

Oral Health Coalition Minutes
Friday, June 11, 2010

PRESENT:

Eugene K. Boone
Terrie Cloud
Bershawna Courtney
Judith Ganser
Anne Gormley
Missy Hahn
Kristin Hendrix
Connie Kracher
Gerardo Maupome

J. W. McKenzie
Jim Miller
Patty Morris
Ed Popcheff
Keith Rice
Keith Roberts
Sara Viernes
Lyvonne Washington

Dr. Ganser began the meeting at 10:51 a.m. by welcoming the attendees and introducing Dr. Jim Miller as the new State Oral Health Director. The attendees introduced themselves and stated whom they represented.

The motion was made to accept the amended minutes from the February 12, 2010, meeting and the minutes from the April 9, 2010, meeting and both were accepted.

Fluoride Varnish:

Dr. Keith Roberts gave a presentation on fluoride varnishes. He reported that there are two kinds of fluoride: systemic and topical. Topical is the one you get on the outside of your teeth and systemic fluoride you ingest.

Fluoride varnish has been found to be very effective and very beneficial. Dr. Roberts would like to see fluoride varnish applied six times a year. Right now, Medicaid will reimburse this procedure twice a year per patient. Dr. Roberts said to use Medicaid code D1206 to get reimbursed for this procedure. A Policy Request has been submitted to Medicaid asking to have this procedure increased to four times a year. Currently, there are 36 states out of the 50 states that have Medicaid reimbursement for medical staff providing a child with fluoride varnish.

Applying fluoride varnish from birth to age 3 would show a big effect in reduction of decay, and the associated cost of emergency room visits and hospital treatments. High risk kids are more susceptible to decay and should have varnished put on their teeth. Dr. Roberts stated that fluoride varnish is safe and effective.

Dr. Miller's opinion is that we need to examine what is the most cost-effective number of fluoride varnish applications before Medicaid institutes this preventative intervention on a population-wide basis.

Dr. Miller presented information from two recent articles on fluoride varnish and its application by health professionals other than dentists. The first article was published in 2009 in the American Academy of Pediatrics and showed the results of a large survey among pediatricians. Over 90% of the pediatricians responded they should perform at least a dental screening exam on their patients. However, only 54% of pediatricians examined over half of their patients. Only 4%

of pediatricians regularly apply fluoride varnish to their patients. The most common reason that pediatricians will not provide fluoride varnish is lack of training. Less than 25% of those who responded said they received any oral health education in medical school. Also, one of the problems they see in their community is that very few dentists accept Medicaid patients to provide fluoride varnish.

Information from the second article, published in 2003, concerned North Carolina's "Into the Mouths of Babes" project to increase the application of fluoride varnish to the teeth of low income children from birth to 35 months. North Carolina was trying to encourage pediatricians, family physicians, and providers in community health clinics to provide dental preventative services. Medicaid reimbursed the pediatrician and family physician for services for risk assessment for dental decay, screening, referral, and for the application of fluoride varnish. It also paid for counseling for care givers to try to address high-risk behaviors with respect to dental decay. In two years, from 2000-2002, they recruited almost 1,600 non-dentists (pediatricians and primary care physicians) to provide these services. In 2002, there were almost 40,000 preventive dental visits.

Organization of Coalitions:

Dr. Jim McKenzie is a Professor at Ball State University. He comes from a background of program planning. He has worked with other programs at the Indiana State Department of Health helping them get organized.

He has looked at the Strategic Oral Health Plan and has gone through the Oral Health Task Force minutes. He read about a coordinating committee, an Oral Health Task Force, and an Oral Health Coalition. He said there are some technical differences between a coalition and a task force. A coalition is a formal alliance of organizations that come together to work for a common goal. A task force has a specific goal and many times the task force is dissolved after it has reached its goal.

He explained how to apply the five-step implementation process to the Strategic Oral Health Plan. These are:

1. Adoption of the program – a part of marketing,
2. Identifying & prioritizing the tasks to be completed,
3. Establishing a system of management,
4. Putting the plans into action, and
5. Ending or sustaining a program.

He reported that Phase 1 is the adoption of the plan. He further explained that the Strategic Oral Health Plan has been created and adopted. The Oral Health Task Force (Coalition) has done a needs assessment and has established eleven goals (and many objectives) that have been included in the Strategic Oral Health Plan. His advice is to make sure everybody knows the goals and objectives. The Strategic Oral Health Plan's goals are:

- Goal 1: Develop a competent and diverse workforce that can provide adequate access to care for all Indiana residents.
- Goal 2: Obtain additional Dental Health Professional Shortage Area (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 who are at risk for dental caries.
- 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.

Dr. McKenzie further explained that it is the Oral Health Program at ISDH and the Oral Health Task Force Committees that are the two groups working on the goals. He explained how to identify and prioritize the tasks to be completed by each group.

He created sample logic models for the Strategic Oral Health Plan. He said that the logic model is a simplified picture of a program, initiative, or intervention. It can explain what the investments (inputs) are, what is done (outputs), and what the results (outcomes) are.

He defined and showed the dimensions and design of implementation. He explained the different levels of implementation.

He explained the many options of communication between and among the committees.

He explained how to determine the ending or sustaining of a program.

He suggested that the State Health Department look for partners with trusted people such as the local health departments. He suggests looking for different counties with different demographics and different types of dental services and approaching the local health departments to help meet the goals of the SOHP. This, of course, will depend upon the resources and the staffing available. He also suggested working with the local dental associations.

The ISDH and the Oral Health Task Force:

Dr. Miller informed the group that the State Oral Health Program applied for a grant with the Centers for Disease Control and Prevention (CDC) recently, which could help with the implementation of some of the goals of the Strategic Oral Health Plan. He showed a slide that outlined the grant and what goals it might address.

The CDC grant, “State Based Oral Disease Prevention Program”, has eight recipient activities that include:

1. Infrastructure (personnel),
2. Data collection and surveillance,
3. State oral health plan,
4. Partnerships and coalitions,
5. School-based dental sealant program,
6. Community water fluoridation,
7. Policy development and evaluation, and
8. Program collaboration.

If this grant is awarded, pursuing its recipient activities would allow for implementation of some of the goals of the Strategic Oral Health Plan.

Committee Discussion of the Direction of the Oral Health Task Force:

Dr. Miller explained that a survey will be sent in the near future. He suggested that the attendees take home the material that Dr. McKenzie handed out at today's meeting and look over it. The main issues are about how we can best use the task force's efforts to plan and *implement* the goals in the Strategic Oral Health Plan.

Dr. Miller discussed having the Oral Health Task Force meetings on a quarterly basis, and plans to set up a method for each committee to have the opportunity to collaborate on-line with other members of their committee (or other members of the Task Force). Committees could meet outside the Oral Health Task Force (Coalition) meetings, and use the quarterly meetings for a chairperson from each committee to report on the progress of their committee and ask questions or solicit help.

There were no other updates and so the meeting was adjourned at 12:20 p.m.

The next meeting will be Friday, August 13, 2010, from 2:30 to 4:15 p.m. in Rice Auditorium at the Indiana State Department of Health, 2 North Meridian Street, Indianapolis.