSS), established in 1984 by the Centers for Disease Control and Prevention (CDC), is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Oral health items were first added to the instrument in 1999.[x]

According to 2006 BRFSS results (the most recent data available), 47.1% of Indiana adults (95% CI: 45.6 – 48.6) have had any permanent teeth extracted. This percentage was significantly higher than the national median of 43.9%. Statistically, Indiana's prevalence has remained stable from 1999 to 2006 (see Figure xx). Groups that had the highest prevalence of tooth extractions included blacks; individuals with an annual household income of less than $35,000; and individuals with lower educational attainment. Also, prevalence was highly associated with age – as age increased so did the percentage of Hoosiers who reported having had any permanent teeth extracted. [For 2006 prevalence rates and 95% confidence intervals by gender, race/ethnicity, age group, income level, and educational attainment, see Appendix xx.]

Roughly one-fifth of Hoosiers 65 years and older (21.1%; 95% CI: 18.9 – 23.5) in 2006, have had all their natural teeth extracted. This is a significant decrease from 1999, when 37.1% of Indiana residents in that age group (95% CI: 28.9 – 45.3) reported to have had all their natural teeth extracted. The current prevalence rates for Indiana and the United States (19.3%) are statistically the same (see Figure xx). Indiana's elderly that were mostly affected included individuals with an annual household income of less than $15,000 and Hoosiers with lower educational attainment. [For 2006 prevalence rates and 95% confidence intervals by gender, race/ethnicity, age group, income level, and educational attainment, see Appendix xx.]

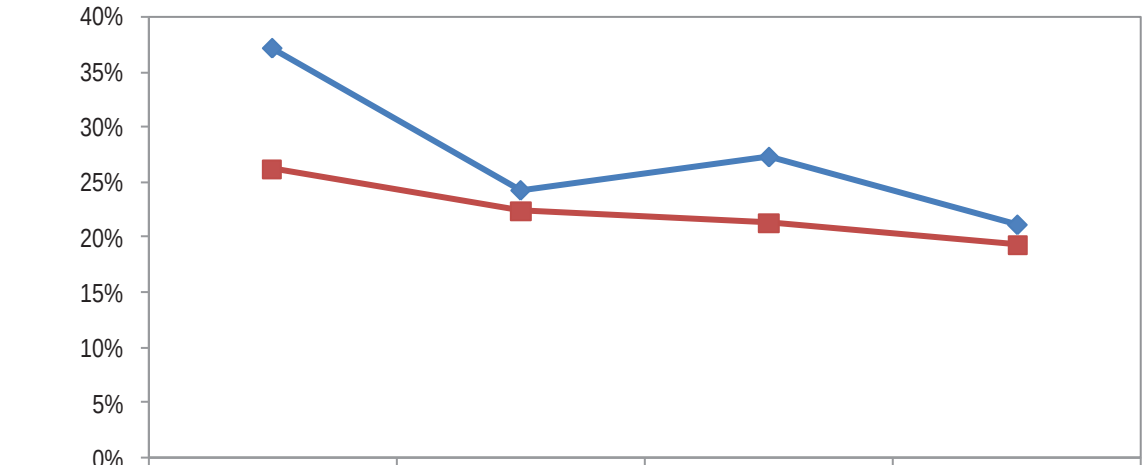
Figure xx: Prevalence Rates of Indiana and U.S. Adults That Have Had Any Permanent Teeth Extracted (Behavioral Risk Factor Surveillance System, 1999 – 2006)



	1999	2004	2006
Indiana	50.6%	46.0%	47.1%
U.S.	50.2%	43.7%	43.9%

Source: Centers for Disease Control and Prevention, 2008

Figure xx: Prevalence Rates of Indiana and U.S. Adults Ages 65 and Older That Have Had All Their Natural Teeth Extracted (Behavioral Risk Factor Surveillance System, 1999 – 2006)



	1999	2002	2004	2006
Indiana	37.1%	24.3%	27.3%	21.2%
U.S.	26.2%	22.4%	21.3%	19.3%

Source: Centers for Disease Control and Prevention, 2008

Prevalence of Cleft Lip and Palette

The Indiana Birth Defects and Problems Registry (IBDPR) is a data system that collects information on birth defects and birth problems for all children in Indiana from birth to 3 years old (5 years old for autism and fetal alcohol syndrome). According to the registry, in 2006, 138 children were born with cleft lip and cleft palate in Indiana. This represents a prevalence rate of 154.36 per 100,000 live births. The rate has been stable from 2003 through 2006 (see Table xx).

Table xx: Number and Rate (per 100,000 Live Births) of Indiana Children Born with Cleft Lip and Cleft Palate, by Birth Year (Indiana Birth Defects and Problems Registry and Indiana Natality Reports, 2003 – 2006)

	Number of Children with Cleft Lip/Palate	Live Births	Rate per 100,000
2003	140	86,382	162.07
2004	167	87,125	191.68
2005	140	87,088	160.76
2006	138	89,404	154.36

Source: Indiana State Department of Health, 2008

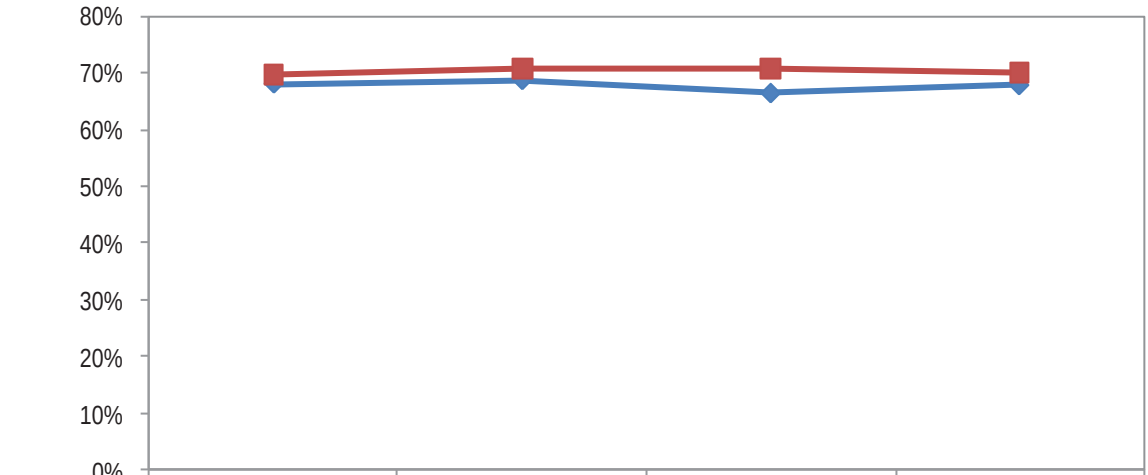
- Hospital discharges due to oral injuries
- Tobacco use
- Mortality due to oral cancers

Access to and Utilization of Oral Health Care Services

Dental Visits

According to 2006 BRFSS results, 68% of people in Indiana (95% CI: 66.6 – 69.4) visited the dentist or dental clinic within the past year for any reason. The rate is comparable to the U.S. median of 70%. The prevalence for past-year dental visits has remained stable from 1999 through 2006 (see Figure xx).

Figure xx: Percentage of Indiana and U.S. Population that Visited the Dentist or Dental Clinic within the Past Year for Any Reason (Behavioral Risk Factor Surveillance System, 1999 – 2006)



	1999	2002	2004	2006
Indiana	68.3%	68.9%	66.6%	68.0%
U.S.	69.8%	70.9%	70.8%	70.3%

Source: Centers for Disease Control and Prevention, 2008

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSA), established under the U.S. Public Health Service Act, are federal designations of a geographic area (usually a county or a number of townships or census tracts) which meet the criteria as needing additional primary health care services. These designations are based on the availability of health professional resources within a rational service area. Primary care, dental, and mental health HPSAs also look at practitioners within a thirty minute travel time. Designations usually are geographic areas, but may apply to population groups and facilities.

HPSA Scores were developed by the National Health Service Corps to determine priorities for assignment of clinicians. Scores range from 1 to 25—a higher score represents greater priority or need. Based on 2008 findings, there are 12 (13?) identified HPSAs in Indiana, with scores ranging from 6 to 21 (see Table xx).[xi]

Table xx: Dental Health Professional Shortage Areas (HPSAs) Currently Designated in Indiana, August 2008

County	Service Area Name	Destination Type	Score
Allen	Ft. Wayne City	Low Income Population	14
Lake	East Chicago SA	Geographic	15
Marion	Highland-Brookside (Indpls) SA	Geographic	19
Marion	Near Northside Indianapolis SA	Geographic	18
Marion	South Central Indianapolis SA	Geographic	15
Porter	Valparaiso	Low Income Population	13
Randolph		Low Income Population	10
Rush		Geographic	6
St. Joseph	Low Income (South Bend)	Low Income Population	17

Switzerland		Low Income Population	11
Tippecanoe	Lafayette City	Low Income Population	20
Vigo	U.S. Prison Terre Haute	Facility	21

Note: This list does not include facilities with automatic HPSA designations [can we get automatic HPSAs?]
Source: Indiana State Department of Health, n.d.

- Among Medicaid population
    - Number of persons receiving routine dental/oral care
    - Number of persons receiving emergency dental/oral care

Oral Health Infrastructure

- Federal and state level funding for oral health
- ISDH: Division of Oral Health (number of staff/FTEs)
- Number of schools/programs dedicated to oral health
- Water fluoridation program (number/percentage population served)
- SEAL Indiana program (number/percentage kids served; areas served/all of Indiana?; number of staff, dental mobiles, etc.)
- Any other programs/services

Oral Health Workforce

- Number of dentists
- Number of dental hygienists
- Number of dentists enrolled as Medicaid providers
- Number of dentists with at least one paid claim

APPENDIX XX

Percentage (and 95% Confidence Interval) of Indiana Adults Who Reported in 2006 That They Have Had Any Permanent Teeth Extracted (Behavioral Risk Factor Surveillance System, 2006)

		Percentage of Adults that have had any permanent teeth extracted
Gender	Male	45.9% (43.5-48.3)
	Female	48.2% (46.3-50.1)
Race	White	46.1% (44.5-47.7)
	Black	56.4% (50.8-62.0)
	Hispanic	45.7% (37.7-53.7)
Age	18 - 24	10.9% (7.2-14.6)
	25 - 34	25.7% (22.4-29.0)
	35 - 44	40.0% (36.8-43.2)
	45 - 54	53.0% (49.9-56.1)
	55 - 64	71.0% (68.0-74.0)
	65 +	81.6% (79.4-83.8)
Income	Less than $15,000	63.0% (56.8-69.2)
	$15,000 - $24,999	59.7% (55.5-63.9)
	$25,000 - $34,999	63.3% (58.9-67.7)
	$35,000 - $44,999	44.4% (40.5-48.3)
	$50,000 +	34.3% (32.0-36.6)
Education	Less than H.S.	60.8% (55.3-66.3)
	H.S. or G.E.D.	57.7% (55.0-60.4)
	Some post-H.S.	42.2% (39.2-45.2)
	College graduate	30.6% (28.2-33.0)

Note: H.S. = High school
G.E.D. = General Educational Development certificate
Source: Centers for Disease Control and Prevention, 2008

APPENDIX XX

Percentage (and 95% Confidence Interval) of Indiana Adults 65 Years and Older Who Have Had All Their Natural Teeth Extracted (Behavioral Risk Factor Surveillance System, 2006)

		Percentage of Adults aged 65+ who have had all their natural teeth extracted
Gender	Male	19.6% (15.9-23.3)
	Female	22.3% (19.5-25.1)
Race	White	20.1% (17.7-22.5)
	Black	n/a
	Hispanic	n/a
Age	65 - 74 years	20.2% (17.2-23.2)
	75 and over	22.2% (18.8-25.6)
Income	Less than $15,000	37.3% (29.9-44.7)
	$15,000 - $24,999	23.9% (19.2-28.6)
	$25,000 - $34,999	21.5% (15.2-27.8)
	$35,000 - $44,999	15.6% (9.5-21.7)
	$50,000 +	7.5% (3.6-11.4)
Education	Less than H.S.	45.4% (38.3-52.5)
	H.S. or G.E.D.	23.5% (20.0-27.0)
	Some post-H.S.	14.2% (9.9-18.5)
	College graduate	4.5% (2.2-6.8)

Note: H.S. = High school
G.E.D. = General Educational Development certificate
Source: Centers for Disease Control and Prevention, 2008

ENDNOTES

[i] U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General. *Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.* 2000.
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[iv] U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General. *Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.* 2000.
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(From the IN Department of Education (www.doe.in.gov), Program year: 2008, Data Source: October, 2007; viewed 05-11-08)
[ix] U.S. Census Bureau. (2007). *American Community Survey.* Retrieved November 11, 2008, from http://www.census.gov/
[x] Centers for Disease Control and Prevention. (2008). *Behavioral Risk Factor Surveillance System - prevalence data*. Retrieved November 10, 2008, from http://apps.nccd.cdc.gov/brfss/
[xi] Indiana State Department of Health. (n.d.). Health Professional Shortage Area. Retrieved November 11, 2008, from http://www.in.gov/isdh/23471.htm

COORDINATING COMMITTEE (CC)

Minutes of meeting on 12/09/2008

Discussed SPC Meeting in January

- Invitations were sent to 200+ people.

  About 22 people have confirmed their attendance for a total of about 35 people (if we include our committee).

  New names were suggested: Kathy Russell (Nursing), Sarah Stelzner MD (IUSM), Wayne Walker DDS, LaQuia Walker DDS, Tonya Stewart DDS, Tim Carlson DDS/Service-Learning, Katherine Kula DDS (Orthodontics), Steve Haug DDS (Prosthodontics), and 2 representatives from the Amish communities.

- We discussed information from the conference call with Wendy Frosh.

The proposed SPC agenda for January 15th, 2009, 9 am to 4 pm is as follows:

1. Welcome + introductions (Kent and the Governor?) – 20 minutes

2. Key note speaker (Dr. Siegal) – 1 hour

3. Overview/summary of what has occurred so far in Indiana + key issues (leaning on Dr. Edelstein's workshop) (Karen) – 30 minutes

4. Purpose of the next 2 days + summary of needs assessment (Eric) – 30 minutes

5. Lunch + speaker (Dr. Geierman) – 1 hour. It was suggested that he speak about what other states are doing regarding oral health, and /or he could talk about HRSA's goals and expectations.

6. Workgroups – 90 minutes

a. Instructions (Wendy)

b. 5 groups (workforce; safety net; finance; and prevention) → identify key issues/ priorities
It was suggested that a fifth group be added: data-epidemiology. Also, the workforce group must discuss lack of diversity of the workforce and its impact.

Facilitators for each group were identified:

Workforce – Kent Smith
Safety Net – Ed Popcheff
Finance – Dom Zero
Prevention – Angeles Martinez
Data – Gerardo Maupome

7. Break – 15 minutes

8. Reporting – 80 minutes

a. Leaders/champions of the 4 groups report on their results (15 minutes per group)
Wendy recommended we identify about 15-30 people from diverse areas to serve as champions.

9. Wrap-up (Wendy) – 15 minutes

Follow-up Meeting, January 16th, from 9 am through 12 pm.

The location of this meeting has not been decided. If we have many people, we will meet in the Pecar Health Center again. Otherwise, we will meet elsewhere (conference room in a nearby hotel?).

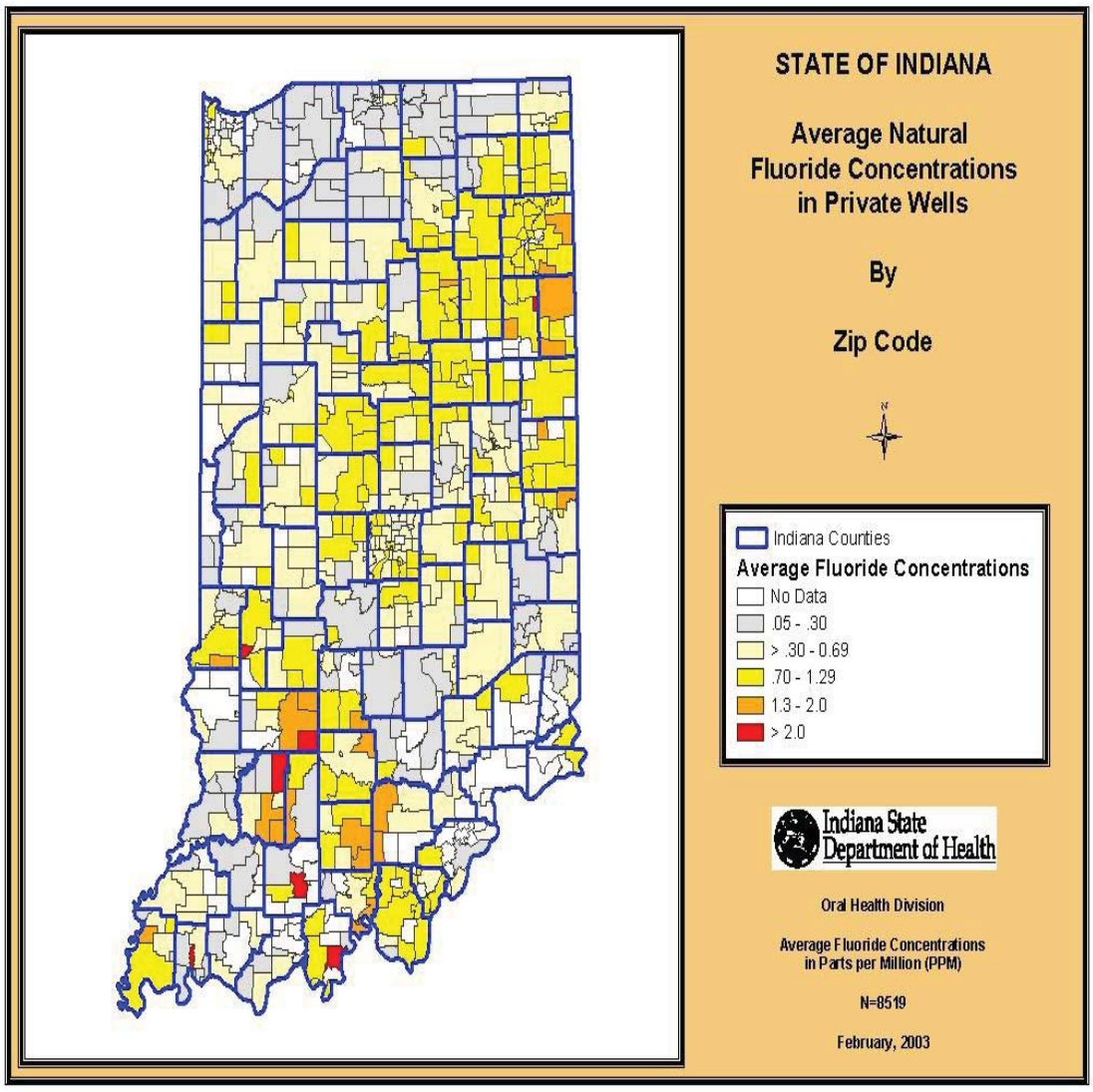
Breakfast meeting with CC members and workgroup champions. Discuss recommendations from workgroups and next steps

The Center for Health Policy will organize a Focus Group Training for our group in early January.

CC - DATA GROUP MEETING MINUTES

We reviewed the needs assessment report.

We discussed the Fluoridation Program and Data Collection



This is a fluoridation map ISDH developed over the years.

We discussed including:

- A list of all the communities that fluoridate their water supplies. It is important to show the geographic area that is served. We need the number of people served by each.
- A map showing the population served by optimally fluoridated community water systems. Over 70% of the population in Indiana has access to fluoridated water, through public water systems.
- We could list these water systems on a map or list them by county, city or utility name
- We could include updated maps similar to what is attached
- It was agreed that it would be very important to include a map with location of fluoridation systems by AGE, to get a picture of how many communities need to replace or update their systems in the near future.

COORDINATING COMMITTEE (CC)

Meeting Agenda, 1/13/2009

Welcome

Discussion of upcoming SPC Meeting

- 110 RSVPs
- Division of participants into 5 workgroups (see handout)
- Name tags and color-coding
- Identification of champions
- 3 dates for subsequent SPC meetings
- Focus group training Wednesday afternoon
- Dinner reservations for Wednesday night
- Follow-up meeting on Friday

Other Business

Adjourn

The next meeting will be on Tuesday, February 10th, at 2pm, at the Center for Health Policy.

COORDINATING COMMITTEE (CC) MINUTES

1/27/2009

Attended by: Pinkie, Marion, Karen, Nancy, Angeles, Odette, Eric, Dom, Kent, Gerardo, Ed.

Discussion of January SPC Meeting

- Evaluation/satisfaction survey – Some changes were made to the form (contact information at end of survey).

- The presenters' (Dr. Siegal, Karen, Wendy Frosh) PPTs and facilitator's workgroup minutes will be available through a link at the Center for Health Policy's (CHP) website.

- Concern of private practitioners in establishing dental homes and oral health education-

  This concern was brought up to Kent's attention by several dentists. Private practitioners questioned the lack of discussion about mother education about children's oral health, early childhood intervention and dental homes. The term "dental home" is controversial, and this must be taken into consideration before including it in future documents.

- Letter asking for representative from professional group (see Appendix A) -

It was suggested that other organizations should be added to the list:

- Dental insurers (not just Delta Dental): Anthem, United Health Care, Cigna, Aetna (Ed can get a comprehensive list)
- Dental Hygiene students
- Dental Assisting students
- Corporate Dental Clinics: Ocean Dental, Cool Smiles, Small Smiles (formerly For Better Access), Heartland, Aspen, Monarch
- Franchise/Retail Dentistry providers
- Indiana Association of Homes for the Aged, Indiana long-term care Association, Home Health Association, Indiana Health and Hospice Care, Indiana Chapter of Assisted Living Federation (Gerardo has information).
- Indiana Health Centers, Texas Migrant Council

Pinkie and Eric pointed out that we, again, have a very long list of stake-holders and this would make drafting the Strategic Plan less efficient (although, the more people are involved, the more support it can garner). It was decided to go back to the original plan of drafting the Strategic Plan within a smaller group, then presenting it in March, to the bigger group for feedback.

- DCS request for childhood oral health presentation (April 20-22 and September 21-23) (see Appendix B) – It was suggested that Carol McKown and/or Joan Kowolik would be interested.

- Discussion of new HRSA grant – To analyze the grant, and decide on the direction/activity to pursue, the group should consider the existing data, our identified needs, and the possibility of finding matching funds. For this purpose, the group will

receive a document with the 12 activities that the grant requests be addressed, the notes from the workgroups (identified needs) and the Needs Assessment document (existing data).

The next meeting will be on Tuesday, February 10th, at 2pm, at the Center for Health Policy.

Appendix A

During the follow-up meeting with Wendy Frosh, on January 16, we discussed sending official invitations to the following professional groups, asking for a representative for the SPC Champions:

- Dental Hygiene Association
- Dental Assistants Association
- Latino Health Organization
- Indiana Minority Health Coalition
- Pediatricians
- Association of School Nurses
- Indiana Department of Education
- Indiana Primary Health Care Association
- Hospital Association
- Nursing Association
- Disability/special needs
- Delta Dental Insurance
- Indiana Medical Society
- Indiana Public Health Association
- Community Health Centers
- Head Start
- Dental Students
- Legislators
- IUSM/AHEC/or Residency Program
- Medicaid
- Indiana Rural Health Association

Appendix B

Hello Marion,
DCS puts on an institute every April and Sept. for the staff of DCS, Community Partners, Healthy Family and other programs statewide that work with ages 0-5. After yesterday I was wondering if someone would want to do a presentation about early childhood oral health. It would be a good access point for the population that normally may not go to the dentist. Another idea might be to have a pamphlet or one page handout for the packets and/or man a table at the conference with info and toothbrushes or some such thing. The institute is April 20 - 22 and Sept. 21 - 23. The training usually has from 500 - 600 participants and is held at the State Office Conference Center. Please pass on to someone who might be interested in this project or let me know who to contact. Thanks.
Roberta Henry-Baker

COORDINATING COMMITTEE (CC)

Meeting Minutes, 2/10/2009

Attendees: Angeles, Karen (by phone), Marion, Nancy, Pinkie, Odette, Eric, Kent.

Update on OHTF Activities (Kent)

OHTF group meets before the Dental Advisory Panel. ~~This group is interested in oral health, but does not have political clout~~ **Amendment from Kent: The OHTF is composed of various individuals with an interest in oral health and serves in an advisory-only capacity to ISDH**. During their most recent meeting, they identified priority activities within the HRSA grant. They identified:

- Promoting sealant use
- Helping ISDH
- Helping with IUSD community outreach
- Water fluoridation

Schedule new SPC Meeting Dates

Marion reported that there has been much interest in future meetings. Possible dates:

- March 19 or ~~March 24~~ **Amendment: We had to suggest March 31st instead of March 24th**
- May 13 or May 14
- End of July – to be determined

Discussion of new HRSA grant

- Review of Kent's, Karen's and Marion's suggestions (see below). Angeles brought a proposal worked in conjunction with Traci Adams-Wilson (Coordinator of Diversity Support at IUSD) (see below).

- The proposal would focus on the following HRSA-approved activities (listed as they appear in the document):

1. Loan forgiveness and repayment programs for dentists who agree to serve as public health dentists for the Federal. State or local government who practice in designated dental health professions shortage areas; and agree to provide services to patients regardless of such patient's ability to pay; and provide a sliding payment scale for patients who are unable to pay the total cost of services.

2. Recruitment and retention efforts.

6. Placement and support of dental students, residents, and advanced dentistry trainees.

10. Coordination with education systems to promote children going into oral health or science professions.

The pre-dental component would mirror the Crispus Attucks model that IUSD has been employing.

The dental component would offer scholarships/stipends of $15,000/year for 3 years to qualified under-represented minority applicants. Dental students, during their fourth-year elective would have a choice of working on a service learning project helping identify dental HPSAs or collecting data on areas in need of improving water fluoridation systems. Upon graduation, stipend-recipients would be eligible for loan repayment/forgiveness by agreeing to practice in a designated dental shortage area (Is there any way to make them practice in an Indiana HPSA?).

The proposal can also include Dental Hygiene students. Stipend recipients can be involved through their Community Health Course or the Practicum.

The Center for Health Policy will be involved in the evaluation.

It was felt that this proposal would be coherent, supports oral health workforce activities and improves accessibility of oral health workforce for underserved areas (HRSA's specified grant purpose). It would also be data-driven. However some information is needed:
-Location of practice of under-represented IUSD and IUDH graduates (from the past 5 years) (city, county and zip code). Angeles and Nancy will get this information, respectively.
-Definition of under-represented/minorities in the sciences – African-American, Hispanic, Native American. **Please see addition from Angeles below**.

Here are the NIH definitions:

Research Supplements to Promote Diversity in Health-Related Research

PA Number: PA-05-015

1. Eligible Applicants

1.B. Eligible Individuals

For the purpose of this announcement, institutions are encouraged to identify candidates who will increase diversity on a national or institutional basis. The strength of an institution's description and justification for the appointment of an identified candidate will be judged along with all other aspects of the proposed experience (see review criteria in Section V.1.). As discussed, the NIH is particularly interested in encouraging the recruitment and retention of the following classes of candidates:

A. Individuals from racial and ethnic groups that have been shown by the National Science Foundation to be underrepresented in health-related sciences on a national basis (see http://www.nsf.gov/statistics/wmpd/). In addition, it is recognized that underrepresentation can vary from setting to setting and individuals from racial or ethnic groups that can be convincingly demonstrated to be underrepresented by the grantee institution are eligible for support under this program.

Here are the statistics (downloaded from http://www.nsf.gov/statistics/wmpd/):

TABLE B-1. Undergraduate enrollment at all institutions, by race/ethnicity, citizenship, sex, and enrollment status: 1997–2004

Race/ethnicity, citizenship, sex, and status	1997	1998	2000	2001	2002	2003	2004
Pacific Islander	745,299	732,167	791,431	810,599	849,951	845,542	865,669
Black	1,382,028	1,362,622	1,505,216	1,524,759	1,615,596	1,666,483	1,716,696
Hispanic	1,253,807	1,233,658	1,418,154	1,479,485	1,560,538	1,594,700	1,656,529
American Indian/Alaska Native	127,191	122,445	128,716	130,488	136,510	141,263	143,024

B. Individuals with disabilities, which are defined as those with a physical or mental impairment that substantially limits one or more major life activities.

C. Individuals from disadvantaged backgrounds which are defined as:

1. Individuals who come from a family with an annual income below established low-income thresholds. These thresholds are based on family size; published by the U.S. Bureau of the Census; adjusted annually for changes in the Consumer Price Index; and adjusted by the Secretary for use in all health professions programs. The Secretary periodically publishes these income levels at http://aspe.hhs.gov/poverty/index.shtml . For individuals from low income backgrounds, the institution must be able to demonstrate that such candidates have qualified for Federal disadvantaged assistance or they have received any of the following student loans: Health Professions Student Loans (HPSL), Loans for Disadvantaged Student Program, or they have received scholarships from the U.S. Department of Health and Human Services under the Scholarship for Individuals with Exceptional Financial Need.

2. Come from a social, cultural, or educational environment such as that found in certain rural or inner-city environments that have demonstrably and recently directly inhibited the individual from obtaining the knowledge, skills, and abilities necessary to develop and participate in a research career. Eligibility related to a disadvantaged background is most applicable to high school and perhaps to undergraduate candidates, but would be more difficult to justify for individuals beyond that level of academic achievement.

The next meeting will be on Tuesday, March 10th, at 2pm, at the Center for Health Policy.

Program Suggestions from Kent

Recruitment and retention efforts AND
Placement and support of dental students, residents, and advanced dentistry trainees AND
Coordination with education systems to promote children going into oral health or science professions

- Apply for funding to assist the dental school so their scholarship offers to qualified under-represented students are more competitive when compared to offers from other dental schools. Consider coordinating activities 2 (Recruitment and retention efforts), 6 (Placement and support of dental students, residents, and advanced dentistry trainees) and 10 (Coordination with education systems to promote children going into oral health or science professions) together in any proposal.

Example:
In order to enhance the scholarship offers to qualified under-represented minority applicants at IUSD, we could request grant funds be used to provide a stipend of $15,000/year for each year of the grant which could be provided to one student once they are officially enrolled at IUSD. This grant could provide up to 3 years of funding. Additional funds could be requested depending on the overall budget submitted in the application. Funds could be provided to just one student or to more students but at a lesser amount per student (Whatever would work best for the school). The funds could be used for education related expenses (living expenses, books, etc.), and could be provided to the student once they meet certain objectives. We could follow current school guidelines on how stipend money can be used or disbursed. If there are not guidelines, we might want to consider providing the money only after certain objectives are met. An example might be once the student successfully completes their first semester they are provided 50% of the funds and the remaining 50 % once they successfully complete the second semester.

Develop, or augment an existing, state dental director office to coordinate oral health and access issues in the State

- Apply for funding to support the state dental director office. Apply for funding so ISDH can hire a full-time office assistant/executive assistant or administrative assistant. I have requested budget info concerning such a position.

Activities that would involve ISDH dental director in more activities at the dental school or in the community. This would be as a non-paid person but part of ISDH official duties. This activity could be used as demonstration of the 40% state match. Examples might be an activity at the dental school or as a volunteer dentist at the Blue Triangle or other clinic site supervising hygiene students.

Program Suggestions from Karen

1. Loan forgiveness and repayment programs for dentists who agree to serve as public health dentists for the Federal. State or local government who practice in designated dental health professions shortage areas; and agree to provide services to patients regardless of such patient's ability to pay; and provide a sliding payment scale for patients who are unable to pay the total cost of services.

2. Establish faculty recruitment programs at accredited dental training institutions whose missions include community outreach and service and that have a demonstrated record of serving the underserved.

3. Community-based prevention services such as water fluoridation and dental sealant programs.

4. Develop, or augment an existing, state dental director office to coordinate oral health and access issues in the State.

Program Suggestions from Marion

Community-based prevention programs

- Supplement school-based sealant programs to reach more schools/more kids
- Combine sealant programs with data collection to create basic surveillance system for children
- Make some money available to help communities update their water fluoridation equipment (great public impact with fairly little investment)

Programs developed in consultation with State and local dental societies to expand or establish oral health services and facilities in dental health professional shortage areas

- Establish a mobile or portable dental clinic (e.g., in rural areas with low access; in high-poverty areas; areas with high percentage of minorities; homeless shelters)

Coordination with education systems to promote children going into oral health or science professions

- September 12 is World Oral Health Day . create a public health awareness event/campaign in Indiana
    - Focus 1: Importance of good oral health
    - Focus 2: Promotion of oral health professions

Suggestions for HRSA grant.

E.A. Martinez Mier in collaboration with T. Adams-Wilson

Dental Summer Institute
Urban Pre Dental Club
Crispus Attucks Medical Magnet High School

Contact Person:
Traci Adams-Wilson
Coordinator of Diversity Support Services
tadams@iupui.edu
317-274-7052

Title of Proposal: Responding to the Needs of Our Community: Initiatives to Increase Recruitment and Retention of Underrepresented Minority Students into the Indiana University School of Dentistry Programs

Collaborative Units:
Metropolitan Indianapolis Central Indiana Area Health Education Center (MICI AHEC)
Crispus Attucks Medical Magnet High School (CAMMHS)
Crossroads of America
Northwest Indiana Area Health Education Center
Indiana University Purdue University Indianapolis (IUPUI) School of Science Biology Club
Hispanic Dental Association
National Dental Association
IUPUI Admissions Center
IUPUI Graduate Office
IUPUI University College
Ronald E. McNair Program at IUPUIMURI (Multidisciplinary Undergraduate Research Institute)

Which of the Approved Activities does the proposal address?
Recruitment and retention efforts

Describe the proposal concept:
Indiana University School of Dentistry (IUSD) is constantly seeking opportunities to increase the number of underrepresented minority students in order to better serve the diverse populations of Indiana. It is well known that patients prefer being treated by individuals that look like themselves. This has, in part, resulted in some of these populations in Indiana being underserved. Unfortunately, IUSD has not been able to accommodate the ever growing demands of these ever changing populations in Indiana. In the past 8-10 years, the number of minority students applying to dental school has remained stagnant. Between 2000 and 2008, underrepresented minority students accounted for only 7.75% of the students applying to US dental schools.
Three initiatives are currently in place that are aimed at enhancing our ability to inform and attract underrepresented minority students to choose a career in the dental profession. These initiatives are the Dental Summer Institute, Crispus Attucks Medical Magnet High School and the IUSD Urban Pre Dental Club.

The Dental Summer Institute was initiated in 2008 and is a summer/academic enrichment program designed to introduce students to the dental profession and give them an overview of what to expect in the first year of dental school. The Metropolitan Indianapolis Central Indiana Area Health Education Center and IUSD collaborated on this initiative to provide a one week session for high school students and one week session for college undergraduate students. In the inaugural year, there were 8 high school and 14 college participants in the Dental Summer Institute. Three of the college participants applied for the IUSD entering class of 2009, 2 began their undergraduate studies at IUPUI in the fall and the remaining 9 are working on their prerequisite courses at IUPUI. An exit survey revealed an overwhelming interest in increasing the amount of hands-on activities, expanding the program length, and providing housing to non-resident participants. In 2009, the Dental Summer Institute will offer a one week program to high school students and a two week program for college students. These sessions include experiences ranging from participating in IUSD Problem Based Learning groups, Infection Control and Health Insurance Portability and Accountability Act (HIPAA) training, learn the history of dentistry and dental hygiene, tour the facility, observe in comprehensive care and dental hygiene clinics, network with current dental students, participate in hands-on activities and much more.
The IUSD Urban Pre Dental Club was created around five years ago to promote awareness and provide guidance to underrepresented minority students in preparing them for careers in the dental professions. Members' benefits include: hands on activities, Dental Admissions Test (DAT) preparation, mock interviews, information from guest speakers, field trips, networking opportunities, assistance with personal statement writing and access to IUSD faculty, staff, and students. Currently there are over 153 members on the distribution list. They are all at various stages in their journey to becoming dental professionals. The club meets one Saturday per month with an average of 15 students in attendance. A total of 9 dental students are former switch these Urban Pre Dental Club- (UPDC) members. Five UPDC members have been interviewed for acceptance into the 2009 entering class.

In addition to the above initiatives, Crispus Attucks Medical Magnet High School and IUSD has worked with Crispus Attucks Medical Magnet High School (CAMMHS) and Metropolitan Indianapolis Central Indiana Area Health Education Center (MICI AHEC) to provide meaningful programming for students in both the 9th and 10th grade who have expressed a desire to pursue careers in dentistry. The 9th grade students visit IUSD once a month and the 10th grade students conduct dental related research coordinated between IUSD and St. Vincent Hospital. IUSD is already involved with the Multidisciplinary Undergraduate Research Institute (MURI) and the Ronald E. McNair Program to provide students with an undergraduate research experience, especially minority students.

This request for funding is to be able to enhance these programs by enabling more students to share in these experiences to enhance their knowledge about dental careers and to provide a pipeline of students to the Indiana University School of Dentistry from diverse backgrounds and well prepared for careers in dentistry. The funds required will be utilized over three years ($15,000 per year for a total of $45,000) to increase the numbers of students that can have access to these experiences. This will be accomplished by increasing the number of sessions which will enable more underrepresented minority student participation.

Rationale: The numbers of underrepresented minority students applying to dental schools is extremely small and the competition between dental schools is high for highly qualified minority students. One of the goals of IUSD is to train dental professionals to serve in a wide variety of communities, especially in underserved regions of Indiana. Therefore, it is imperative that we

admit students who represent all the diverse populations in the state. IUSD is constantly seeking talented underrepresented minority students to provide quality dental care to the citizens of Indiana. Black/African-Americans make up of 8.5% and Hispanic/Latinos account for 4.3% of the population in Indiana. Therefore based on these percentages, IUSD should have at least 8 Black or African-Americans and 4 Hispanic or Latino students in each class in order train the number of dental professionals needed to serve the population. IUSD is working diligently to identify students who have an interest in becoming dental professionals by offering meaningful dental related experiences designed to enhance, foster and encourage their interest. Working with high school and college students early on will develop a strong bond with IUSD and students will feel at home once they are eligible to apply. This will enable IUSD to "grow" the number of diverse students that will help solve issues related underserved populations and access to care.

Budget: $15,000 for three years for a total of $45,000

Possible Matching funds: IUSD could provide matching funds as release time for the Coordinator of Diversity Support Services

The funds will be used to ensure the continuity of and further enhance the programs that are currently in place. Monies will be used for dental materials and supplies, food, promotional items, and housing.

Consultation with Dr. Burton Edelstein on Indiana's Strategic Oral Health Initiative (SOHI)
Thursday, February 26, 2009

AGENDA

- Welcome
- Update on SOHI activities
- Current strategic planning processes (discussion of workgroup comments)
- Recommendations by Dr. Edelstein

EMAIL QUESTIONS

PINKIE: I'd like to get Dr. Edelstein for suggestions when we "take the show on the road". What has he found that works best for oral health public forums? What should we anticipate? How can we best get the message out about this strategic planning process? Not just get the message out, but try to build some excitement?

Also, some suggestions on building consensus on the issues. All are important, how do we determine which issues have priority? How can we have some initial success while continuing the process?

Has he been through the planning process when funding is tighter than usual? If so, we'd appreciate suggestions.

GERARDO: I would also suggest as a discussion topic with Burton the strategic question of whether he has found that lobbying key individual players, prior to a large townhall meeting, accrue benefits by keeping them in the loop and in the group. The objective here would be that they don't feel blindsided because of their expectations of the plan as a whole. This is perhaps more important when money and professional turfs are on the table.

COMMENTS FROM SPC MEETING ON JANUARY 15, 2009

WORKFORCE/DIVERSITY

What does the workforce look like?

- Dental assistants – generally clinical, future: could expand into access-to-care (example: head start, apply preventative procedures)
- Rural regions – demand for oral care from the people
- Cannot get practitioners to go into rural areas

Solutions:

- Alaska example, tax incentives for student loans
- Not one … but a multi-hit

Goals

Work force mimics population

- Explore admissions improvements
- Grow your own
- Priorities
    - Increase diversity
    - Increase service to rural areas

- Novel scope-of-work, prescription, and supervision arrangements

Practice at "top of training"
- Potentially expand D.A. curriculum
- Modest statutory changes
- Maximize tele-dentistry & tech use

Services in rural
- Explore admissions improvements
- Grow your own
- Teach for America model
- Untapped socialization early in training

Responsible
- Community leaders
- Clinician leaders
- IUSD and ed/training programs
- Statewide
- AHECs

Work-in-progress
- IUSM admissions
- Dental board
- Clinicians
- Training programs & CE providers
- Partnerships across disciplines & agencies
- Riley tele-health project – Evansville

The Multi-hit Formula
- Community-based learning
- GPR – general practice residency
- Re-evaluate admissions criteria

Describe what the oral health workforce look like today?
- Focused primarily on treating dental disease in private practice settings, with dentist, hygienists and dental assistants.
- Not very diverse workforce. Does not reflect society

What would the ideal workforce look like?
- Would reflect the demographics of society.
- Would have new technology and techniques available to all.
- Would facilitate cooperation between private practitioners, community health centers, dental school and others.

How can we go about creating the ideal workforce?
- Recent changes in licensure procedures for dentists has helped.
- More collaboration with the dental school and other entities.
- Have student loan reimbursement more available. Currently not available in Indiana.
- Increase oral health information in the public school curriculum. This would raise the awareness of the importance of oral health.
- Provide opportunities for hygienists to become dentists and dental assistants to become hygienists.
- Improve the diversity of the workforce.
- Look at initiatives for increasing the diversity of nurses, teachers and other professions to see if there are any successful activities that can be used to promote diversity in dentistry.

- Significant pay disparity for those working at the dental school and facilities treating the poor as compared to private practice. If this pay difference were less, more individuals might work in the public health sector.
- Consider tax incentives for practitioners to locate in underserved areas.
- Need to increase the availability of bilingual providers.
- Opportunities to work with AHECs to increase diversity and encourage youth to enter dental professions.
- Need more role models to encourage under-represented youth to enter profession.
- Need to collect data on the diversity of the workforce. There could be an optional check off or data collection at time of license renewal for dentists and hygienists or when renewal of radiology certification for dental assistants.
- Dentists tend to be very independent. When they work with schools or health centers, they may feel they lose this independence. If this perception could change, more dentists might work with community health centers.

SAFETY NET

Goals

- Move like a tight rope – need more resources to make a net
- No specialty programs – must fit an existing program , dental practice
- Programs we have do not meet needs of homeless
- Resources too low for adults $600
- HIP stops @ 19 ---no dental care due to cost of dental care
- Prevention doesn't happen
- Target population: start at maternity ward, prenatal care very important
- Access due to jobs lost – must take off from my job, more accessible dental hours
- Education -- parents + children employers
- MUST KEEP CURRENT PROGRAMS

  Era of single bullet is over
  Early intervention – fluoride varnish, sealants
  Availability

Accessibility

- Education – Indiana Dental Association educate other healthcare providers
- Talk to mid-level providers
- Maintain/enhance current programs
- Develop PSAs – public service on Oral Health Announcements
- Go where the need is – nurses are the advocates, 1st line private dentist – often after school nurse referral
- Sealants programs are very successful
- Building incentives into the system
- PSA – collaborative groups led by Health Dept, state and national

Collaborations

- Prenatal medical groups, AHA, PSAs in collaboration with other health groups
- Partner with Indiana State Health Department
- Require health professions to include dental health or they lose funding

Economic Development Program

- Use incentives that make sense to families – with reasonable requirements
- Incentives to dental care providers
- Rewarding healthy behaviors

    - Acute pressing need 5 to 7%
    - Leave some needs
    - Totally healthy
- Give school nurses resources for those who have additional pressing needs
- Goal of these services is worth the effort
- Should we focus on 95% who wants service but don't have access

Goal – facilitate school nurses and social workers priority #1

Responsibility
- State Professional Associations
- State Dental Director
- IUSD including Auxiliary programs
- Mobile preventative care

Work in Progress – mobile programs @ work

Necessary resources
- State referral system
- School nurse oral education
    - Screening tools
    - resources
    - Interventions
    - Help line – 211 info/referral, refine existing and update
- Public Service Announcements
- Provider incentives
- Reward healthy behavior

Goal – Public Service Announcements priority #2 –systemic DX, xerostomia etc.

Responsibility
- Professional organizations
    - Cardiology
    - Ob-gyn
    - Diabetes
    - Education (Public Health)
    - Geriatrics
- Corporate foundations

Work in Progress
- ?

Necessary resources
- Money
- PR firm
- Media cooperation
- Cartoonist/songwriter (kids audience)

Goal – Provider Incentives tied to Safety Net priority #3+

Responsibility
- IDA: Public & private incentives
- IUSD
- State legislature – Medicaid

Work in Progress
- Some nursing home mobile units
- ?

Necessary Resources
- Provider educators
- Suppliers

Goal – Reward Healthy Behavior priority 3-

Responsibility
- All dental program directors 3+

Work in Progress
- ?

Necessary resources
- Off- hour facilities
- $ from added license or associated dues tax
- License plates
- Gas tax ($2.00 gal)

1. Safety net is an organization trying to help underserved; also can be used for education and prevention
2. Safety net is not good for our broken health care system, due to more and more people falling through the cracks (people getting laid off or losing jobs – no health ins).
3. We have to find safety nets within private sector; private offices need to be more accessible and available financially
4. Problems w/staffing and retention @ safety nets
5. Do we need a safety net for Medicare recipients? (special program)
6. We cannot continue to drill and fill w/o education
7. Prenatals have to visit the dentist
8. Having a pediatrician use fluoride varnish on a child won't work unless they explain to parent about modifying behavior at home and continue to explain the ins and outs of prevention. The parent has to be educated on dental prevention in order for this to work. Varnish alone won't help w/o the other components.
9. OB doctors and dentists have to be able to communicate in order to give OB patients the best care
10. Cost effective to provide treatment to kids early in life
11. Dental students should get more exposure to non-traditional dental clinics
12. Mobile units offer no dental home, no emergency care and no interaction w/parent
13. How effective Born to Smile is ????
14. We try to educate parents on oral health care but WIC is giving out free juice and sippy cups.

<u>Goals</u>
1. Prevention w/education
2. How to make people value oral health care
3. Interaction w/child and parent about oral health care
4. Expose students to federally-funded clinics

<u>Not addressed</u>
1. Disease prevention/liability in kids
2. WIC – giving out vouchers for juice

PREVENTION

Assets & Problems

- School based fringing
- Sealants programs
- Water fluoridation
- OH instructions, education emphasis, by Dental School students – WIC & Elderly
- Education in dental school (need more) +outCAD campaigns
- Born to Smile -> increase 1-year visit
- Healthy Choices – partner with others (ex: Diabetes Association), OB/GYN, nursing students, pediatricians, school nurses, school administrators

Reasons lack prevention

- Low income/reimbursement
- Dental belief
    - Need of prevention
    - Consequences

Opportunities

- Access to "in need" populations ….minorities, rural
- Community driven
- Fairs/festivals/church

Workforce

- Hygienist
- Assistants
- School nurses

How to Fix IT

- Increasing prevention "valve" knowledge + comfort in treating young children in (dental education, legislators (funds)
- Helping replace water fluoridation pumps – matching Grants
- Partnering with Associations (Eg: Diabetes, Heart), community centers, other health professionals (pediatricians, OBGYN) -> consistency of message
- Nature of dental disease (mom transmitting to baby)
- Nursing students, pediatricians, school nurses, school administrators

Things we know about Prevention

- Good fluoridation
    - Diligent/maintenance
    - Investments
- Underrepresentation of ethnic groups/diversity
    - AA
    - Latinos
    - Community barriers
    - Culture/wave of immigrants
    - Diet & effects on Oral Health
    - Disabilities-cognitive
- Poverty
- Lack of insurance
- Lack of outreach programs
    - Educating on prevention @health fairs, etc

    - Marion County has a program where hygienists go out to schools, daycare, camps, dental prevention health fairs, F/u w/smile mobile
- Best management practices
- Head Start programs
- Programs that allow Oral Health providers to go out to the kids/parents have to miss work

Summary work

- Fluoridation – strength
- Head Start programs/Marion county dental service
- Born to smile

Weaknesses

- Finances, funding/lack of money
- Lack of diversity/cultural sensitive
    - Program & professionals educational
- Lack of insurance/outreach problems with access

Fix

- Best management models
- Non-traditional settings
- Education/public/dental professional
- Picking a target audience
- ID target population for prevention education
    - Mom/infants
    - Dental decay-> cardiovascular risks
    - 20's – 40's year olds
    - 50's & older
- Increase referrals from physicians
- Increase dental workforce to provide services
- Public service announcements
- Access to care – no insurance
- Value of dental care
    - People perceive low value & don't want to pay
- TV commercials to include all groups
- Specialty training programs for foreign trained professionals
- Teach dental professionals on OH education
- Make public health more desirable
- More nontraditional dental settings
    - Churches
    - Daycares
    - Social clubs
    - Associations
- Foster Care programs – these kids don't get needs met
- Born to Smile program – Fort Wayne
    - Brochure/reply card/gift @ 1 year
    - Dental visit – free exam
    - 2nd brochure @9 months on
    - Pilot program
- Find a way to get the message of OH to the population (people don't fear dental disease)
- Mom/infant OH education
- Coordinate w/prenatal visits
- Increase referrals from physicians
- Educate public on infectious nature of dental disease (mom transmitting to baby)

FINANCE

What are the strengths & weaknesses of how we currently finance dental care in Indiana?

Strengths

- Compared to other states we have a fairly strong program –Medicaid
- HIP legislation – currently supporting expansion for funding dental care to children & adults as well
- Leg. & admin. support dental Healthy Indiana
- Privatized or universal – not solved
    - 48 health centers
    - 90 sites – sliding scale
    - 18 federally qualified health centers – have dental
    - 30 state funded w/o dental
- Some employers have dental insurance for the employees
- Coverage for prenatal women

Weaknesses

- No data to understand financing
    - How many dental uninsured?
- Unknown needs?
- What is cost to not provide needs? – health, economic, social
- Can capture some costs – chronic diseases
- Dental community doesn't understand all of coverage available.
- Some DDS think Medicaid reimbursement is easier to get
- Fragment reimbursement systems
- Not enough money in the system doesn't cover overhead for dental offices

To what extent should the financing of dental care be integrated with medical care?

- A system that covers all health – medical, dental, vision
- Dental has separate packages than medical
- Advantage – easier for Medicaid & personal
- Dental codes handles differently than medical codes
- Some states have dental covered under their medical managed care

What steps need to be taken to improve the financing of dental care in Indiana?

- Fluoride program paid by federal funds
- Shouldn't the state invest in the fluoride program
- Workforce & financing issue RDH – underutilized, scope of practice
- Government needs to understand importance of Oral Health
- Mid-level practice utilized
- Quicker way to review reimbursement
- MD reimbursement hasn't been raised since 1994—Jan '08
- Managed care organizations will have to look@ can DDS handle the influx in certain areas
- General overhead ~70%
- Typical DDS office 1 or 2 clinicians
- DDS – independent – like autonomy
- Future may see shift of dentists to larger corporations
- Mental health was in legislation required years ago – must be provided.
- Who will fund the raises in reimbursement
- Should we look at services reimbursed and re-evaluate

Focus on preventative care

- Healthy Indiana Plan
  - $500 for preventative care
  - Include dental services
  - Managed care took care off
- Medicaid covers 1 cleaning a year—could we change that to twice a year
- People financing health care wait for their reward
- Prevention doesn't save money just improves quality of life—medical
- Educations standpoint – indigent peoples don't choose dental insurance , education needed
- There have been movements to include dental health in medical health
- Could it be to dentist advantage to have them combined?
- Dentists could shift paper work to manage care – maintain control of practice get access to new stream of funding
- Which states have done this?
- Physicians doing some dental treatments – fluoride varnish –to address access to care
- If DDS was part of managed care they wouldn't need referrals
- Medicaid doesn't come close to private insurance reimbursement.

DATA

- Ability to find a provider
- Level of dental literacy/IQ
  ➔ Use of pictorial

Direct data collection vs. telephone
➔ Health fairs; IBE
Governments already interested
PTA mandated eye exams

- Number of states that mandate oral care
- Support structure
  ➔ Access; ER (trauma)
- Regular nursing home care
- Gap in regulation of special needs and long-term care facilities

Access to care (availability of care, quality, desire)
Last visit treatment
Clinical: decay, missing, perio, oral cancer, how many times, barriers, time lapse?

How important is dental health
Use YRBS or some other Department of Education survey
YRBS Survey High School to provide random sample and provide teenager data

- Dental phobias (avoid dentists)
- ATOD (alcohol, tobacco, drugs)

Geriatric population is difficult to survey
Consider using AARP
Central Indiana Council on Aging

CC Meeting

March 10, 2009

Welcome

Discussion of next SPC Meeting

- Meeting location: Campus Center
- Structure of SPC meeting and tentative agenda:
    - Attendees will have previously received the Needs Assessment document and the document with the comments from the prior SPC meeting. They will also choose 2 groups for possible placement.
    - Eric will facilitate and give the introduction (9:00-9:15 am)
    - Attendees will be divided into 5 groups (Data, Finance, Prevention, Safety Net and Workforce/Diversity). Group discussion will be facilitated by: Angeles, Kent, Dom, Dr. Grey –to be confirmed, and Dr. Platt -to be confirmed. Facilitators must be at the Campus Center by 8:30 am. Scribes for each group will be provided or identified; laptops and recorders will be provided.
    - The small groups will draft 3-6 SMART* objectives/goals, including the rationale. Objectives must be data-driven or evidence-based (in other words, based on the Needs Assessment or on the focus group comments). (9:30-11:00 am).
    - Lunch break (11:00-11:30 am)
    - Groups reconvene and apply the matrix to prioritize their chosen objectives (11:30-12:30 pm)
    - Groups report their prioritized objectives to the whole group. Closing comments (12:30-1:00 pm).

  *SMART goals are Specific, Measurable, Achievable, Realistic, and Timely.
- Meeting dates for next SPC meeting in May: Wednesday 13th in the morning or Friday 15th in the afternoon

Next CC meeting on April 14th at 2pm

CC Meeting Minutes

May 12, 2009

Attendance

Pinkie Evans, Marion Greene, E. Angeles Martinez-Mier, Gerardo Maupome, Kent Smith, Karen Yoder, Eric Wright, Domenick Zero

Next SPC Meeting

We briefly discussed the next SPC meeting, which is scheduled for Friday, May 15, from 12 noon through 4pm, at the Pecar Health Center. At the SPC forum, the entire group will review the SMART priorities (no division into individual workgroups). Some of the priorities still lack a clear 'who/when/how', but this will be addressed at the meeting. Eric will be the facilitator.

Focus Groups

After the SPC meeting, Pinkie, Odette, and Marion will refine the SMART priorities, including suggestions from SPC members. The CC will then conduct five focus groups to introduce these priorities to stakeholders throughout Indiana. It is planned to hold focus groups in Gary (Lake County/NW), Fort Wayne (Allen County/NE), Evansville (Vanderburgh County/SW), New Albany (Floyd County/SE), and Indianapolis (Marion County/Central); probably in the time period between June 15 and 26. However, details are still being worked out.

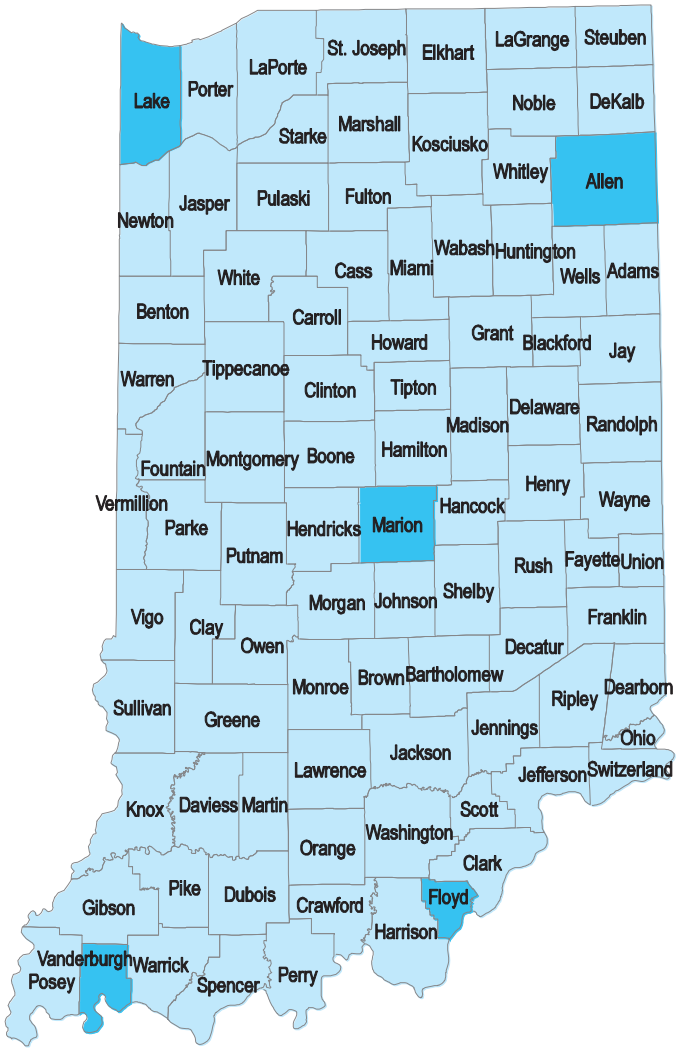
Marion will be present at all focus group meetings; Kent, Karen, and Pinkie volunteered to participate in some of the meetings; Gerardo mentioned interest depending on scheduled dates. Focus group dates and venues will be announced through ISDH monthly calls with local health departments; possibly through IDA; and through invitations sent to key informants. We hope to have 10-20 attendees at each meeting.

Final SPC Meeting

A date for the final SPC meeting was set for Wednesday, August 19, from 11am through 1:30pm.

The next CC meeting for June 9 was cancelled. We will meet again on July 14, at 2pm.

Indiana Counties



FOCUS GROUPS IN INDIANA

Lake County
Indiana University Northwest
3400 Broadway
Gary, IN 46408-1101

Allen County
Ivy Tech Main Campus, Fort Wayne, Indiana
3800 N. Anthony Boulevard
Fort Wayne, IN 46805-1430

Marion County
IUPUI (Campus Center)
420 University Blvd.
Indianapolis, IN 46202

Vanderburgh County
University of Southern Indiana
University Boulevard
Evansville, IN 47712-3534

Floyd County
IU Southeast
4201 Grant Line Road
New Albany, Indiana 47150-2158

CC Meeting July 14, 2009
Meeting Minutes

Attendance: Pinkie Evans, Marion Greene, E. Angeles Martinez-Mier, Gerardo Maupome, Ed Popcheff, Kent Smith, Karen Yoder, Nancy Young (Gerardo also brought 3 guests from Mexico who were interested in observing the meeting)

General introductions were made and Gerardo introduced his guests. Marion gave a brief summary of the SOHI project.

Discussion of SMART Goals
A document containing SMART goals + edits/comments from CC members was handed out (see Appendix A). The question that was put in front of the group was:

Should we limit the number of goals (as had been suggested by some)? If so, how many and which goals should be included; should we rank-order them by importance; should the goals that were not chosen be listed in the report as additional oral health needs/gaps that will have to be addressed?

Opinions in the group differed. Basically, the following five models were suggested:

1. Keep all goals as suggested in the draft (but do some word-smithing).
2. Focus only on the most important goals (maybe workforce/diversity, data, and education/oral health promotion).
3. Keep all goals but sort them according to short-, medium-, and long-term.
4. Combination of #3 and #4: Focus on a couple of easily-achievable goals (that are under our control) and list the rest according to short-, medium-, and long-term.
5. Create only one goal that states that a workgroup will be established who will decide which goals to address.

Gerardo proposed to reconvene the meeting when the decision-makers of the represented organizations (Drs. Ganser, Zero, and Wright) were available. The group concurred and Marion agreed to schedule the meeting.

Additional comments on the goals were made, but agreement was not necessarily achieved

APPENDIX A

SMART Goals, including comments from Karen, Kent, and Dr. Ganser:

To ensure that Indiana is planning to meet the current and future oral health needs of its residents, the following goals were established:
Kent: It was suggested to minimize the total number of goals by combining these goals when possible.

GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents.

1. Designees of the Indiana State Department of Health and Indiana University School of Dentistry will work with state professional entities (including, but not limited to, the Indiana Dental Association, Indiana Dental Hygienists' Association, and Indiana Dental Assisting Association) to encourage the Public Health Committee of the Indiana Legislature to hold informational hearings by ***[insert date or time period]***. Results of the informational hearing will be shared with the before-mentioned partnership organizations and the Statewide Planning Council to support legislation during the 2011 Legislative Session. These informational hearings will include:

    a. Discussion of resources and infrastructure necessary to educate the next generation oral health workforce;
    b. Discussion of demographics (such as gender, race, and ethnicity) of the current oral health workforce and strategies to increase its diversity;
    c. Discussion of the oral health needs of rural Indiana and strategies to increase availability of the oral health workforce in these areas;
    d. Discussion of additional resources needed to meet the oral health needs of Indiana's underserved populations, including underinsured, low-income, unemployed, aging, and special needs populations.

Dr. Ganser: Please take ISDH out as a designee for this one. Our role would be to give information, discuss what other states have done, but we cannot be "encouraging, advocating, etc.", we can educate and give information. Suggested leader: IDA

Kent: Need to define who takes the lead. ISDH is not able to lobby or approach the legislature expect at a very high level. ISDH can provide data when asked.

2. ***[Based on various comments, it was suggested to add a goal that directly targets (a) the declining number of dentists and (b) the lack of diversity. Let's try to come up with a SMART objective that reflects this.]***

Petition the State Legislature and/or Governor to convene a commission to develop effective methods for increasing access to oral health services in Indiana through these means:

Karen:

- **Improve the ratio of dentists to population in underserved counties**
- **Increase the number and widen the distribution of community health centers with dental clinics**
- **Significantly increase the proportion of dentists who accept patients covered by Medicaid reimbursement**
- **Facilitate increased recruitment and retention of ethnic and racially diverse dental student to insure a diverse workforce in Indiana**
- **Effectively use the plentiful dental hygienists' workforce and their broadened scope of practice in public health settings to provide preventive services for underserved populations, especially school-based dental sealant programs for children from low-income families.**

GOAL 2—Obtain additional Dental Health Professional Shortage Area (DHPSA) designations.

1. Designees of the Indiana State Department of Health, Indiana Dental Association, and other interested professional entities (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will work with communities to identify areas with the greatest oral health needs. Designees will help communities with the process of establishing a DHPSA, as defined by federal guidelines from the Health Resources and Services Administration. **Recommend this process begin by *[insert date or time period]*.**

Dr. Ganser: Suggested Leader: ISDH and IPHCA
Ann Alley: Regarding Goal number 2—establishing more dental health professional shortage area designations seems like one that you could drop because HPSA designations are currently an ongoing activity. If you want to convene a group outside ISDH that would concentrate on gathering data to help with establishing a case for designation that would be a value added activity and could better serve as a goal I think.

GOAL 3— Increase dental students' involvement in working in underserved areas.

a. Designees from the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, and other interested parties (e.g., Area Health Education Centers, Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will meet with dental directors (or their representatives) of safety net clinics[1], by March 31, 2010.
b. Designees and dental directors (or their representatives) will develop recommendations for service learning opportunities for Indiana University dental students ***[shall we include hygienist and assistant students?]*** Yes at these safety net clinics, by August 2010.
c. Designees will present recommendations to the Dean of Indiana University School of Dentistry and to the Heads of Indiana's safety net clinics by March 2011.

[1] The Institute of Medicine defined safety net clinics as, ""Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients" (2000).

Dr. Ganser: Suggested Leader: IUSD

Kent: Who should take the lead—Karen Yoder? Does the IUSD have the resources to accomplish this goal?

GOAL 4—Encourage school-based oral health education and promotion for K-12 students and their families. Include public, private, charter, and parochial schools.

1. Designees from the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, Indiana Department of Education, and other interested professional entities (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will work with assigned school staff (e.g., nurses, social workers, health educators, dental hygienists) to encourage and assist schools in providing oral health education to children and their families. This process will start by ***[insert date or time period]***.

    a. Designees will assist school staff in organizing an oral health promotion per school district and in out-of-home child care facilities.
    b. Designees will present at a symposium targeting school staff (e.g., nurses, social workers, health educators, dental hygienists).
    c. The Indiana State Department of Health and representatives from Indiana University School of Dentistry will provide the Statewide Planning Council with annual updates through 2011.

Dr. Ganser: This objective has never seemed practical to me. A school is lucky if they have a school nurse. Most do not have social workers, health educators or dental hygienists. The designees or a committee will not be able to directly assist school staff. There is a possibility of a presentation at the School Nurse's Symposium put on by DOE. In fact Dr. Smith is to speak there in November. Updates should be provided by every committee annually. Suggested Leader: State Dental Hygienist's Association.
Kent: Need DOE involvement, Phyllis Lewis or someone else. There are no staff assigned to do this.

GOAL 5—Develop a Public Service Announcement (PSA) and Reference Tool for statewide oral health promotion.

1. The development of the PSA and Reference Tool will start by ***[insert date or time period]***.

    a. Designees from the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, and other interested parties (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association, United Way of Indiana) will identify a theme and target population, and develop an appropriate PSA.
    b. Together with the PSA, a reference tool (website, brochure, or 'hot line') will be established to provide information on oral health issues and a referral list of oral

health professionals, services, and programs, as well as safety net clinics with dental clinics.

Dr. Ganser: I doubt there is a need to "develop" a PSA. Surely the National Dental Association has some type of PSA. PSAs will be run voluntarily by TV or Radio stations, but often at odd times (e.g. 3AM) Information could be added to ISDH Oral Health Website, but we could never list individual dentists, as it might be considered an endorsement. Suggested leader: IDA
Kent: Is a PSA already available? ISDH is not able to keep a referral list. We can keep information on offices that accept Medicaid.

GOAL 6—Develop a community-based promotion campaign on diet and nutrition and its consequences for oral health.

1. Designees of the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, and other interested professional entities (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will partner with state and local agencies and organizations, such as community health centers and other safety net clinics, healthcare professionals, WIC offices, and other community-based and/or faith-based entities to promote oral health, prevent oral disease, and educate about optimal diet and nutrition. The planning process for the campaign will start by ***[insert date or time period]***.

    a. Designees will develop campaign as part of local health fairs.
    b. Designees will work with state and local agencies that provide food and nutrition counseling to encourage them (the agencies) to educate on oral health consequences of food choices.
    c. Designees will develop a mechanism to bring schools together for an oral health promotion/campaign that would educate families on issues of diet, nutrition, and oral health.

Dr. Ganser: This goal could be the committee working with the Division of Nutrition and Physical Activity at the ISDH to be sure oral health is included in their Healthy Weight campaign and coalition. I don't think there is a need to develop new materials, but need to make sure impact on oral health is included in the overall campaign. Dr. Smith could take lead on coordinating this and perhaps Dental Assistant Organization could work with him.
Kent: Integrate the importance of a PREVENTION STATEGIES FOR healthy diet and lifestyle choices (exercise, nutrition, obesity preventions, smoking cessation, good pre-natal care, etc) and other chronic disease prevention strategies.

GOAL 7—Maintain and provide funding for the State Fluoridation Program.

1. Maintain and provide funding for fluoridation equipment, maintenance and procurement through community, state, federal, and associated sources.

    a. Designees from the Indiana State Department of Health and Indiana Dental Association will identify funding to maintain/improve infrastructure for public fluoridation programs and develop a plan by December 2010.

b. Designees will educate communities on the importance and benefits of water fluoridation.
c. Additional staff will be added to the Indiana State Department of Health to implement the plan.

Dr. Ganser: Instead of "identify funding", I would say, make recommendations for funding. Again the designees or committee is not going to be out there doing the education. Committee could bring together appropriate materials for local dentists to use. It is not appropriate for this group to say, "staff will be added". No one can guarantee that.

GOAL 8—Fund community-based oral disease prevention programs.
Kent: Combine goal 8 and 9 into one goal of education/integrate.

1. Designees of the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, and other interested professional entities (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will help communities to identify funding for community-based oral disease prevention programs (e.g., sealant programs). This process will start by ***[insert date or time period]***.

    b. Designees will help communities secure funding to maintain and expand current preventive programs.
    c. Designees will help communities establish new local/regional preventive programs.
    d. Designees will help communities develop a system to connect people to treatment.

Dr. Ganser: I think the committee should identify evidence-based prevention programs that can be used at the local level. Then explore funding. Suggested leader: IUSD with ISDH

GOAL 9—Educate pregnant women on oral health issues and give them access to oral health care.

1. Designees from the Indiana State Department of Health, Indiana University School of Dentistry, Indiana Dental Association, and other interested professional entities (e.g., Indiana Dental Hygienists' Association, Indiana Dental Assisting Association) will create partnerships with maternal health clinics, OB/GYNs, physicians offices, safety net clinics, and WIC[2] offices, to initiate health promotion strategies to educate expecting mothers, focusing on preventive oral health care, and providing resources to help them access oral health services by June 2010.

[2] WIC (Women, Infants, and Children) is a food and nutrition program for pregnant women and families with young children. The program is sponsored by the U.S. Department of Agriculture and provides nutritious foods; nutrition and health education; breastfeeding education and support; and referrals to health and human services.

a. The Indiana State Department of Health and local health departments will strive to provide dental health care and oral health education for pregnant women.
b. Designees will stress the importance of establishing a dental home by age of 1. **[Kent: Very important!]**
c. Designees will connect expecting mothers with the Born to Smile program.

Dr. Ganser: The materials already exist – look at NY State Health Dept website. This could be done by the Indiana Perinatal Network, MCH, and the Pediatric dentists working on Born to Smile.

GOAL 10—Educate pediatricians and family physicians to provide oral screenings and fluoride varnish in children ages 0-3 ***[ages okay?]***.

1. Since most young children see a physician many times before seeing a dentist, encourage Medicaid to establish a medical code to reimburse appropriately trained healthcare providers for providing oral assessment, fluoride varnish, and referral for young children ages 0-3 ***[ages okay?]***. This process will start by ***[insert date or time period]***.

    a. Work with Medicaid and private insurers for oral health promotion.
    b. Work with physicians to be included as part of a health mission.
    c. Provide training for healthcare providers for proper oral health assessment, application of fluoride varnish, and referral to oral health providers.

GOAL 11—Engage in discussions with the Office of Medicaid Policy and Planning for better utilization of Medicaid funds and more effective reimbursement and payment policies.

1. Designees of the Indiana State Department of Health, Indiana University School of Dentistry, and Indiana Dental Association will meet with representatives from the Office of Medicaid Policy and Planning to encourage utilization of school-based health clinics, private practices, or Community Health Center Dental Clinics to promote the "dental home" model for continuity of care. Discussions will start by ***[insert date or time period]***.

    a. Form an Oral Health Commission to engage the Office of Medicaid Policy and Planning in more effective reimbursement and payment policies to provide more seamless dental care for children.

2. Designees will meet with appropriate program directors to discuss utilization of Medicaid funds for more efficient financing, with emphasis on dental health education and prevention, and based on clinical outcomes. Discussions will start by ***[insert date or time period]***.

    a. Engage in discussions with the Office of Medicaid Policy and Planning and other payers at regular meetings.
    b. Discuss the problems associated with the $600 cap for dental treatment in adults.

Dr. Ganser: Why not use current Oral Health Advisory Workgroup? It does need some leadership and perhaps IDA could take a more active role.
Kent: We have the Dental Advisory Panel. ISDH is not able to do this.

GOAL 12—Provide dental coverage through the Healthy Indiana Plan (HIP).

1. Designees of the Indiana State Department of Health, Indiana University School of Dentistry, and Indiana Dental Association will work with the state to identify funds to provide dental coverage to adults through the Healthy Indiana Plan. This process will start by ***[insert date or time period]***.

    a. Ask State Legislators to add dental care to the Healthy Indiana Plan.

Dr. Ganser: Instead of working to "identify funds", I would suggest giving the reasons why this is important and any cost effectiveness data you can find.

GOAL 13— Establish an oral health surveillance system[3] in Indiana.

1. The Indiana State Department of Health will establish a committee of stakeholders to set up and execute a data system and guide the development of a surveillance system. This process will start by ***[insert date or time period/Kent:*** **February, 2010*]***.

    a. The committee will identify existing and accessible data sources to assess oral health needs; barriers to access care; and the state's resources and capacity to deliver adequate oral health care.
    b. The committee will identify additional data required to quantify, by county, the numbers and groups of people (subpopulations) with unmet dental needs.
    c. The committee will review data, strategic plan, and vulnerable populations at least every 2 years.

Dr. Ganser: This should probably be number 1 goal. Data should be used to identify needs and evaluate if changes are being made by interventions. An oral health "burden" or a more positive name report should be done every two years. ISDH can do this with the help of epidemiologists at IUSD and perhaps Dept of Public Health.

[3] The term 'surveillance system' in this context refers to a system for collecting, analyzing, interpreting and disseminating health data on an ongoing basis.

APPENDIX II

STRATEGIC ORAL HEALTH INITIATIVE (SOHI)

Statewide Planning Council (SPC) Meeting Agenda

Thursday, 1-15-2009, 9 a.m. through 4 p.m.

Pecar Health Center, Indianapolis

Light Continental Breakfast

9:00 Welcome (Dr. Kent Smith and Dean Lawrence Goldblatt)

9:20 Purpose of SPC Meeting (Dr. Eric Wright)

9:45 Key Note Speaker: Dr. Mark Siegal

10:45 Overview – Oral Health in Indiana (Dr. Karen Yoder)

11:15 Lunch Buffet*

11:30 Guest Speaker: Dr. Steven Geiermann

12:15 Strategic Planning (Wendy Frosh)

Five Workgroups

- Workforce and Diversity (Facilitators: Dr. Karen Yoder and Dr. Kent Smith)
- Prevention (Facilitators: Dr. E. Angeles Martinez-Mier and Dr. Armando Soto)
- Finance (Facilitator: Dr. Domenick Zero)
- Safety Net (Facilitators: Dr. Charles Gray and Dr. Jeffrey Platt)
- Data (Facilitator: Dr. Gerardo Maupome)

2:15 Break/Refreshments

2:30 Results from Workgroups

3:30 Wrap-up (Wendy Frosh)

* A “working lunch” is provided.

STRATEGIC ORAL HEALTH INITIATIVE (SOHI)

Statewide Planning Council (SPC) Meeting Agenda

Thursday, 3-19-2009, 9 a.m. through 1 p.m.

IUPUI Campus Center, Indianapolis

9:00 – 9:15	Welcome
9:15 – 9:30	Introduction (Dr. Eric Wright)
9:30 – 10:45	Workgroups – Write Priorities into SMART[1] Goals
	Workforce and Diversity (Dr. Kent Smith)
	Safety Net (Dr. Charles Gray)
	Prevention (Dr. E. Angeles Martinez-Mier)
	Finance (Dr. Domenick Zero)
	Data (Dr. Jeffrey Platt)
10:45 – 11:15	Working Lunch (Dr. Eric Wright) (box lunches will be provided)
11:15 – 12:15	Workgroups – Apply Matrix to Rank Priorities
12:15 – 12:30	Break
12:30 – 1:00	Reporting of Results (individual workgroups)
	Wrap-up (Dr. Eric Wright)

Thank you for your participation. If you have any questions, please contact Marion Greene at 317-261-3029 or msgreene@iupui.edu.

[1] **SMART** goals are **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime-bound.

STRATEGIC ORAL HEALTH INITIATIVE (SOHI)

Statewide Planning Council (SPC) Meeting Agenda

Friday, 5-15-2009, from 12 noon through 4pm

Pecar Health Center

12:00 – 12:15	Welcome
12:15 – 2:00	Discussion of SMART[1] Priorities
2:00 – 2:30	Break/Snacks are provided
2:30 – 4:00	Revision of SMART Priorities

Thank you for your participation. If you have any questions, please contact Marion Greene at 317-261-3029 or msgreene@iupui.edu.

[1] **SMART** goals are **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime-bound.

STRATEGIC ORAL HEALTH INITIATIVE (SOHI)

Statewide Planning Council (SPC) Meeting Agenda

Wednesday, 8-19-2009, from 11am through 1:30pm

IUPUI Campus Center

11:00 - 11:15	Welcome (Dr. Kent Smith)
11:15 - 12:00	Mediterranean Lunch Buffet (Four Course Catering)
12:00 - 1:15	Presentation of Final Oral Health Goals (Dr. Karen Yoder)
1:15 - 1:30	Questions, Comments, and Wrap-up

Thank you for your participation. If you have any questions, please contact Marion Greene at 317-261-3029 or msgreene@iupui.edu. Additional information about SOHI can be found at the Center for Health Policy's website at www.policyinstitute.iu.edu/health/SOHI.

APPENDIX III

SPC Meeting Evaluation 1.15.09

1. Welcome

The Indiana State Department of Health (ISDH) was recently awarded a federal grant from the Health Resources and Services Administration (HRSA). Through this Strategic Oral Health Initiative, ISDH partnered with the IU School of Dentistry and IU Center for Health Policy to develop a strategic plan.

The heart of this effort is the creation of a Statewide Planning Council (SPC) of key stakeholders who will identify priority oral health needs in Indiana.

You have been identified as an SPC participant. If you attended the SPC meeting on Thursday, January 15th, please complete this brief 5- to 10-minute survey. Your feedback is greatly appreciated and will be treated confidentially. Thank you!

2. Survey

Please answer the following questions, regarding the SPC meeting on Thursday, January 15th, 2009.

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
The information provided at the meeting was	◯	◯	◯	◯
The meeting's focus on the most important issues was	◯	◯	◯	◯
The division into workgroups according to 5 topic areas (workforce and diversity; safety net; prevention; finance; and data) was	◯	◯	◯	◯
The opportunities attendees had to provide input were	◯	◯	◯	◯
The openness to ideas participants showed was	◯	◯	◯	◯
The respect and cooperation attendees showed was	◯	◯	◯	◯
The timeliness of the meeting was	◯	◯	◯	◯
The overall quality of the meeting was	◯	◯	◯	◯

SPC Meeting Evaluation 1.15.09

2. Please rate the speakers that presented at the meeting, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
Dr. Mark Siegal, Ohio Department of Health/Bureau of Oral Health Services	◯	◯	◯	◯
Dr. Karen Yoder, Indiana University School of Dentistry	◯	◯	◯	◯
Wendy Frosh, Healthcare Management Strategies	◯	◯	◯	◯

Explain (optional)

3. Please rate the facilitator of the workgroup you participated in, on a scale ranging from 'poor' to 'excellent':

[Only answer this question for the facilitator of your workgroup.]

	Poor	Fair	Good	Excellent
Workforce and Diversity, Dr. Karen Yoder	◯	◯	◯	◯
Workforce and Diversity, Dr. Kent Smith	◯	◯	◯	◯
Safety Net, Dr. Charles Gray	◯	◯	◯	◯
Safety Net, Dr. Jeffrey Platt	◯	◯	◯	◯
Prevention, Dr. E. Angeles Martínez-Mier	◯	◯	◯	◯
Prevention, Dr. Armando Soto	◯	◯	◯	◯
Finance, Dr. Domenick Zero	◯	◯	◯	◯
Data, Dr. Gerardo Maupome	◯	◯	◯	◯

Explain (optional)

4. Based on the discussions you heard and participated in, what are the three most important areas that should be addressed in the new Strategic Plan to improve oral health?

Priority 1

Priority 2

Priority 3

SPC Meeting Evaluation 1.15.09

5. What did you like best about the SPC meeting?

6. What did you like least about the SPC meeting?

7. Do you have any other comments or suggestions?

8. For future planning purposes, in which of the following topics are you most interested? Check all that apply:

- [ ] Workforce and Diversity
- [ ] Safety Net
- [ ] Prevention
- [ ] Finance
- [ ] Data

9. Please provide your contact information (optional):

Name:

Organization:

Email Address:

Thank you for participating in the Statewide Planning Council (SPC) and completing the survey.

If you have any other questions or comments, please contact Marion Greene at msgreene@iupui.edu or 317-261-3029.

SPC MEETING 1/15/2009
EVALUATION RESULTS

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent'

	Poor	Fair	Good	Excellent
The information provided at the meeting was	0.0% (0)	7.5% (3)	62.5% (25)	30.0% (12)
The meeting's focus on the most important issues was	2.5% (1)	10.0% (4)	60.0% (24)	27.5% (11)
The division into workgroups according to 5 topic areas was	2.6% (1)	15.4% (6)	59.0% (23)	23.1% (9)
The opportunities attendees had to provide input were	2.5% (1)	7.5% (3)	42.5% (17)	47.5% (19)
The openness to ideas participants showed was	2.5% (1)	5.0% (2)	57.5% (23)	35.0% (14)
The respect and cooperation attendees showed was	0.0% (0)	5.0% (2)	37.5% (15)	57.5% (23)
The timeliness of the meeting was	0.0% (0)	2.5% (1)	50.0% (20)	47.5% (19)
The overall quality of the meeting was	2.5% (1)	7.5% (3)	55.0% (22)	35.0% (14)

2. Please rate the speakers that presented at the meeting, on a scale ranging from 'poor' to 'excellent'

	Poor	Fair	Good	Excellent
Dr. Mark Siegal	0.0% (0)	5.1% (2)	43.6% (17)	51.3% (20)
Dr. Karen Yoder	0.0% (0)	12.8% (5)	48.7% (19)	38.5% (15)
Wendy Frosh	0.0% (0)	21.6% (8)	48.6% (18)	29.7% (11)

COMMENTS:

A) Wendy Frosh's contribution was not that apparent.
B) When I press on the excellent circle, nothing happens.
C) Could not attend Ms. Frosh's presentation.
D) Seemed Dr. Siegal's presentation highlighted too many of the failures of their strategic plan, than the successes (if there were any).
E) Had to leave and then come back so did not hear Ms. Frosh.
F) I would have like less time on speakers and more time on brainstorming. I felt that we were unable to do justice to this large unmet need. The presentations however were good.

3. Please rate the facilitator of the workgroup you participated in, on a scale ranging from 'poor' to 'excellent': [Only answer this question for the facilitator of your workgroup.]

	Poor	Fair	Good	Excellent
Workforce and Diversity, Dr. Karen Yoder	0.0% (0)	0.0% (0)	40.0% (2)	60.0% (3)
Workforce and Diversity, Dr. Kent Smith	0.0% (0)	20.0% (1)	40.0% (2)	40.0% (2)
Safety Net, Dr. Charles Gray	0.0% (0)	16.7% (1)	50.0% (3)	33.3% (2)
Safety Net, Dr. Jeffrey Platt	0.0% (0)	14.3% (1)	57.1% (4)	28.6% (2)
Prevention, Dr. E. Angeles Martínez-Mier	0.0% (0)	0.0% (0)	83.3% (5)	16.7% (1)
Prevention, Dr. Armando Soto	0.0% (0)	40.0% (2)	40.0% (2)	20.0% (1)
Finance, Dr. Domenick Zero	0.0% (0)	20.0% (1)	60.0% (3)	20.0% (1)
Data, Dr. Gerardo Maupome	0.0% (0)	0.0% (0)	66.7% (4)	33.3% (2)

COMMENTS:

A) I was a facilitator.
B) We had good discussion but we didn't have enough time to thoroughly evaluate the questions and I think it could have been more structured.
C) Slight language barrier. Also did not seem to show much self confidence in his ability to lead or facilitate the group.
D) I was not able to attend the workgroup portion.
E) Left so was not able to be part of the group.
F) I think I rated the right person. The group was safety net. However, it has been too long for me to swear on the name of my facilitator.

4. Based on the discussions you heard and participated in, what are the three most important areas that should be addressed in the new Strategic Plan to improve oral health? [Priorities are listed as written down, including repeats]

PRIORITY 1

Workforce/Diversity (including access to care)

- Distribution of providers, with incentives for underserved areas
- Access/availability
- Workforce diversity (retention & recruitment)
- Workforce and diversity
- Workforce and diversity

- Retention of new dentists in Indiana
- Access to dentists for all children in Indiana
- Increasing access to primary dental care services
- Creative ways to deliver oral health services
- Integrate oral health into primary care
- State recognition and address of problem

Safety Net (including the underserved/special populations)

- Updating and communicating the existing safety net
- Demographics of practitioners in certain parts of Indiana
- Safety net providers for dental services
- Uninsured
- Attention should be paid to the thousands out of work and insurance, potentially once thriving and now struggling
- Improving dentists' activity level RE: Medicaid and underserved
- Oral health for seniors

Prevention (including education and marketing)

- Fluoride water treatments
- Prevention
- Prevention
- Education - help public understand importance of care
- Education
- Marketing oral health issues
- Develop an oral health campaign to increase awareness of its importance
- Public service (health) announcements on oral health issues
- Diet education in collaboration with other parties
- Tobacco issues
- Ideas on how to remove barriers to oral health

Finance

- Reimbursement levels
- Finance management / Medicaid
- Cost
- Financing public oral health care
- Funding/Finance
- Funding of services
- Payment for dental services to low income/uninsured

Data

- Accurate statewide data
- Community evaluations to assess oral health status and gain a better understanding of the current state of our State
- Using existing resources to gather additional data

PRIORITY 2

Workforce/Diversity (including access to care)

- Need more rural providers
- Change practice acts to allow non-dentists to perform more dental functions
- Oral healthcare for those with poor access to care
- Future dental workforce
- Diversity of the oral health workforce
- Dental workforce diversity
- Workforce diversity
- Workforce
- Oral health becoming a major issue within health disparities
- Maximizing scope of practice among all dental professionals
- More focus on getting dental students
- More education and facilities that provide treatment
- Program development
- Education of existing practitioners as to ethical obligation for care
- Create financial incentives to recruit and retain more dental professionals to Indiana
- New modalities of oral health human resources
- Ease of system use for practitioners and patients

Safety Net (including the underserved/special populations)

- Reaching the often forgotten underserved communities e.g. elderly
- Disabled
- Expansion of dental safety net and Medicaid-accepting providers
- Providing care to the under- and uninsured -- safety net
- Safety net

Prevention (including education and marketing)

- Young children cannot be left behind. Young mothers can be educated while they are still expecting, so baby will come into an educated household
- Education / Communication
- Prevention of childhood caries
- Maintenance and expansion of sealant programs
- Preventative services for children
- Pre-natal oral health
- Using existing resources/minimal cost to add educational material

Finance

- Reimbursement at a reasonable level for services
- Adequate financing
- Finance
- Access to primary dental services for all; strategies for financing these services
- Measurement of oral health improvement/dollar spent

- Developing solutions that are "outside the box" I.E. Other avenues of funding
- Funding - address need for more state funding

Data
- [None was mentioned]

PRIORITY 3

Workforce/Diversity (including access to care)
- Access to communities of need
- Access to care for patients
- Facilitating providers for underserved geographical areas
- Appropriate workforce
- Workforce issues
- Building support from the dental community in rural area to aid in oral health assessments and expand services to clients with State funded Dental Ins. programs. Addressing the fact that expanding coverage would increase the need for providers and that incentives would need to be in place for this to succeed.
- Access
- Oral health screening by non-dental personnel early in life
- Broadening the scope of practice of dental hygienists
- Access - where are the true shortage areas
- Use non-traditional venues to recruit more individuals, particularly minorities, into oral health professions
- Allowing anyone to apply varnish for children
- New models to enhance access to care
- Interfacing more with each other as a group to share ideas

Safety Net (including the underserved/special populations)
- Focus on schools to identify students in need and give them resources to refer to
- Oral healthcare for children
- Senior citizens
- Medicaid reimbursement system for AT LEAST the safety nets - Prospective Payment System handicaps safety net providers

Prevention (including education and marketing)
- Expansion of preventative services
- Formulating a campaign to stress the importance of oral health just as it is for smoking or abstinence
- Oral health education
- Oral health education
- Marketing of preventive strategies to the public
- Prevention

- Prevention
- Patient need and prevention

Finance

- Protection of affordable private care
- Finance
- Finance
- Money to be able to help the people and educate them

Data

- Collect and manage oral health data like Ohio does

5. What did you like best about the SPC meeting?
[Comments are listed as written down, including repeats]

- open discussion of some of the issues that cause problems in access to dental care
- Information provided
- Well organized and I felt I was able to add my thoughts freely
- Networking
- Networking
- Networking and sharing of ideas
- Excellent networking opportunity
- Getting stakeholder together to talk and listen
- Multiple stakeholders and perspectives
- A large group with multiple perspectives in the room at the same time
- The diversity of folks involved was refreshing
- Broad spectrum of disciplines involved
- The broad representation
- Large and diverse group of participants
- Very informative and many people involved
- Brain storming with people from different backgrounds
- Great information, great cross-section of participants
- I enjoyed the speakers
- Speakers
- Presentations by guest speakers
- Information presented and dialogue
- Learning about what is done in Ohio. Karen Yoder's data was very compelling
- It was very helpful to have the Dr Siegal explain how Ohio is currently addressing the needs in their State
- The encouragement to share my thoughts and ideas about how I see the oral health situation in my area/community of practice and ways to improve it. The lunch was very nice too
- Everyone genuinely cared

- Coming together to meet a significant need
- The breakout discussion were very good
- The topic
- Effectively gathered a large group of those concerned and knowledgeable re oral health care needs in Indiana
- Ideas, hearing what was already going on as opposed to what needed to be done
- Hearing other's ideas
- Sharing ideas with all of the participants; the whole was far greater than the sum of its parts, which is the best kind of group meeting.
- Laid-back meeting, not stuffy. everyone was very concerned and worried about the future of oral health in Indiana
- Open Forum Discussion was beneficial
- Well organized

6. What did you like least about the SPC meeting?
[Comments are listed as written down, including repeats]

- Nothing that I didn't like
- N/A
- Some of the major barriers to dental care were not addressed
- Setting was not particularly conducive to such a large group
- The seating was an issue for those who sat in the back of the room
- It was hard to hear everyone in the small group environment because of the room
- Very crowded (although that signals outstanding interest)
- Too many folks for meaningful interaction
- Too many people to make participation effective
- To many people for too little time
- the space was too small and did not accommodate the break out groups so that people could hear one another
- Room configuration. Need to have more room for the breakout groups. It got too loud at times as the next group was right beside us
- The facility was somewhat difficult for the breakout groups
- It was hard to get into groups in that space and hear each other
- Lack of space. Round tables for group discussion would have been a good idea, but given the space, difficult
- Almost too many participants. Sometimes easier to accomplish the goal and maintain focus when not so many
- There was a lack of coordination with Wendy regarding the charge of the focus groups
- Would have liked more time to brainstorm and rotate to different groups
- We needed more time for group's discussion
- that we did not have more time to discuss other issues, ideas and solutions
- No one really had a sound understanding of the economics of dental care delivery systems
- Wrap up from the individual groups

- The work groups were not very focused
- Break out groups did not have enough structure to keep them focused
- Not a real clear sense of what this group will do or future role/tasks/needs
- Not sure there was any out of the box thinking that was really happening
- The timeline and presentation of Ohio's program. Good to know examples, but we need to spend more time to develop programs for Indiana
- There were many "editorial" comments by participants who were pushing their own agendas...natural, but still a bit annoying
- Length of time - it was too long
- COLD!!
- The weather
- Too much food. There should be about half that much & more carb-light.
- Day of meeting

7. Do you have any other comments or suggestions?

- I'm glad I was asked to participate in this!
- Great job for first time, look forward to progress being made at future meetings
- Need to address patient education that drives need and financing that allows services to be delivered to all geographical corners of the state
- More structured workgroups and longer break out times for workgroup discussions
- More large-group meetings.
- I'd like to look into different ways to finance services. It just seems that finances can make or break a plan
- RE my #6 comment, this is not something I'd expect project personnel to try to take on alone. It requires a lot of communication and collaboration to jointly identify an agenda that empowers the participants in well-aligned directions. This will require more work in groups to identify, review, reflect on, and then prioritize the initiative's key objectives and measures. Perhaps that is a next meeting topic -- review of possible key objectives and measures
- Linkage with pediatrician to promote early preventive care -- peds could give a dental book as part of their Reach Out and Read program with a referral at one year of age
- I appreciate the opportunity to work with the Center for Health Policy and the council members! It has been terrific. Compliments on this survey, also.
- We need to get more people from the Hispanic community to participate
- Let's do something like this more often as a planning group...otherwise we will lose momentum
- Well planned and organized - Great job!
- Continue the process as indicated
- Have presentations by Indiana practitioners who take Medicaid and/or work in a community health center

8. For future planning purposes, in which of the following topics are you most interested? Check all that apply:

Workforce and Diversity	59.0% (23)
Safety Net	28.2% (11)
Prevention	59.0% (23)
Finance	15.4% (6)
Data	20.5% (8)

SPC Meeting Evaluation 3.19.09

1. Welcome

The Indiana State Department of Health (ISDH) was recently awarded a federal grant from the Health Resources and Services Administration (HRSA). Through this Strategic Oral Health Initiative, ISDH partnered with the IU School of Dentistry and IU Center for Health Policy to develop a strategic plan.

The heart of this effort is the creation of a Statewide Planning Council (SPC) of key stakeholders who will identify priority oral health needs in Indiana.

You have been identified as an SPC participant. If you attended the SPC meeting on Thursday, March 19th, please complete this brief 5- to 10-minute survey. Your feedback is greatly appreciated and will be treated confidentially. Thank you!

2. Survey

Please answer the following questions, regarding the SPC meeting on Thursday, March 19th, 2009.

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
The information provided at the meeting was	◯	◯	◯	◯
The meeting's focus on the most important issues was	◯	◯	◯	◯
The division into workgroups according to 5 topic areas (workforce and diversity; safety net; prevention; finance; and data) was	◯	◯	◯	◯
The opportunities attendees had to provide input were	◯	◯	◯	◯
The openness to ideas participants showed was	◯	◯	◯	◯
The respect and cooperation attendees showed was	◯	◯	◯	◯
The timeliness of the meeting was	◯	◯	◯	◯
The overall quality of the meeting was	◯	◯	◯	◯

SPC Meeting Evaluation 3.19.09

2. Please rate the facilitator of the workgroup you participated in, on a scale ranging from 'poor' to 'excellent':

[Only answer this question for the facilitator of your workgroup.]

	Poor	Fair	Good	Excellent
Workforce and Diversity, Dr. Kent Smith	◯	◯	◯	◯
Safety Net, Dr. Charles Gray	◯	◯	◯	◯
Prevention, Dr. E. Angeles Martínez-Mier	◯	◯	◯	◯
Finance, Dr. Domenick Zero	◯	◯	◯	◯
Data, Dr. Jeffrey Platt	◯	◯	◯	◯

Explain (optional)

3. Based on the discussions you heard and participated in, what are the three most important SMART objectives that should be addressed in the new Strategic Plan to improve oral health?

SMART Objective 1

SMART Objective 2

SMART Objective 3

4. What did you like best about the SPC meeting?

5. What did you like least about the SPC meeting?

6. Do you have any other comments or suggestions?

SPC Meeting Evaluation 3.19.09

7. For future planning purposes, in which of the following topics are you most interested? Check all that apply:

- [ ] Workforce and Diversity
- [ ] Safety Net
- [ ] Prevention
- [ ] Finance
- [ ] Data

8. Please provide your contact information (optional):

Name:

Organization:

Email Address:

Thank you for participating in the Statewide Planning Council (SPC) and completing the survey.

If you have any other questions or comments, please contact Marion Greene at msgreene@iupui.edu or 317-261-3029.

SPC MEETING 3/19/2009
EVALUATION RESULTS

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent'

	Poor	Fair	Good	Excellent
The information provided at the meeting was	0.0% (0)	16.7% (3)	44.4% (8)	38.9% (7)
The meeting's focus on the most important issues was	0.0% (0)	5.6% (1)	66.7% (12)	27.8% (5)
The division into workgroups according to 5 topic areas was	0.0% (0)	5.6% (1)	50.0% (9)	44.4% (8)
The opportunities attendees had to provide input were	0.0% (0)	0.0% (0)	38.9% (7)	61.1% (11)
The openness to ideas participants showed was	0.0% (0)	11.1% (2)	22.2% (4)	66.7% (12)
The respect and cooperation attendees showed was	0.0% (0)	0.0% (0)	33.3% (6)	66.7% (12)
The timeliness of the meeting was	5.6% (1)	5.6% (1)	50.0% (9)	38.9% (7)
The overall quality of the meeting was	0.0% (0)	11.1% (2)	50.0% (9)	38.9% (7)

2. Please rate the facilitator of the workgroup you participated in, on a scale ranging from 'poor' to 'excellent': [Only answer this question for the facilitator of your workgroup.]

	Poor	Fair	Good	Excellent
Workforce and Diversity, Dr. Kent Smith	0.0% (0)	50.0% (1)	0.0% (0)	50.0% (1)
Safety Net, Dr. Charles Gray	0.0% (0)	0.0% (0)	100.0% (5)	0.0% (0)
Prevention, Dr. E. Angeles Martínez-Mier	0.0% (0)	0.0% (0)	60.0% (3)	40.0% (2)
Finance, Dr. Domenick Zero	0.0% (0)	0.0% (0)	50.0% (1)	50.0% (1)
Data, Dr. Jeffrey Platt	0.0% (0)	0.0% (0)	50.0% (1)	50.0% (1)

COMMENTS:

A) He let the group have active exchange of ideas but kept control of the meeting and brought the ideas into focus.
B) Needed more time to gather input.
C) Dr. Zero was an excellent moderator as tough issues were addressed.

D) Dr. Martinez was well versed on the topic of discussion and did an excellent job of conducting the session--allowing time for open exchange but also refocusing the group when needed.

3. Based on the discussions you heard and participated in, what are the three most important SMART objectives that should be addressed in the new Strategic Plan to improve oral health?
[Priorities are listed as written down, including repeats]
SMART Objective 1

Workforce/Diversity (including access to care)

- Access to providers
- Expanding infrastructure of Community Health Dental Clinics, especially in rural and underserved areas

Safety Net

- Accessibility/availability of dental care for uninsured or underinsured
- Provide care for uninsured low income residents suffering acute problems

Prevention

- Obtain funds to assist communities to continue/initiate fluoridation programs
- Maintain funding for current water fluoridation program
- Aiding cities in repairing/maintaining fluoridation
- Fluoridation equipment maintenance
- Water Fluoridation Pumps - Repair/Maintenance
- Mass media public service/health announcement(s) on key issues in oral health
- Education
- Education/Access

Finance

- Finances

Data

- Utilize existing data and gather more specific data to find out why people aren't going to the dentist; education, lack of finance, not a priority, etc...
- Collect the data
- Find Data to show existing needs

SMART Objective 2

Workforce/Diversity (including access to care)

- Incentives for dentists to serve the underserved areas of the state
- Provider incentives
- Rural Access

Safety Net

- Increase number of dedicated, service-driven dentists working in safety net setting

Prevention

- Sustainability of sealant programs
- Continuation/Funding of Seal Programs
- Maintain and expand school based sealant programs
- Support for sealant programs
- Allocating funds to Indiana's fluoridation program
- Educating the population of the importance of oral health and it's relation to systemic health
- Community education about the importance of dental care
- Public service announcements/Pt.& DDS education
- Plan prevention

Finance

- Available funds to get it done

Data

- Gather the Data

SMART Objective 3

Workforce/Diversity (including access to care)

- People that are going to be dedicated
- Educating dental professionals on compassionate care and fear of dental care
- Have diversity/cultural background included in the curriculum of dental professionals

Safety Net

- Geriatric Care Issues
- Support for dental education among the poor

Prevention

- Review of policies to support preventive oriented strategies
- Early childhood/maternal oral health focus
- Educate expectant mothers on caries prevention
- Continue education of politicians and the public on dental health
- Dental Care Education
- Education on oral health care and care coordination for the underserved areas
- Patient and provider education

Finance

- Direct Medicaid to revise coverage for recipients age 19-64
- Expanding coverage of Medicaid to 300 percent above poverty for children and also expanding coverage for adults

Data
- Examine and continue to gather data statewide

4. What did you like best about the SPC meeting?
[Comments are listed as written down, including repeats]

- The diversity of stakeholders within my workgroup
- The diverse occupations of the group
- The 2009 Needs Assessment Report is an excellent resource when writing grant requests!
- The format was good
- Well organized
- I was able to talk and express my opinion regardless of my title or position
- Free exchange of ideas
- Organization and free forum to express ideas
- Open dialogue and collaboration
- The openness to all who wish to participate
- The open discussion between professional who provide care and government employees who administer payment for that care
- Location of meeting was great
- Location and immediate group discussion
- The dialogue and discussion about issues that interested me
- Getting to know other "players'
- The workgroups were much more organized. Points for discussion were well defined
- Small group discussions and the opportunity to be part of something meaningful
- Most people were well intentioned, but just ill informed

5. What did you like least about the SPC meeting?
[Comments are listed as written down, including repeats]
- Not enough time in workgroups
- Not enough time to discuss objectives
- Not enough time to review all group objectives adequately
- Not enough time for thorough discussion of many different good ideas
- We ran out of time
- It was too short. I would have liked more time for each group to present with open forum discussion afterwards
- That we did not spend more time
- Work group reports were too long
- Objectives were not put in the format suggested leaving many of them hanging in the air

- It wasn't immediately clear what exactly was expected of each individual or what the short and long term goals were for the meetings
- The report at the end of the day from the Workforce and Diversity subgroup didn't articulate goals or priorities
- Lack of any science to link oral health spending to oral health improvement
- Not enough water to drink
- The veggie sandwich
- Many people had not been at the first meeting and we had to start from zero...not everyone participates, so at the end you have a very limited group making decisions

6. Do you have any other comments or suggestions?

- It would have been nice to have the objectives summarized and given to each participant at the end of the day. Not sure you had enough time.
- In order to adequately address the Smart objectives and flesh out the ideas, need more time to do so.
- I suggest planning the meetings for at least a whole day
- I think other states are doing similar data driven oral health care studies. Since we are still in the early stages of this process, talking with dental health professionals from other states may expedite the steps necessary to proceed.
- I believe community leaders from underserved and low economic areas should be included at this meeting
- I felt the format was great, the participation was appropriate no negatives about the day.
- Keep up the good work!

7. For future planning purposes, in which of the following topics are you most interested? Check all that apply:

Workforce and Diversity	16.7% (3)
Safety Net	50.0% (9)
Prevention	55.6% (10)
Finance	33.3% (6)
Data	22.2% (4)

SPC Meeting Evaluation 5.15.09

1. Welcome

The Indiana State Department of Health (ISDH) was recently awarded a federal grant from the Health Resources and Services Administration (HRSA). Through this Strategic Oral Health Initiative, ISDH partnered with the IU School of Dentistry and IU Center for Health Policy to develop a strategic plan.

The heart of this effort is the creation of a Statewide Planning Council (SPC) of key stakeholders who will identify priority oral health needs in Indiana.

You have been identified as an SPC participant. If you attended the SPC meeting on Friday, May 15th, please complete this brief 5- to 10-minute survey. Your feedback is greatly appreciated and will be treated confidentially. Thank you!

2. Survey

Please answer the following questions, regarding the SPC meeting on Friday, May 15th, 2009.

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
The information provided at the meeting was	◯	◯	◯	◯
The meeting's focus on the most important issues was	◯	◯	◯	◯
The structure of the meeting (large group discussion on SMART objectives) was	◯	◯	◯	◯
The opportunities attendees had to provide input were	◯	◯	◯	◯
The openness to ideas participants showed was	◯	◯	◯	◯
The respect and cooperation attendees showed was	◯	◯	◯	◯
The timeliness of the meeting was	◯	◯	◯	◯
The overall quality of the meeting was	◯	◯	◯	◯

SPC Meeting Evaluation 5.15.09

2. Please rate your level of agreement with the identified SMART goals.

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Regarding the SMART goals for workforce and diversity, I...	◯	◯	◯	◯	◯
Regarding the SMART goals for safety net, I...	◯	◯	◯	◯	◯
Regarding the SMART goals for prevention, I...	◯	◯	◯	◯	◯
Regarding the SMART goals for finance, I...	◯	◯	◯	◯	◯
Regarding the SMART goals for data, I...	◯	◯	◯	◯	◯

Comments (optional)

3. Please rate the group facilitator, Dr. Eric Wright, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
Dr. Eric Wright	◯	◯	◯	◯

Explain (optional)

4. What did you like best about the SPC meeting?

5. What did you like least about the SPC meeting?

6. Do you have any other comments or suggestions?

7. Please provide your contact information (optional):

Name:

Organization:

Email Address:

Thank you for participating in the Statewide Planning Council (SPC) and completing the survey.

If you have any other questions or comments, please contact Marion Greene at msgreene@iupui.edu or 317-261-3029.

SPC MEETING 5/15/2009
EVALUATION RESULTS

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent'

	Poor	Fair	Good	Excellent
The information provided at the meeting was	0.0% (0)	3.4% (1)	58.6% (17)	37.9% (11)
The meeting's focus on the most important issues was	0.0% (0)	17.2% (5)	37.9% (11)	44.8% (13)
The structure of the meeting (large group discussion on SMART objectives) was	0.0% (0)	10.3% (3)	48.3% (14)	41.4% (12)
The opportunities attendees had to provide input were	0.0% (0)	3.4% (1)	44.8% (13)	51.7% (15)
The openness to ideas participants showed was	0.0% (0)	3.4% (1)	48.3% (14)	48.3% (14)
The respect and cooperation attendees showed was	0.0% (0)	0.0% (0)	58.6% (17)	41.4% (12)
The timeliness of the meeting was	0.0% (0)	6.9% (2)	44.8% (13)	48.3% (14)
The overall quality of the meeting was	0.0% (0)	10.3% (3)	48.3% (14)	41.4% (12)

2. Please rate your level of agreement with the identified SMART goals.

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Regarding SMART goals for workforce and diversity	6.9% (2)	3.4% (1)	58.6% (17)	31.0% (9)	0.0% (0)
Regarding SMART goals for safety net	3.4% (1)	3.4% (1)	55.2% (16)	37.9% (11)	0.0% (0)
Regarding SMART goals for prevention	3.4% (1)	0.0% (0)	51.7% (15)	44.8% (13)	0.0% (0)
Regarding SMART goals for finance	3.4% (1)	3.4% (1)	55.2% (16)	34.5% (10)	3.4% (1)
Regarding SMART goals for data	3.6% (1)	3.6% (1)	53.6% (15)	39.3% (11)	0.0% (0)

COMMENTS:

A) The Stakeholders present represented predominantly public health officials, educators, and social workers. Dentists in private practice provide over 95% of all dental care in Indiana, and I saw only 2 full time private practicing dentists in the group of 30 or 40 people tasked with formulating these goals.

B) Although I strongly agree with the objectives set forth I am not satisfied that they are complete. For instance nothing on agency. Nothing about Strengthening the DDH. I think that office should take the lead on many of these issues, but you cannot do it with one person.
C) With the goals as they will be revised, based on the group's discussion.

3. Please rate the group facilitator, Dr. Eric Wright, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
Dr. Eric Wright	0.0% (0)	3.4% (1)	34.5% (10)	62.1% (18)

COMMENTS:
A) I appreciated him keeping the group focused and on task. He listened to those indifferent fields to get a variety of perspectives, and then took their information back to the goal being discussed. He injected humor, which is always good.
B) Sometimes it was as if the floor took over.
C) Eric did a great job with the group he was working with.
D) He did a great job of staying on task and explaining the process to those not familiar with it. He had patience and did not rush those speaking.
E) I though he did very well in moderating the group and revising the objectives.
F) Dr. Wright did an outstanding job of leading the meeting and keeping everyone focused on the work that needed to be accomplished.

4. What did you like best about the SPC meeting?
[Comments are listed as written down, including repeats]

- The diverse group of participants
- The diversity of those involved
- I think we have a diverse group of oral health care professionals who are truly wanting to serve the needs of the public. I appreciate the open forum, the variety of workers represented, and the overall professionalism of the group.
- Open interaction from many diverse communities
- Discussion from all points of view.
- I found the discussions on the various categories on target. It was good to hear new points of view and to learn about additional resources.
- Getting to know the different people
- Everybody was very congenial and got the work done
- Excellent interactive dialogue, especially with such a large group. Dr. Wright was a wonderful facilitator for this detailed group discussion.
- Discussion of the issues
- Very well organized. Stayed on task. Allowed active participation.
- Organization; knowledge of the group facilitator; group cooperation

- Dr. Eric did not let the audience lose focus of the issue at hand and knew when to cut it off!!!!
- We were on time and on schedule!
- Location was convenient
- The opportunity for group feed back
- The opportunity to be in the group that may be able to make a difference in oral health
- Eye opening to the degree of socialism present in the public health infrastructure.

5. What did you like least about the SPC meeting?
[Comments are listed as written down, including repeats]

- Unfortunately, I was unable to attend earlier meetings and felt somewhat out of the loop. This was not the fault of the SPC meeting...I only wish I could have attend the other meetings.
- Nothing.....everything was great!
- nothing
- Nothing. Nicely run and monitored.
- N/A
- N/A
- Room was freezing and set up made discussion somewhat difficult
- lack of water at beginning
- I did not have lunch before hand and was very hungry by break time. Not sure I understood lunch was not going to be served.
- we should have had an introduction of all the people so we know who was there
- There were spots where it was hard to hear discussion. People needed to be encouraged to speak up &/or the facilitator needed to repeat comments. This was requested at every meeting and it NEVER happened.
- Word smithing at times was too much.
- The participants were getting too much into the details of the goals. At this point in the meetings, I thought the purpose was a high level overview to solidify the goals.
- Lack of any accountability to measure oral health improvement under public funded plans.
- This being the 3rd meeting was the most organized and productive. I am concerned about funding and had hoped to learn more about that.

6. Do you have any other comments or suggestions?

- I appreciated Dr. Wright giving us a timeline with general goals so we know what to expect.
- keep up the good work
- I would suggest decisions about public financing of oral health projects should not be made by individuals who are being paid by these public funds.

- I thought the afternoon was well done and I thank those who planned it. The location was great for me and the available parking was an added plus.
- The food was much appreciated, since many participants travelled a significant distance to attend the meeting.
- I would like a chance to sit back and have a little time to review the objectives.

SPC Meeting Evaluation 8.19.09

1. Welcome

The Indiana State Department of Health (ISDH) was recently awarded a federal grant from the Health Resources and Services Administration (HRSA). Through this Strategic Oral Health Initiative, ISDH partnered with the IU School of Dentistry and IU Center for Health Policy to develop a strategic plan.

The heart of this effort was the creation of a Statewide Planning Council (SPC) of key stakeholders to identify priority oral health needs in Indiana.

You have been identified as an SPC participant. If you attended the SPC meeting on Wednesday, August 19th, please complete this brief 5- to 10-minute survey. Your feedback is greatly appreciated and will be treated confidentially. Thank you!

2. Survey

Please answer the following questions, regarding the SPC meeting on Wednesday, August 19th, 2009.

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
The information provided at the meeting was	◯	◯	◯	◯
The meeting's focus on the most important issues was	◯	◯	◯	◯
The presentation of the final oral health goals was	◯	◯	◯	◯
The respect and cooperation attendees showed was	◯	◯	◯	◯
The timeliness of the meeting was	◯	◯	◯	◯
The overall quality of the meeting was	◯	◯	◯	◯

SPC Meeting Evaluation 8.19.09

2. Please rate your level of agreement with the identified final oral health goals:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents	◯	◯	◯	◯	◯
GOAL 2—Obtain additional DHPSA designations in areas of unmet need	◯	◯	◯	◯	◯
GOAL 3— Increase dental students' involvement in working in underserved areas	◯	◯	◯	◯	◯
GOAL 4—Educate the public and raise awareness of oral health issues	◯	◯	◯	◯	◯
GOAL 5—Assist communities with Water Fluoridation Program	◯	◯	◯	◯	◯
GOAL 6—Increase community-based oral disease prevention programs	◯	◯	◯	◯	◯
GOAL 7—Educate pregnant women on oral health issues and increase their access to oral health care	◯	◯	◯	◯	◯
GOAL 8—Encourage pediatricians and family physicians' medical offices to provide oral screenings and fluoride varnish in children ages 0-3, who do not have a dental home	◯	◯	◯	◯	◯
GOAL 9—Engage the Office of Medicaid Policy and Planning (OMPP) in discussions on dental reimbursement and payment policies	◯	◯	◯	◯	◯
GOAL 10—Educate on the benefits of dental coverage through the Healthy Indiana Plan	◯	◯	◯	◯	◯

SPC Meeting Evaluation 8.19.09

(HIP)

GOAL 11— Establish an oral health surveillance system in Indiana	◯	◯	◯	◯	◯

Comments (optional)

3. Please rate the group facilitator, Dr. Karen Yoder, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
Dr. Karen Yoder	◯	◯	◯	◯

Explain (optional)

4. What did you like best about the SPC meeting?

5. What did you like least about the SPC meeting?

6. Do you have any other comments or suggestions?

7. Please provide your contact information (optional):

Name:

Organization:

Email Address:

Thank you for participating in the Statewide Planning Council (SPC) and completing the survey.

If you have any other questions or comments, please contact Marion Greene at msgreene@iupui.edu or 317-261-3029.

SPC MEETING 8/19/2009
EVALUATION RESULTS

1. Please rate the following statements, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
The information provided at the meeting was	9.1% (1)	9.1% (1)	54.5% (6)	27.3% (3)
The meeting's focus on the most important issues was	9.1% (1)	0.0% (0)	36.4% (4)	54.5% (6)
The presentation of the final health goals was	9.1% (1)	9.1% (1)	45.5% (5)	36.4% (4)
The respect and cooperation attendees showed was	9.1% (1)	0.0% (0)	27.3% (3)	63.6% (7)
The timeliness of the meeting was	0.0% (0)	18.2% (2)	36.4% (4)	45.5% (5)
The overall quality of the meeting was	10.0% (1)	0.0% (0)	60.0% (6)	30.0% (3)

2. Please rate your level of agreement with the identified final oral health goals:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents	9.1% (1)	0.0% (0)	9.1% (1)	81.8% (9)	0.0% (0)
GOAL 2—Obtain additional DHPSA designations in areas of unmet need	9.1% (1)	0.0% (0)	18.2% (2)	72.7% (8)	0.0% (0)
GOAL 3— Increase dental students' involvement in working in underserved areas	9.1% (1)	0.0% (0)	18.2% (2)	72.7% (8)	0.0% (0)
GOAL 4—Educate the public and raise awareness of oral health issues	9.1% (1)	0.0% (0)	18.2% (2)	72.7% (8)	3.4% (1)
GOAL 5—Assist communities with Water Fluoridation Program	9.1% (1)	0.0% (0)	36.4% (4)	54.5% (6)	0.0% (0)
GOAL 6—Increase community-based oral	9.1% (1)	0.0% (0)	9.1% (1)	81.8% (9)	0.0% (0)

disease prevention programs					
GOAL 7—Educate pregnant women on oral health issues and increase their access to oral health care	9.1% (1)	0.0% (0)	9.1% (1)	72.7% (8)	9.1% (1)
GOAL 8—Encourage pediatricians and family physicians' medical offices to provide oral screenings and fluoride varnish in children ages 0-3, who do not have a dental home	9.1% (1)	9.1% (1)	18.2% (2)	63.6% (7)	0.0% (0)
GOAL 9—Engage the Office of Medicaid Policy and Planning (OMPP) in discussions on dental reimbursement and payment policies	9.1% (1)	0.0% (0)	27.3% (3)	63.6% (7)	0.0% (0)
GOAL 10—Educate on the benefits of dental coverage through the Healthy Indiana Plan (HIP)	9.1% (1)	0.0% (0)	27.3% (3)	63.6% (7)	0.0% (0)
GOAL 11— Establish an oral health surveillance system in Indiana	0.0% (0)	0.0% (0)	20.0% (2)	80.0% (8)	0.0% (0)

COMMENTS:

A) For comment A, see pages 4-7.
B) With the net loss of 300+ dentists in Indiana since 1990, and a population growth of .8 million, trying to push 1 year olds into a dental home is taking up resources that would be better served by an older population.

3. Please rate the group facilitator, Dr. Karen Yoder, on a scale ranging from 'poor' to 'excellent':

	Poor	Fair	Good	Excellent
Dr. Karen Yoder	0.0% (0)	9.1% (1)	45.5% (5)	45.5% (5)

COMMENTS:

A) Karen always does an excellent job.
B) Was hard to hear her, not close enough to the mic.
C) Reading the slides became boring. They could have been given or shown during lunch and then discussed after.
D) I didn't like being read to...

4. What did you like best about the SPC meeting?

- Topics
- Presentation and question/answer session.
- Getting to meet some of the other people involved with the project.
- Setting time lines
- Net working
- The conversation at the tables was very interesting.

5. What did you like least about the SPC meeting?

- Some of the small group discussion during the first meeting.
- n/a
- Wish there could have been more discussion on some of the goals. As presented, they are very worthy goals; but implementation of some of them are going to be more difficult. I think most attendees really didn't have to chance to digest the presentation and then ask questions or submit ideas.
- The slide presentation
- Being read to...

6. Do you have any other comments or suggestions?

- I just hope this works!
- Excellent work!
- It would have been nice to have had the presentation first, then lunch, then the question and comments session so that there would have been some time to have read over the final goals and ponder questions.
- It is important that timely follow up information is given to keep those responsible for the Health Goals on track and working to the set timeable.
- The location was great, parking was great and the lunch menu was really great!

Comment for Question #2: Please rate your level of agreement with the identified final oral health goals:

8- 24-09
Dr. Judith A. Ganzer and Members of the Indiana Strategic Oral Health Initiative
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
Re: Strategic Oral Health Initiative

Dear Dr. Ganzer and all that served on the committee:
After attending the Strategic Oral Health presentation on Wednesday August 19, 2009 I feel that I must express my concerns about the exclusion of dental assistants in the final report presented by Dr. Karen Yoder. I was deeply perturbed by the lack of any mention of our participation, since we are an integral part of dental practices. In this letter I will discuss the following topics: my education and employment background, dental assistants' employment in dentistry, the clinical duties that different levels of educated dental assistants have in this state, the changes in the Indiana Dental Practice Act that enlarge the scope of practice for dental assistants, the participation of the Indiana University School of Dentistry's (IUSD) Dental Assisting Program during this process, and last but certainly not least the dental assisting research grant awarded in 2008 to Dr. Joan Kowolik and myself from the American Dental Education Association to research dental assisting students giving oral hygiene instructions to underserved minority, prenatal women. This letter proves to be a little lengthy, but I feel this information is important to be heard before strategic decisions are finalized.
For those of you who do not know me, please let me first elaborate on my background because I think it is important that you know I didn't just arrive on the dental scene last week. I am currently employed as the Director of Dental Assisting at Indiana University School of Dentistry Dental Assisting Program. I am a 30 year veteran of dentistry, beginning my dental career in 1974 as a student in the campus dental assisting program I now direct. I have been employed as a dental assistant, a dental hygienist and an educator and I have worked in the following practice settings: hospital dentistry, specialty dental practices: Periodontics and Pediatric Dentistry, multiple solo general practices, a large group practice, and academia. I began my teaching career in 1989. My credentials include: I am a Certified Dental Assistant, I hold an Expanded Functions Dental Auxiliary Certificate (EFDA), I am a Registered Dental Hygienist with an active Indiana license, I hold a Bachelors Degree in Dental Hygiene Education and a Masters Degree in Social Work.
Dental assistants in the United States have been utilized since 1885. Dr. C. Edmond Kells first employed women in his office so women could come to his office in New Orleans and receive treatment (Bird, D. & Robinson, D., 2009). As you can see dental assistants have been around for a long time and dental assistants are employed all over the world, not just in Indiana. We are an integral part of the dental team (J Am Dent Assoc, Vol 135, No 4, 531; Nash, D., Ruotoistenmäki, .J, Argentieri, A., Barna, S., 2008). As you can see the profession of dental assisting is nothing new.
A literature search or a reading of any of the textbooks in dentistry will show references to the dental team. The list includes: the dentist, dental assistant, dental hygienist and dental laboratory technician. The laboratory technician is not usually employed in the dental practice, but this is

not an unheard of notion. However, I am only going to focus on dental assisting, but I wanted to point out who the team members were for those of you who may not be familiar with this concept.

Dentistry is a team effort and dental assistants are very much a part of this effort. If you have knowledge of dentistry, you already know the important role dental assistants have in patient care. Traditionally we are seen assisting at chairside with the dentist, but we also provide direct services to patients. Graduates of dental assisting programs that are accredited by the American Dental Association's Commission on Dental Accreditation (CODA accredited programs) have a great body of knowledge and clinical skills they take into the dental office. On an entry level basis in a general practice, the direct services we provide for patients are the exposing of and processing of radiographs, taking and then pouring preliminary impressions, fabricating provisional restorations and custom impression trays. Of course assistants also manipulate all of the materials used in dentistry and pass instruments to speed up treatment to reduce stress on the patients and our employers. Dentists delegate many other responsibilities as a new graduate develops new skills.

If an assistant has had the EFDA courses, they will be educated to place all materials inside a prepared tooth during the filling process. Unfortunately during the decay process and the preparation procedures, anatomy of the tooth is lost. During the placement of the filling material, the Expanded Assistant carves the anatomy back into the filling material before the patient is dismissed. EFDA's also place pit and fissure sealants to protect teeth from decay because of very deep occlusal (chewing surface) anatomy.

Our students take this expanded class as an elective in the spring semester and by mid-terms they are in the Comprehensive Clinics placing restorations (fillings) into patients' teeth under the direction of the Pre-Doctoral student and their dental faculty. Expanded Duties Dental Auxiliaries allow the dentist to prepare the tooth and the EFDA takes over from there, allowing the dentist to move on to another patient. EFDAs are employed in 27 states and in all branches of the armed forces (Chaffin, J., Spadaro, S., Pirofsky, T., 2003, http://www.med.navy.mil/sites/navmedmpte/nshs-sd/Pages/ExpandedFunctionsDentalAssistant.aspx , 8-22-09). With the access to care issue and retiring baby boomer dentists in this state, I can't imagine why this was not discussed during the final stages of this document as an important way to increase the number of patients seen per dentist.

As you can see, many more patients can receive the treatment they need when dental assistants are part of the treatment process and soon this is going to expand even further. This legislative year, the Indiana Practice Act was changed to increase the scope of practice for dental assistants. The rule is still being promulgated, but should be finished soon. When the State Board of Dentistry and others are completed with the rule, dental assistants will have an expanded scope of practice to include coronal polishing and fluoride application under the direction of a dentist. Through the hard work of IUSD's Dental Assisting Program faculty member and Director of the Distance Learning Dental Assisting Program Professor Patricia Capps, the lecture and lab materials have been developed for clinical assistants to take and be prepared to provide these new services to patients. IUSD's Continuing Education Department will offer these courses soon after the rule is completed.

Without dental assistants to keep the offices running, much less dentistry would be provided by the dentist. If our employers had to do everything in the office their production would plummet! Just answering the phone alone could cause doctors to have difficulty getting treatment

completed. Let alone if they had to set up and tear down operatories before and after treatment, disinfect all materials and equipment that could not be sterilized, clean, package and sterilize instruments and monitor sterilizers effectiveness and restock sterilized instruments or take and process all of their own radiographs as well as check all of the hygiene patients.

I have not gone into all of the functions and duties possible that dental assistants perform as part of their employment as they also work in the business office, they are employed to manage dental offices and complete lab work. With a profession that is so important to the treatment of patients and the running of dental offices, how could we have possibly been left out of this important report?

You might think that dental assisting had no representatives at the meetings but that is not the case. Patricia Capps and I began attending these meetings in October of 2007. We attended most if not all of the early meetings and we have also attended the most recent meetings that began this year in January 2009. Early on, we shared information about the curriculum that dental assisting students take so that informed decisions could be made about greater utilization of dental assistants. We shared information about the health disparities in this state and the importance of trying to contact the underserved patients. Late last fall our Administrative Assistant participated in this process by digging through old student files to gather the statistics on the diversity of our graduates.

The next important topic is the research grant for dental assistants; this grant is funded by the American Dental Education Association (ADEA) which awarded almost $9,000.00 in 2008 for this project. ADEA is the professional association for all dental educators. The grant supplies funding for dental assisting students to go into the community to provide oral hygiene instructions to underserved minority prenatal women. We have been partnering with medical facilities in order to connect with the women prior to their medical appointments. This research grant is researching whether the dental assisting educational process has any effect on how the students feel about service learning and working with underserved minority populations. Dr. Joan Kowolik is the Principal Investigator, and I am the Co-investigator on this project. We are well aware of the dental health disparities and there are many populations that could use the information that our students learn while in our program. We recognize the knowledge base that the dental assisting students develop while they are in school and we are partnering with organizations where the information can be shared and have the most impact.

At the January 2009 meeting Dr. Kent Smith said something to the effect that it was important to encourage career dentists and dental hygienists. I also believe that it is very important to encourage career dental assistants! There are many dental assistants that are career dental assistants so this is not a new idea either. The Indiana Dental Assistants Association membership is made up of career dental assistants. I truly think it is important that we encourage as many people as we can to enter dentistry at whatever level their education is appropriate. Indiana needs to increase their dental workforce and the diversity of their workforce. The patient populations we provide treatment to are more diverse than ever and will continue to change. Our professions need graduates that reflect the same racial and ethnic proportions as we have in the resident populations of Indiana. Not only do we need to recruit these diverse students, but we must work to maintain them in our ranks if we are going to adequately be able to provide the culturally competent care that all patients deserve. In order to achieve this challenge, we will need to develop a culture of openness, respect for each other, inclusiveness and a feeling of being valued and appreciated (Lee, B. 1999, Anderson, K., McLaughlin, G., Smith, C. 2007).

When you spell the word team… T.E. A. M. there is no "I" or "ME" in the word. Because a team is a group effort. When we all work together … Together Everyone Achieves More and the residents of Indiana – our patients are the winners.
I welcome written comments by snail mail or e-mail.
Sincerely,
Pamela Ford, CDA, EFDA, RDH, BS, MSW
Indiana University School of Dentistry Dental Assisting Program
1121 West Michigan Street – DS 430
Indianapolis, Indiana 46202
ptavenne@iupui.edu
CC:
Dr. Larry Goldblatt
Dr. Jeffrey Dean
Dr. Vanchit John
Indiana Dental Assisting Educators Association
Indiana Dental Assisting Association - Officers

APPENDIX IV

SPC Satisfaction Survey

1. Welcome

The Indiana State Department of Health (ISDH) was recently awarded a federal grant from the Health Resources and Services Administration (HRSA). Through this Strategic Oral Health Initiative, ISDH partnered with the IU School of Dentistry and IU Center for Health Policy to develop a strategic plan.

The heart of this effort was the creation of a Statewide Planning Council (SPC) of key stakeholders to identify priority oral health needs in Indiana.

You have been identified as an SPC participant. Please complete this brief 5- to 10-minute survey. Your feedback is greatly appreciated and will be treated confidentially. Thank you!

2. Survey

Please answer the following questions, regarding the Statewide Planning Council (SPC), the strategic planning process, and the final oral health goals.

1. Regarding your participation in the SPC, please check all that apply:
I attended the meeting(s) on

- ☐ January 15, 2009
- ☐ March 19, 2009
- ☐ May 15, 2009
- ☐ August 19, 2009
- ☐ I did not participate in any of the meetings

2. How satisfied were you with the community-participatory process, i.e., having a group of key stakeholders from different agencies, organizations, and professional areas come together to identify oral health needs and discuss the most important oral health goals?

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
My level of satisfaction with the process is	◯	◯	◯	◯	◯

Comments (optional)

SPC Satisfaction Survey

3. How satisfied were you with the opportunities given to provide input in the development of the plan and the respect shown to particpants?

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
The opportunities participants had to provide input	◯	◯	◯	◯	◯
The openess to ideas/input of participants	◯	◯	◯	◯	◯
The respect and cooperation given to particpants	◯	◯	◯	◯	◯

Comments (optional)

4. How did you provide input? Check all that apply:

- ☐ I attended at least one of the SPC meetings
- ☐ I attended at least one of the focus groups (Evansville, New Albany, Gary, Fort Wayne, Indianapolis)
- ☐ I sent input via email
- ☐ I did not provide any input
- ☐ Other (please explain)

Comments (optional)

5. Have you read the final oral health goals / strategic oral health draft?

- ◯ Yes
- ◯ No

SPC Satisfaction Survey

6. Please rate your level of agreement with the identified final oral health goals:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents	◯	◯	◯	◯	◯
GOAL 2—Obtain additional DHPSA designations in areas of unmet need	◯	◯	◯	◯	◯
GOAL 3— Increase dental students' involvement in working in underserved areas	◯	◯	◯	◯	◯
GOAL 4—Educate the public and raise awareness of oral health issues	◯	◯	◯	◯	◯
GOAL 5—Assist communities with Water Fluoridation Program	◯	◯	◯	◯	◯
GOAL 6—Increase community-based oral disease prevention programs	◯	◯	◯	◯	◯
GOAL 7—Educate pregnant women on oral health issues and increase their access to oral health care	◯	◯	◯	◯	◯
GOAL 8—Encourage pediatricians and family physicians' medical offices to provide oral screenings and counseling for children ages 0-3, who do not have a dental home, and fluoride varnish for those at high-caries risk.	◯	◯	◯	◯	◯
GOAL 9—Engage the Office of Medicaid Policy and Planning (OMPP) in discussions on dental reimbursement and payment policies	◯	◯	◯	◯	◯
GOAL 10—Educate on the benefits of dental	◯	◯	◯	◯	◯

coverage through the Healthy Indiana Plan (HIP)					
GOAL 11— Establish an oral health surveillance system in Indiana	◯	◯	◯	◯	◯

Comments (optional)

7. Do you have any other comments or suggestions?

8. Are you interested in becoming a member of the Oral Health Task Force (OHTF), and want to participate in the implementation of the final oral health goals?

- ◯ I am already a member of the OHTF
- ◯ Yes, I am interested in becoming a member of the OHTF
- ◯ No, I am not interested in becoming a member of the OHTF
- ◯ I don't know yet

9. If you want to participate in the OHTF and have not signed up previously, please provide your contact information:

Name:

Organization:

Email Address:

Phone Number:

Thank you for participating in the Statewide Planning Council (SPC) and completing the survey.

If you have any other questions or comments, please contact Marion Greene at msgreene@iupui.edu or 317-261-3029.

SPC SATISFACTION SURVEY RESULTS

TOTAL SURVEY RESPONSES: 51

1. Regarding your participation in the SPC, please check all that apply: I attended the meeting(s) on

January 15, 2009	--	51.0% (26)
March 19, 2009	--	47.1% (24)
May 15, 2009	--	56.9% (29)
August 19, 2009	--	41.2% (21)
I did not participate in any of the meetings	--	17.6% (9)

2. How satisfied were you with the community-participatory process, i.e., having a group of key stakeholders from different agencies, organizations, and professional areas come together to identify oral health needs and discuss the most important oral health goals?

Very dissatisfied	--	2.0% (1)
Dissatisfied	--	2.0% (1)
Neutral	--	7.8% (4)
Satisfied	--	56.9% (29)
Very satisfied	--	31.4% (16)

COMMENTS:

A) I didn't feel there were many members of the profession represented at the meeting.
B) Structure of subcommittees did not allow for input of all the participants in some key issues.
C) How were the key stakeholders of the SPC selected?
D) The forum was obviously centered around Dentists but it would have been helpful to have more social service agencies lead in the discussions as well as the topic related to the populations they serve and their goals around dental/oral health.
E) I attended a focus group at IUS in New Albany on 6/18/09.
F) Out of 30-40 participants I counted 4 or less full time practicing dentists.

3. How satisfied were you with the opportunities given to provide input in the development of the plan and the respect shown to participants?

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
The opportunities participants had to provide input	2.1% (1)	2.1% (1)	8.3% (4)	47.9% (23)	39.6% (19)
The openness to ideas/input of participants	2.2% (1)	4.3% (2)	6.5% (3)	45.7% (21)	41.3% (19)
The respect and cooperation given to participants	2.1% (1)	2.1% (1)	4.3% (2)	42.6% (20)	48.9% (23)

COMMENTS:

A) I feel bad my schedule did not permit attendance at more than the first meeting...great process however well organized.
B) Even though several of us presented information to involve dental assistants in the process, dental assistants are not even mentioned.
C) I worked in the technology group, and our facilitator was excellent.

4. How did you provide input? Check all that apply:

I attended at least one of the SPC meetings	76.0% (38)
I attended at least one of the focus groups (Evansville, New Albany, Gary, Fort Wayne, Indianapolis)	36.0% (18)
I sent input via email	26.0% (13)
I did not provide any input	6.0% (3)
Other (please explain)	2.0% (1)

COMMENTS:

A) I expressed interest due to a movement in our County to establish a clinic or program for the uninsured. The SPC focus group meetings were not convenient to attendance from our area.

5. Have you read the final oral health goals / strategic oral health draft?

Yes -- 100.0% (50)
No -- 0.0% (0)

6. Please rate your level of agreement with the identified final oral health goals:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
GOAL 1—Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents	4.0% (2)	2.0% (1)	4.0% (2)	30.0% (15)	60.0% (30)
GOAL 2—Obtain additional DHPSA designations in areas of unmet need	4.0% (2)	2.0% (1)	4.0% (2)	34.0% (17)	56.0% (28)
GOAL 3— Increase dental students' involvement in working in underserved areas	4.0% (2)	0.0% (0)	2.0% (1)	34.0% (17)	60.0% (30)
GOAL 4—Educate the public and raise awareness of oral health issues	2.0% (1)	2.0% (1)	2.0% (1)	34.0% (17)	60.0% (30)
GOAL 5—Assist communities with Water Fluoridation Program	2.0% (1)	2.0% (1)	10.0% (5)	38.0% (19)	48.0% (24)
GOAL 6—Increase community-based oral disease prevention programs	2.0% (1)	2.0% (1)	6.1% (3)	34.7% (17)	55.1% (27)
GOAL 7—Educate pregnant women on oral health issues and increase their access to oral health care	2.0% (1)	2.0% (1)	4.0% (2)	26.0% (13)	66.0% (33)
GOAL 8—Encourage pediatricians and family physicians' medical offices to provide oral screenings and counseling for children ages 0-3, who do not have a dental home, and fluoride varnish for those at high-caries risk.	4.0% (2)	8.0% (4)	10.0% (5)	24.0% (12)	54.0% (27)
GOAL 9—Engage the Office of Medicaid Policy and Planning (OMPP) in discussions on dental	2.0% (1)	2.0% (1)	8.0% (4)	24.0% (12)	64.0% (32)

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
reimbursement and payment policies					
GOAL 10—Educate on the benefits of dental coverage through the Healthy Indiana Plan (HIP)	4.0% (2)	2.0% (1)	4.0% (2)	32.0% (16)	58.0% (29)
GOAL 11— Establish an oral health surveillance system in Indiana	2.0% (1)	4.0% (2)	8.0% (4)	28.0% (14)	58.0% (29)

COMMENTS:

A) IDA has a prenatal program that they are rolling out statewide. Maryland has introduced an interesting way to allow dental students to work in underserved areas. Also the IDA had loan forgiveness program to help induce recent grads to practice in underserved areas.
B) Assist communities with moving forward with these goals.
C) All doable - yet incredibly lofty - goals! We can do this; it will take all of us to succeed.
D) I wasn't involved in the discussions where I've checked 'agree'.

7. Do you have any other comments or suggestions?

- No
- No
- Not at this time
- Establish an Oral Health Task Force in the Counties to access dental care needs.
- This is a good start. The well founded science into the link between what dentistry can do for overall physical health and well being goes way far beyond what we discussed. The state would be money ahead to look into these options in the future. Even organized dentistry is in the dark ages regarding implementation of these issues. Dentistry has a long history of providing appropriate, cost effective care for patients.
- IMHC is interested and will assign a staff member to participate.
- Look forward to the implementation of the Plan. It will not be easy. There must be more resources provided to the Division of Oral Health if this is to happen.

8. Are you interested in becoming a member of the Oral Health Task Force (OHTF), and want to participate in the implementation of the final oral health goals?

I am already a member of the OHTF	32.0% (16)
Yes, I am interested in becoming a member of the OHTF	30.0% (15)
No, I am not interested in becoming a member of the OHTF	14.0% (7)
I don't know yet	24.0% (12)

APPENDIX V

INDIANA
CENTER FOR HEALTH POLICY
RESEARCH FOR A HEALTHIER INDIANA
MAY 2009

Oral Health Needs in Indiana:
Developing an Effective and Diverse Workforce

Oral health is an integral part of overall health and wellbeing. Damage to oral structures can result in poor nutrition due to eating difficulties or pain, limitations in speech that affect learning and academic achievement, lowered self-esteem, and decreased social interaction. Every day, millions of children and adults in the United States suffer the burden of oral diseases that significantly affect their quality of life. They may not be aware that oral health is essential to general health, or that oral diseases can be prevented or controlled. Also, they may know these facts but are not able to access needed services. Cavities are not a rite of passage of childhood, and tooth loss and gum disease don't have to be inevitable results of aging.

The two most common oral diseases are dental caries (cavities) and periodontal disease (gum disease). According to the Centers for Disease Control and Prevention, about 78 percent of Americans have had at least one cavity by age 17.[1] Periodontal disease typically affects adults. The National Institute of Dental and Craniofacial Research estimates that 80 percent of American adults currently have some form of the disease.[2] Both dental caries and periodontal disease are infectious diseases that require treatment by dental professionals. To prevent them, continuous monitoring and maintenance is required. Other oral conditions such as cleft lip and palate, oral cancer, and reduced salivary flow can also be prevented or treated.

Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable. Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems. Individuals who are medically compromised or who have disabilities are at greater risk for oral diseases, and, in turn, oral diseases further jeopardize their health.

(Oral Health in America: A Report of the Surgeon General[5])

A Public Health Approach

The oral health of children is a special concern. Extensive tooth decay causes difficulty eating and talking, and inhibition of normal growth. Poor oral health often continues and worsens in adulthood and affects economic productivity and quality of life.[3,4] While growing up, the most common chronic disease that a child will encounter is dental caries, as it is five times more common than asthma and seven times more common than hay fever. Caries is also the most prevalent unmet health need for U.S. children.[3,5] The prevalence of early childhood caries is particularly high among some racial and ethnic minorities and low socioeconomic groups. According to the Department of Health and Human Services, the distribution of dental decay is such that 80 percent of caries in permanent teeth are concentrated in 25 percent of the most vulnerable children and adolescents.[6] Children who are poor, belong to a minority group, or have special needs have higher rates of dental decay, more severe destruction of the affected teeth, higher rates of untreated disease and higher frequency of dental pain than the rest of children.[4]

The oral health of the U.S. population has improved in recent decades due to fluoridation of public water supplies, knowledge about causative agents and risk factors for oral disease, and the development of effective and safe treatment and prevention measures. However, oral diseases continue to affect millions of people in the United States, and, while they can afflict anybody, they disproportionally affect vulnerable population groups, such as racial and ethnic minorities, children (especially those with special needs), low-income citizens, and rural or geographically isolated populations. The Surgeon General's report on oral health in America highlights the disparities in distribution of oral diseases and access to care. The report lists lack of access to care as a major barrier to achieving or maintaining oral health. This lack of access may be due to limited income, lack of insurance, transportation issues, or the flexibility to take time off from work.[5] The Department of Health and Human Services developed a data-driven comprehensive set of disease prevention and health promotion objectives for the United States. These national health objectives, as published in *Healthy People 2010*, were designed to identify the most significant preventable threats to our health and to establish national goals to reduce those threats.

The publication addresses 28 public health areas with specific goals and targets to aim for by the year 2010. Oral health is one of the focus areas with the overarching goal to prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.[6]

Oral Health Epidemiology in Indiana

Although there is a lack of a formal and continuous surveillance system on oral health in Indiana, some state-level information is available from the Behavioral Risk Factor Surveillance System (BRFSS), a random telephone survey of state residents age 18 and older in households with a telephone. The BRFSS, established in 1984 by the Centers for Disease Control and Prevention (CDC), is a state-based monitoring system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Results from the survey give us a glimpse of the nation's oral health status and allow us to compare Indiana with other states as well as the entire nation.[7] The most recent BRFSS oral health results available for Indiana are from 2006, and include information on three items: visits to the dentist, prevalence of tooth extractions, and prevalence of extraction of all natural teeth.

In 2006, 68 percent of adults in Indiana visited the dentist or dental clinic for any reason within the past year. Indiana's prevalence rate for past-year dental visits has remained stable from 1999 through 2006, but lies below the U.S. median of 70 percent (see Figure 1).[7]

The elderly, minorities, and low income citizens often face the unfortunate need to have some or all of their teeth extracted. After teeth are extracted, more complicated and expensive dental treatment will be needed to restore oral function. It is clear that, as life expectancy for adults continues to increase, there is an urgent need to increase the life expectancy of the natural dentition, too. This is especially important in population subgroups that have limited resources available to afford further or more complex dental treatments.

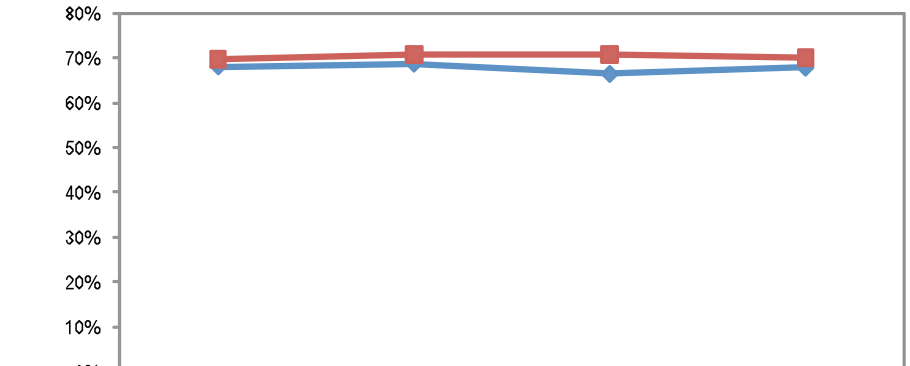
Results from the 2006 BRFSS also indicated that 47 percent of Hoosiers ages 18 and older have had permanent teeth extracted—a percentage that was significantly higher than the national median of 44 percent (see Figure 2). Groups with the highest prevalence of tooth extractions included blacks; individuals with an annual household income of less than $35,000; and individuals with lower educational attainment. Prevalence of extractions was highly associated with age – as age increased so did the percentage of Hoosiers who reported having had any permanent teeth extracted.[7]

Additionally, the survey reported that about one-fifth of Hoosiers 65 years and older had all their natural teeth extracted, a significant decrease from the 37 percent reported in 1999. The current prevalence rates for Indiana and the United States (19.3 percent) are statistically the same. Indiana's elderly that were mostly affected included individuals with an annual household income of less than $15,000 and Hoosiers with lower educational attainment.[7]

Another item that is recorded by the BRFSS is tobacco use. Tobacco products contain a variety of toxins that have been associated with cancers of the mouth, lip, tongue, and larynx (voice box); periodontal disease; and other oral health related conditions.[8] Adult smoking prevalence has been consistently higher in Indiana than the rest of the nation for at least the past nine years. In 2007, almost one-fourth of Hoosiers (24.1 percent) reported past-month cigarette use, compared to one-fifth of U.S. residents (19.8 percent). The prevalence for every-day smoking was also significantly higher in Indiana (18.2 percent) than the rest of the country (14.5 percent); although rates decreased among Hoosiers from 22.5 percent in 1999, to 18.2 percent in 2007.[7]

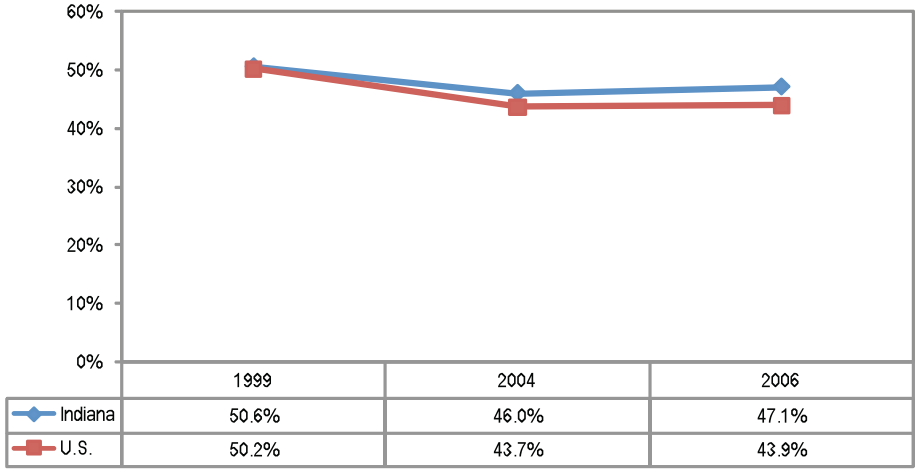
As part of the Federal Balanced Budget Act of 1997, Congress created the Children's Health Insurance Program (CHIP) as a way to encourage states to provide health insurance to uninsured children. Indiana's CHIP (formerly known as SCHIP), a part of Hoosier Healthwise, provides health

Figure 1: Percentage of Indiana and U.S. Population that Visited the Dentist or Dental Clinic within the Past Year for Any Reason (Behavioral Risk Factor Surveillance System, 1999 – 2006)



	1999	2002	2004	2006
Indiana	68.3%	68.9%	66.6%	68.0%
U.S.	69.8%	70.9%	70.8%	70.3%

Figure 2: Prevalence Rates of Indiana and U.S. Adults That Have Had Any Permanent Teeth Extracted (Behavioral Risk Factor Surveillance System, 1999 – 2006)



	1999	2004	2006
Indiana	50.6%	46.0%	47.1%
U.S.	50.2%	43.7%	43.9%

insurance for children in families with household incomes above the threshold for Medicaid eligibility. Based on the 2007 annual report, a total of 70,655 children were enrolled in Indiana's CHIP program (51,957 in CHIP A and 18,698 in CHIP C). Of these, 16 percent were ages 1 through 5, 50 percent were ages 6 through 12, and 34 percent were ages 13 through 18. Seventy percent of CHIP members visited a dentist for a preventive appointment in 2007. Utilization of preventive dental services was similar by race and ethnicity in Indiana, although utilization rates for Hoosier children on CHIP were lower compared to national rates.[9] It is imperative to investigate why not more low-income Indiana children take advantage of these preventive dental services.

[CHIP A is the no-premium component of CHIP which covers children in families with incomes up to 150% of the federal poverty level, FPL ($25,755 per year for a family of three in 2007) who are not already eligible for Medicaid.

CHIP C is the State-designed portion which covers children in families with incomes above 150% up to 250% of the FPL ($42,925 per year for a family of three in 2007) and requires premiums based on a sliding scale of income.[9]]

Populations Most Vulnerable to Untreated Oral Disease

The most vulnerable group of Hoosiers is the uninsured. It has been reported that the number of Americans without dental insurance is three times higher than the number of people without medical coverage.[10] Even though Indiana's rates of the uninsured have been consistently lower than the national rates from 2003 to 2007, and the percentage of Hoosiers without insurance decreased in that time period (from 13.9 percent to 11.4 percent), it is important to note that in 2007, there were still over 0.7 million people under 65 who had no insurance coverage at any time, 83,000 of whom were under the age of 18.[11] The number of people without dental insurance is certainly higher.

Hoosiers that are on Medicaid are another vulnerable group, since coverage of dental services in Indiana is limited to $600 per recipient per year.[12] In 2007, a total of 732,000 Hoosiers were covered by Medicaid, representing 11.7 percent of the population. In regard to race, 444,000 were identified as white; 191,000 as black; 76,000 were Hispanic; 2,000 were American Indian or Alaska native; 2,000 were Asian; and 18,000 belonged to two or more races. The biggest age group covered by Medicaid were children ages 0 to 17 years (466,000); followed by adults ages 18 to 64 (235,000); and adults ages 65 and above (31,000).[11]

Children are particularly vulnerable when families face difficulties in affording medical and dental care. Some of the gaps in insurance coverage have widened in recent years, especially among minority children, and will become even more extensive based on current demographic trends. It has been predicted that the numbers of low-income, minority, and immigrant children will rise more rapidly than the general population of U.S. children.[13] Latinos, for example, constitute the largest and fastest-growing minority in the United States. This population has grown exponentially in recent years, to the point where they constituted 15 percent of the total U.S. population, and almost 5 percent of Indiana's population in 2007.[14] One astonishing fact is that half of the U.S. Latino population is younger than 27 years old, and 20 percent of all U.S. children younger than 5 are Hispanic.[15]

Undocumented immigrant children, who are predominantly Latino,[16] face some of the highest obstacles to obtaining medical and dental care. Not only do they come from very low income families who lack employer-sponsored health coverage, but also, federal law limits eligibility for federally funded health benefits to qualified immigrants with permanent legal residency. In Indiana, undocumented immigrant children qualify only for emergency medical and dental services, and are ineligible for full coverage through Hoosier Healthwise.[17]

The elderly are also a vulnerable group in view of the fact that they suffer from considerable oral disease (gum disease, oral and pharyngeal cancer, dry mouth), cumulative dental problems, decreased income and difficulties accessing dental providers. As a population, it has been reported that people over 65 make up a higher percentage of patients in private dental practices than expected from their representation in the U.S.

population.[18] Medicare does not cover routine dental care or most dental procedures, so that payment for dental services will be out-of-pocket, if they visit the dentist at all.[19]

Populations living in rural areas are also more prone to suffer from untreated oral disease. There are fewer providers in these areas, as the majority of dentists locate their practices in metropolitan areas with populations greater than 100,000.[20] Dental practitioners in rural areas may be overburdened or may only accept patients with dental insurance. Indiana has 50 percent of its counties officially designated as rural.[21] As of 2008, it was estimated that the population for rural Indiana was 1,387,419, or 22 percent of the total population.[22]

Critical Issues and Challenges

To analyze issues of demand and access to dental services, one has to consider the size, distribution and diversity of Indiana's dental workforce and their typical patient pool. The population and, therefore, the need for dental services continue to grow. Demand for services may also rise because of increased popularity of procedures such as dental implants and cosmetic dentistry, and because people are living longer and conserving their teeth longer. However, populations experiencing the most growth are the elderly and young minorities, for whom it is hard to afford even simple dental procedures or preventive services. Another population group that is becoming larger in the current economic climate is the uninsured. Is Indiana prepared for the increased need of dental services by vulnerable populations; and is the Hoosier workforce well distributed geographically, and adequate in number and diversity to treat its increasing population? Available data indicate that this is not the case.

Access to dental care depends heavily on available workforce. The Indiana University School of Dentistry (IUSD) is the only school in the state that educates and trains future dentists. There are also several ADA-accredited institutions that train health professionals in dental hygiene and dental assisting. The availability of dental health professionals in Indiana relies on how many of them establish a practice in the state. According to the American Dental Association (ADA), almost 180,000 dentists were professionally active nationwide, and 1.7 percent of them practiced in Indiana, in 2006.[23] It was reported that about 70 percent of the 498 dentists that graduated from IUSD between 1994 and 1999 remained in Indiana.[21] Between 2000 and 2007, a total of 755 dentists graduated from IUSD,[24] but no data are available about how many of them have remained in the state.

Indiana's ratio of dentist-to-population is low, and it has become progressively worse over the past 17 years. As the population of the state has increased, the number of dentists has decreased. In 1990, Indiana's population was over 5.5 million with almost 3,600 licensed dentists in the state, for a dentist-to-population ratio of 1 to 1,541.[21] In 2007, almost 3,300 dentists practiced in Indiana, serving a population of 6.3 million Hoosiers.[25] This represents a dentist-to-population ratio of 1 to 1:1,923. In other words, the number of active dentists in Indiana decreased from 1990 to 2007 by almost 300, while the population increased by over 0.8 million. It is also important to note that the dentist-to-population ratios vary considerably from one Indiana county to another. For example, in 2007, Newton County had one dentist per 14,014 residents, while Hamilton County had one dentist per 931 residents.[25]

The shift in ratios may be due to a combination of factors, including the continuous increase of the population; a greater number of dentists retiring; and migration of established dentists and recent graduates to other states. Declining dentist numbers are an undeniable problem, but it has been suggested that an increase in numbers of dental health professionals may not be enough to address the challenges that Hoosiers face in accessing oral health care. One of the problems may also be that of a disconnect between the traditional dental practice model, the patterns of disease, and the population that needs care the most.[18] Many dentists do not accept Medicaid patients or limit the number of Medicaid patients they see. This leaves a large part of Indiana's population without dental services.

In 2006, a total of 3,661 dental hygienists were registered in Indiana, for a hygienist-to-population ratio of 1 to 1,722. Again, ratios differed substantially at the community level, ranging from 1 to 923 in Hamilton County to 1 to 10,892 in Crawford County.[21] Even though the ratios were low in many counties, a positive development has been the steady increase in the dental hygienist population over recent years. They constitute a segment of the dental workforce that could help bridge the gaps in access to dental care, if their scope of practice were to be expanded (as has been done in some states and is being considered in others). In Indiana, dental hygienists require direct supervision from a dentist in dental offices, long-term facilities, state institutional facilities, state/federal funded community centers, and depending on their function, in school-system settings.[26]

The Indiana State Board of Dentistry (ISBD) recently released a proposed draft of rules that will change the scope of practice for dental hygienists by allowing prescriptive supervision of hygienists who practice in public health settings. The new rule draft is the result of House Enrolled Act (HEA) 1172-2008, a bill advocated jointly by the Indiana Dental Association and Indiana Dental Hygienists' Association, and passed by the Indiana General Assembly during the 2008 legislative session. The process is expected to be completed by the end of summer 2009. [27]

Historically, racial and ethnic minorities, and the poor have encountered many barriers to accessing dental services. However, in the current economic climate, more people will likely face these troubles as they drop or lose their dental insurance. More people

will not be able to afford dental treatment, putting into question the traditional dental practice model of fee-for-service treatment of insured patients, with lack of alternatives in the delivery or financing of care. Even when people are covered by Medicaid, they may not fare better. Several reasons have been identified to explain the underutilization of dental services offered through Medicaid. The U.S. General Accounting Office reported that the main reason dentists cited for not treating more Medicaid patients was low payment rates. Other reasons included Medicaid administrative requirements (difficulties with handling claims, burdensome pre-authorization requirements, complicated enrollment and eligibility verification process, complicated rules, slow payments) and patient issues (frequently missed appointments that result in loss of time and income, patients who lack awareness of the importance of oral health or lack information about dental benefits).[28] Another issue to consider is that state Medicaid programs do not adjust reimbursement rates on a regular basis, while dentistry experiences increases in production costs—a reported 40 percent from 1993 to 2000.[29] In Indiana, changes in administration of the dental Medicaid program and an increase in fees resulted in improved dentist participation and more use of services in children. However, three-fourths of dentists in Indiana did not participate in the Medicaid program, or provided services to less than 10 Medicaid–enrolled children in 2000.[30]

Workforce issues are compounded by two additional problems: the provider workforce does not mirror the population, and there is a geographic maldistribution of dentists. U.S. dentists tend to be middle-aged, male, and non-Hispanic white. In 2006, the average age of all professionally active dentists in the nation was 49.4 years, and over 80 percent of them were male.[18,23] However, the trend seems to be changing. Among the new professionally active dentists, i.e., those who graduated from dental school in 1997 or later, the percentage of females was higher (36 percent).[23] A major component in the underuse of available dental services may be the culture gap between dentists and patients from varying social and ethnic groups. Underuse or lack of awareness of available dental services may be explained by cultural or language barriers, preferred method of receiving information, or the

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs), established under the U.S. Public Health Service Act, are federal designations of a geographic area (usually a county or a number of townships or census tracts) which meet the criteria as needing additional primary health care services. A HPSA scoring system was developed by the National Health Service Corps to determine priorities for assignment of clinicians. Scoring criteria include: population and provider ratio, level of poverty within population, infant health index, and traveling distance to the nearest provider. To be designated as a dental HPSA (DHPSA), the geographic area must have a population to full-time-equivalent dentist ratio of at least 5,000:1, or have a ratio between 4,000:1 and 5,000:1 and unusually high needs for dental services. Dental professionals in contiguous areas must be excessively distant or inaccessible, and overutilized. Members of federally recognized Native American tribes are automatically designated, as are federal and/or state correctional institutions and/or non-profit medical facilities (see table 1).[36] Based on the most recent information on provider-to-population ratio, there is a need to further investigate whether more counties are eligible for a DHPSA designation in Indiana.

Table 1: Dental Health Professional Shortage Areas (DHPSAs) Currently Designated in Indiana, 2008[36]

County	Service Area Name	Destination Type	Score
Allen	Central Fort Wayne	Low Income Population	14
	Neighborhood Health Clinics, Inc.	Comprehensive Health Center	8
Delaware	Open Door/BMH Health Center, Inc.	Comprehensive Health Center	10
	Center Township	Low Income Population	9
Lake	East Chicago Service Area	Geographical Area	15
	East Chicago Community Health Center	Comprehensive Health Center	10
Marion	Highland-Brookside (Indianapolis)	Geographical Area	19
	South Central Indianapolis	Geographical Area	15
	Near North Side (Indianapolis)	Geographical Area	10
	Indiana Health Centers	Comprehensive Health Center	9
	Health and Hospital Corporation of Marion Co.	Comprehensive Health Center	10
	Shalom Health Care Center, Inc.	Comprehensive Health Center	6
	Raphael Health Center	Comprehensive Health Center	10
	Healthnet	Comprehensive Health Center	4
Porter	North Shore Health Center	Comprehensive Health Center	8
	Valparaiso Service Area	Geographical Area	13
	Healthlinc, Inc.	Comprehensive Health Center	8
Randolph	Randolph County	Low Income Population	10
Rush	Rushville Township	Low Income Population	8
St. Joseph	Southwest South Bend	Low Income Population	15
Switzerland	Switzerland	Low Income Population	11
Tippecanoe	Lafayette City	Low Income Population	25
	Tippecanoe Community Health Center	Comprehensive Health Center	11
Vanderburgh	Echo Community Health Care	Comprehensive Health Center	10
Vigo	U.S. Penitentiary Terre Haute	Correctional Facility	21

Note: Scores for DHPSAs range from 1-26; the higher the score the greater the need.

doctor-patient relationship.[15] It has been reported that there is a high correlation between race/ethnicity of dentists and the majority of their patients. This may be due in part to the location of their practices or to a preference for a racially concordant dental provider.[31,32] More importantly, racial and ethnic minority dentists are twice as likely as white dentists to accept new Medicaid patients, and are also more likely to practice in underserved communities.[20,33] Looking at provider-to-population ratios by race/ethnicity, we see that for every 100,000 white residents, there are 55 white dentists. The ratios for blacks and Hispanics are not so favorable, with 15 and 12 dentists per 100,000 residents, respectively.[31]

No data are currently available about race and ethnicity of dentists practicing in Indiana. However, we know that only few students of underrepresented minorities have graduated as dental health professionals from Indiana schools. At IUSD, only 3.6 percent of all graduates from 2000 to 2007 were underrepresented minorities, including 17 Hispanic/Latino graduates, 9 African-American graduates and one American Indian graduate.[34] Almost all dental hygiene graduates from Indiana schools have been Caucasian (99 percent), and the trend is very similar for dental assistants.[35]

Increasing the diversity within the dental profession would be a way of addressing difficulties in access to care and disparities among racial/ethnic minority groups and the underserved.

Thoughts for Policy Makers

The American Dental Education Association (ADEA) emphasizes that every American should receive necessary care for good oral health, and that any comprehensive reform of the U.S. health care system must include coverage and access to affordable oral health services. ADEA has also recognized that the oral health of vulnerable populations has a unique priority, and that a diverse and culturally competent workforce is necessary to address oral health disparities and improve access to oral health care.[37]

Indiana's oral health professionals play a crucial role in improving access to care among all Hoosiers. By developing a culturally competent and diverse oral health workforce, we can improve provider-to-population ratios, increase access to care in minority and vulnerable populations, and provide services in underserved communities. Comprehensive strategies are needed to address these issues and adequately develop and strengthen Indiana's dental workforce. Policy recommendations include:

Increase Medicaid reimbursement rates—Studies suggest a strong correlation between Medicaid reimbursement rates and the number of Medicaid patients seen by dental providers. Increased rates are associated with more dentists participating in the Medicaid program; dentists accepting more new Medicaid patients; and more children on Medicaid receiving dental services.[28,38] Reimbursement rates should be evaluated regularly and, if necessary, increased to be more competitive in the dental market.

Train a culturally competent and diverse workforce—Racial and ethnic minority groups are significantly underrepresented in the oral health field. There is a high correlation between dentists' race/ethnicity and the race/ethnicity of the majority of their patients.[31] Also, black and Hispanic dentists are more likely than white service providers to accept new Medicaid patients and work in underserved areas.[20,33] By putting a greater emphasis on recruiting and retaining underrepresented minorities, dental schools will help create a more diverse workforce and, therefore, improve access to care for underrepresented and underserved populations.

Assist underserved communities—Currently, there are 25 designated dental health professional shortage areas (DHPSAs) in Indiana, but based on most recent information, the actual number of eligible, but not yet designated areas, is probably higher.[36] An important benefit of DHPSA designations is that it allows new graduates working in community health centers in these areas to apply for student loan repayment.

Particularly in rural areas, the number of oral health professionals is low, which makes accessing proper care difficult. Potential solutions to the problem include integrating medical and dental services in community-based healthcare settings (e.g., community health centers with dental clinics); expanding school-based oral health programs to provide screening and basic preventive services, including dental sealants; and incorporating dental screenings into other existing health/medical services (e.g., baby wellness checks).

Oral health care is an important but often overlooked aspect of general health. The "silent epidemic of dental and oral diseases", as Dr. David Satcher (former Surgeon General) called it, can significantly diminish one's quality of life. The poor and racial/ethnic minorities are disproportionately affected.[5] The reasons for these disparities are complex. To help all Hoosiers gain access to dental services, workforce development has to be addressed. Comprehensive strategies to increase provider participation in Medicaid programs; to raise the number of black and Hispanic dentists; and to expand availability of dental services in underserved communities, are needed to boost a dwindling workforce so it can effectively serve Indiana's growing population.

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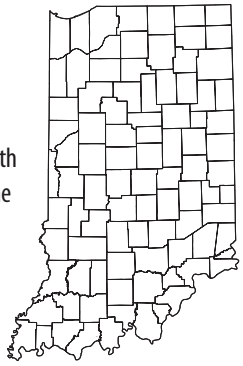

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