

**Indiana State Dept. of Health
Indiana Oral Health Coalition (IOHC) Minutes
Friday, June 10, 2011
IDA Annual Session (French Lick, IN)**

Mission: The IOHC is a collective voice of individuals, groups, organizations, and businesses working together to promote, protect and provide for the oral health of the residents of Indiana.

PRESENT:

Steve Beebe
Diane Buyer
Stephanie Cohen
Marion Greene
Richard Jones
Kashif Khan
Gordon Klockow
Richard Martin

David Matthews
David Miller
James Miller
Sandy McIrath
Ed Popcheff
J. Keith Roberts
Ed Rosenbaum
Terry Schechner

Will Sears
Mark Stetzel
Laverne Whitmore
John N. Williams
L. Jack Windsor
Terri Winn
Ben Yoder

WELCOME

Dr. Buyer opened the meeting with a warm welcome to all in attendance. She explained that the Indiana Oral Health Coalition (IOHC) brings together public agencies, academic faculties, physicians interested in oral health, dental hygienists, dental assistants, pediatric dentists, oral surgeons, businesses, and the faith communities. She further explained that this group has been around in some form for over ten years. In that ten years time, it mainly did reporting of the different agencies to one another so they would know what was going on. It was handled primarily through the Indiana State Dept. of Health (ISDH). The Coalition is taking a step forward to try to affect some changes by including the private practice partners that they have in the oral health community. The mission of the IOHC is to serve as a collective voice of individuals, groups, organizations, and businesses working together to promote, protect, and provide for the oral health of the residents of Indiana.

Dr. Buyer went on to say that some of the headlines in the past two weeks emphasize the need that Indiana has for this Coalition. There's the need to improve the oral health of our residents and the Indiana strategy begins right here. Awareness of health choices promotes actions that ultimately produce an advantage. The advantage is to give all Hoosiers an opportunity to live a full and healthy life free of oral disease and pain.

She then had the attendees introduce themselves and state what organization they represent, if any, and their background.

REVIEW MINUTES

Dr. Buyer asked if there were any corrections to the minutes; there were none. Dr. Buyer asked for a motion and second to approve the minutes. A motion and second were offered and the Indiana Oral Health Coalition minutes from the March 11, 2011, meeting were approved as submitted by a unanimous voice vote.

ANNOUNCEMENTS

Dr. Buyer introduced Dr. James Miller, State Oral Health Director at the ISDH and Vice Chair of the Indiana Oral Health Coalition.

Dr. Miller explained what the ISDH does to support dental public health in Indiana. The ISDH has six commissions and two of them influence dental public health. These two commissions are Health and Human Services (HHS) and Public Health and Preparedness. Oral Health is a program within the Human Health Services Commission at ISDH. The Community Water Fluoridation program is in Environmental Public Health in the Public Health and Preparedness Commission. Dr. Miller is paid by the state. Dr. Miller's staff, and the staff associated with the Community Water Fluoridation program, are all paid from funds that Maternal and Child Health, within the HHS Commission, receive from a federal grant.

The fluoridation staff inspect community water fluoridation systems throughout the state. They monitor the concentration in the water once a week. They also look at the equipment and try to help with minor repairs. They also test the fluoride concentration of water sent in from wells. In Indiana, fluoridation is not mandated by the state. Each local community has jurisdiction over their community water fluoridation system along with the responsibility of any repair or replacement of the equipment. The ISDH has a collaborative relationship with maintaining a safe and effective level of fluoridation in the water. The recommended level of fluoride in community water has recently been reduced.

Pew Failing Grade in Oral Health in Indiana

Dr. Miller reported on a recent article in the Indiana Star about the Pew Center giving Indiana a failing grade for children's oral health in their 2011 report. He acknowledged his appreciation to the President of the IDA for writing a letter to the Editor responding to that report.

He then went over the *eight benchmarks that the Pew Center* used to arrive at their decision. See *Appendix A*. There are basically three benchmarks that fall *somewhat* under the influence of the ISDH. Another three benchmarks revolve around Medicaid policies. The other two deal with issues that would likely need a change of dental law in Indiana to be met.

Using the Pew Center grading scale, a state must meet three or more benchmarks to get a passing grade. Indiana has traditionally met the two benchmarks dealing with community water fluoridation and enrollment of children in Medicaid. However, in the most recent report Indiana didn't pass the benchmark for reimbursement by Medicaid for dental services, which it passed in 2010. However, Dr. Miller stated that the Pew Center calculates the measurement for this benchmark in a complicated manner that may put Indiana at a disadvantage compared to other states.

The three benchmarks that don't include ones related to state law or Medicaid policy, that is the ones that the ISDH might be able to help address, include: the percentage of communities with optimally fluoridated water; the percentage of high-risk schools with sealant programs; and the availability of population-based data on the oral health status of children. The last two Indiana did not pass. The last year the ISDH did a screening of a random sample of children *statewide* that included an oral exam was in the early 1990's. A basic state screening of children to estimate the statewide prevalence of dental sealants, treated and untreated decay in children would cost a minimum of \$50,000 in 2011 dollars. Increasing the percentage of high-risk schools with dental sealant programs would also require an investment. However, the investment could

be minimal. Dr. Miller showed data he requested from Medicaid covering the years 2005 to 2010 where an analysis demonstrated that 51% of the approximately 60,000 six-year old children enrolled in Medicaid in 2005 had dental sealants placed on one or more molars between 2005 and 2010, which would indicate that Indiana is doing better than the PEW Center indicates when they use their benchmark related to the percentage of high-risk schools with dental sealant programs.

With respect to the three benchmarks related to Medicaid policy, Indiana met the Pew Center benchmark related to the percentage of Medicaid children receiving dental services, although this percentage appears to be showing a downward trend. However, Indiana did not meet the other two Pew Center benchmarks related to Medicaid policy. With respect to reimbursement rates, Medicaid might at least reconsider the reimbursement rate for the services that the Pew Center uses to calculate their benchmark. With respect to paying primary care physicians to help prevent childhood decay, Medicaid might consider this when the economy improves.

Pew suggests that dental hygienists should be able to place dental sealants in school-based dental sealant programs *without prior examination of the child by a dentist*. Current Indiana law prevents this. However a new dental law might allow for a dentist to write a prescription for a hygienist to place a dental sealant; however, this would need to be clarified. The other benchmark involving the dental law would be the one involving the authorization of a *new primary-care provider (dental therapist)*, a benchmark that in all likelihood Indiana will not meet in the near future.

Dr. Miller concluded by saying that The Pew Center is a well respected national organization that actively promotes its benchmarks for oral health for children. They are also sophisticated in their interaction with the media. You can expect a report from the Pew Center each year, most likely using the same eight benchmarks, which is likely to garner media attention.

Dr. Buyer said that we might not be in agreement with some of the findings of the Pew Center but one of the good things that could come out of this would be for us to use our collective wills, brains, needs, wants, and desires to improve the oral health in Indiana. Dr. Buyer suggested that the Coalition create their own benchmarks to gauge their success.

SPEAKER

Dr. Buyer introduced the speaker, Marion Greene, MPH. She is a PhD student in Epidemiology at the Dept. of Public Health, IU School of Medicine. She has a MPH degree with concentrations in Epidemiology and Behavioral Health Science and a B.S. degree in Psychology. She is employed as a Program Analyst for the IU Center for Health Policy. In that capacity, she has helped conduct the research on various health policy issues. Ms. Greene was the Project Manager of the Indiana Strategic Oral Health Initiative (SOHI).

Ms. Greene said that there are two components to her presentation: 1) The community participatory process to develop the Strategic Oral Health Plan; and 2) The oral health goals that were identified and included in the plan.

She said that we already know that there are oral health disparities among minority groups and that a focus on vulnerable populations is encouraged.

The Strategic Oral Health Initiative (SOHI) was a one-year collaboration between the ISDH, the IU School of Dentistry, and the Center for Health Policy. The project was funded by a federal workforce development grant from Health Resources and Services Administration (HRSA). The

primary purpose of the grant was to develop a strategic plan designed to improve the state's oral health workforce and service delivery infrastructure for the underserved.

The focus was on workforce development and also on building cooperation within the community. There were three key components to the project: 1) A statewide assessment to measure the current state of oral health in Indiana and to look at needs, gaps, and workforce issues; 2) The development of the strategic plan to address those issues identified and to encourage and involve community participation and include primary health care, minority health communities, representatives from social service agencies, and, in general, entities that had an interest in the state and the oral health of Indiana residents; and 3) The formation of a Coordination Committee of thirteen members, including the ISDH, Dental School, Center for Health Policy, and also a representative from the IDA.

Next, a Statewide Planning Council (SPC) was established. This Council had over 80 participants that included members from the ISDH, Dental School, Medical School, Indiana Minority Health Coalition, Local Health Departments, IDA, Family and Social Services Administration, Medicaid Policy and Planning, the Department of Child Services, Department of Education, Indiana Rural Health Association and the Oral Health Task Force (OHTF). Dentists, hygienists, and dental assistants also participated.

The whole SOHI process was divided into three phases. The first phase was the assessment, the second phase the planning, and the third phase was to finalize the plan and publish it. The key findings of the assessment showed data taken from the Behavioral Risk Factor Surveillance System from 1999 through 2010. It showed that the percentage of adults seeing the dentist in the past year was around 68-69%. Children on Medicaid received a 41% increase in receiving some kind of dental services between 1999 through 2006. They found health disparities at household income levels and race or ethnicity. Rural area residents are more likely to suffer from oral health disease because there are fewer providers in rural areas. The ratio for all of Indiana is 1900 residents per 1 full-time dentist. However, in rural counties there are fewer dentists, if any. HRSA uses population to measure dental health professional shortage areas (HPSA) and based on their definition areas that have a ratio of 4,000 to 5,000 residents per one dentist can be considered underserved areas. Based on the 2007 data, 15 counties in Indiana had a ratio greater than 5,000 residents per dentist and 27 counties had a ratio greater than 4,000 residents per dentist.

The Statewide Planning Council (SPC) met four times throughout 2009. In order to keep a strategic plan manageable they needed to prioritize and narrow down all the potential goals that had been identified. Using two types of strategies in narrowing down the goals they used Specific Measurable, Attainable, Realistic and Time bound (SMART) goals. The work groups identified the things they wanted to address. They described what needed to be done, who should do it, when it should be done, how long it should take, and how they could measure it to make sure it was really done. All priorities identified were put into SMART format. After that they took each SMART goal and gave it a score according to six criteria: 1) *Community Reach* referred to how much of the population would be reached by implementation of the goal; 2) *Urgency* meant that the goal was time sensitive 3) *Cost*; 4) *Effort*; 5) *Ready to Implement* referred to whether a community was ready to implement the goal or if there was political will to support the goal; and 6) *Existing Infrastructure* referred to if there was existing resources or existing infrastructure in place to help with the implementation of the goal. Then the group members scored the SMART goals. Each SMART goal received the final score and the goal was kept in the final strategic plan based on the final score.

After the first three meetings, the Council concentrated on final oral health goals, and shared these with the community. There were five focus groups throughout the state that included the oral health field and the academic community. Many of the suggestions from these focus groups were included in the final version of the oral health goals. The final part was the publication of a strategic plan. The end product contained 11 goals that include at least one strategy per goal, one sub-strategy, and the outcome objectives for each goal. The order of the goals listed in the *Strategic Oral Health Plan* (SOHP) was arbitrary. The development of the strategic plan was considered only the beginning; implementation would be the important part. The group thought the Oral Health Task Force would be the overseeing body to guide the implementation of the goals, or at least some of the goals. Based on this project, three publications were written: 1) *Strategic Plan Report*; 2) *Briefs on Workforce Issues*; and 3) *Oral Health and Tobacco Use*.

Dr. Miller explained that the Coalition is free to adopt any or all of the 11 goals identified by the SOHP, or to modify them and then adopt any or all of them. The Coalition is free to establish the goals that they see fit.

Dr. Buyer said the Task Force that did the Strategic Report did a great service for the state of Indiana because it is a framework to build on.

DISCUSSION

Dr. Buyer explained that Maryland recently produced a similar report that came about because of a child who died due to a dental infection. Maryland was willing to put a lot of money into improving the oral health care of their citizens. They used their report as the basis for the implementation of a five-year plan. Dr. Buyer explained that the IOHC could develop and implement a similar type of five-year plan. It will not happen overnight, but it is the direction to go.

BUSINESS MEETING

Dr. Miller read the *first resolution* that the IOHC adopt the Indiana Strategic Oral Health Initiative Project Report (2009) as a guideline to improve the oral health of Indiana residents.

Before proceeding with the vote, Dr. Miller explained that the IOHC has a set of Bylaws under which votes are cast for resolutions. Dr. Miller explained there are three types of memberships: standing organizational membership, other organizational membership, and individual members. (Currently, there are no “other organizational members”.) For attendees to vote, they would have to be on the IOHC roster. Members can only vote once, so that a person representing an organization, and voting for that organization, cannot also vote as an individual member. IOHC votes will be weighted so the standing organizational members get one vote, the other organizational members get one-half vote, and the individual members get one-quarter vote. Votes are cast via signed ballot. Using the voting provision in the Bylaws, a resolution passes or not according to the majority of weighted votes. For an organization to vote during a meeting, Dr. Miller needs to have received a letter (or email) stating who the organization has designated as their representative.

The standing organizational members are the ISDH, Indiana State Board of Dentistry, Indiana University School of Dentistry, Indiana Dental Association, Indiana Dental Hygienists’ Association, Indiana Dental Assistants Association, and Medicaid.

The representative for the ISDH is the State Oral Health Director. The Board of Dentistry named Clance LaTurner. The School of Dentistry named Dean Williams. The IDA has not named a representative. The Indiana Dental Hygienists' Association has not named a representative. The Indiana Dental Assistants Association named Angela Swatts. Medicaid named John McCullough.

Dean Williams and Dr. Miller were the only representatives for their respective standing organizations that were present.

Dr. Miller explained that everyone else whose name was on the roster prior to the meeting, and who signed the roster, can vote as an individual member. If someone wants to attend meetings in the future and vote, they should send their name to State Oral Health Director (Dr. Miller).

The members voted on the **first resolution** placed on the agenda for the IOHC to adopt the *Indiana Strategic Oral Health Initiative (SOHI) Project Report (2009)* as a guideline to improve the oral health of the Indiana residents. After some discussion about these goals, the members voted on the **second resolution** that the IOHC establish the 5 most important goals from among the 11 goals mentioned in the SOHI Project Report (2009), and prioritize these 5 goals. Dr. Miller stated that the results from these votes would be emailed to the IOHC members.

Dr. Buyer concluded that this was a productive meeting. She said that the attendees would receive the minutes from the meeting and the results from the votes on the two resolutions by e-mail. She suggested that members should choose a goal (from among the 5 most important goals). The Oral Health Coalition is looking into non-profit status to apply for grants.

The next meeting is September 9th at the ISDH, starting at 10:00 a.m.

ADJOURNMENT

Dr. Buyer called for a motion for adjournment and a second. Dr. Miller made a motion to adjourn, and it was seconded and passed. The meeting was adjourned.

NEXT MEETING

September 9, 2011 @ 10:00 a.m. in 8T1 and 8T2 (8th Floor Training Rooms)

December 9, 2011 @ 10:00 a.m. in 8T1 and 8T2 (8th Floor Training Rooms)