

STATEWIDE ORAL HEALTH STRATEGIC PLAN

The Commonwealth of Kentucky - 2006



Healthy Kentucky Smiles:

A lifetime of

Oral Health

STATEWIDE ORAL HEALTH STRATEGIC PLAN

For the Commonwealth of Kentucky 2006



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To all Kentuckians:

Kentucky's Oral Health Strategic Plan is a living document that outlines the paths that the citizens of Kentucky can decide to take to improve and enhance the oral and general health status of Kentuckians. The Plan is an example of an incredible product of working partnerships with a broad array of experts and others interested in the health status of our citizens. The Plan was developed by more than 100 individuals meeting over a two-day period (and in numerous follow-up sessions) to create this guide for oral health in Kentucky's future. The framers of this extraordinary document came from all facets of Kentucky life and the guide represents the consensus view of that expansive coalition of those interested in oral health in Kentucky.

The Plan will be reviewed annually by an Executive Committee of the original participants in the planning process using a consensus development process similar to the original. The review will result in well-considered modifications to the Plan that coincide with the changes, opportunities and challenges experienced by the Commonwealth over time.

Since this is every Kentuckians guide and Plan, please contact the Kentucky Oral Health Program administrator at 502-564-3246 if you have recommendations for making the Plan the best possible. All suggestions will be considered by the Executive Committee for inclusion in future editions.

Thank you for using this Plan and I hope you will continue to make appropriate updates to this important, living, and flexible guidepost. Use this Plan to make a difference in Kentucky's oral and general health status!

Sincerely,

A handwritten signature in cursive script, appearing to read "James C. Cecil, III".

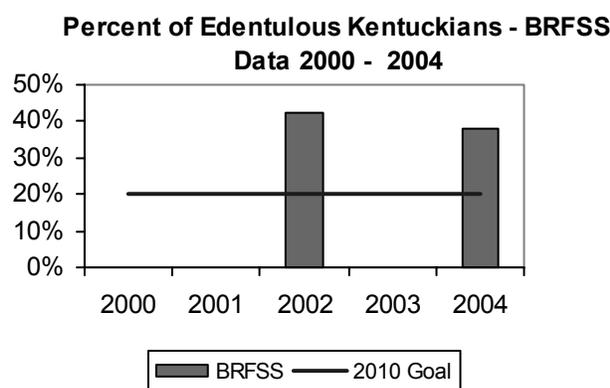
James C. Cecil, III DMD, MPH
Administrator, Kentucky Oral Health Program

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Introduction

Assure Oral Health in Kentucky

On December 19, 2003 the “Mortality and Morbidity Weekly Report” reported that Kentucky, from data from the 2002 Behavioral Risk Factor Surveillance System (BRFSS) survey, was **number one in toothlessness** among our older adult citizens (> 65 years of age). In fact, 42.3% of Kentuckians 65 years and older were toothless – they had lost all their natural teeth. This total did drop slightly in 2004 with 38.1% of older adults edentulous.



Other 2002 BRFSS data indicated that 26.6% of Kentuckians of all ages had lost 6 or more teeth due to tooth decay or gum disease (17.6% nationwide). For states neighboring Kentucky, the total toothlessness rates were: Tennessee 36.0%; Indiana 24.7%; Ohio 23.6%; West Virginia 41.9%; Illinois 24.0%; and Virginia 21.3%.

What’s wrong with toothlessness? Some people contend that it is not only a health issue (not able to eat a balanced diet, speech is difficult),

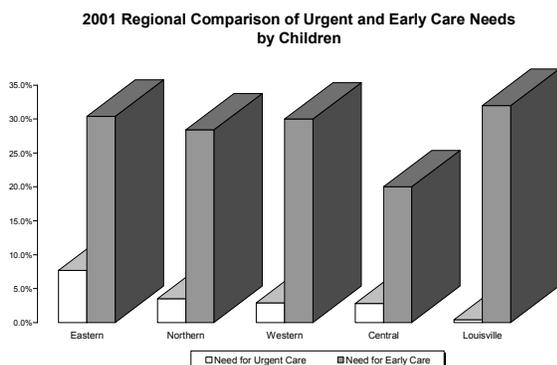
but also a quality of life issue (appearance, self esteem, self confidence) as well as an economic development issue (toothless individuals have difficulties in finding employment and advancement).

The self-reported data on toothlessness are discouraging particularly as the public health system in Kentucky has worked so diligently over the past three decades to have the second highest rate of citizens exposed to optimally fluoridated water (90%) in the country – second only to Minnesota. The reality, though, is that fluoridation of public water supplies prevents about 60% of tooth decay in children. Therefore, there are a large number of children who still are at-risk for tooth decay even if exposed to fluoridated community water supplies. **Community water Fluoridation is a first step in preventing toothlessness** – preventing toothlessness is a lifetime endeavor and it is easy.

The prevalence of Early Childhood Caries (ECC - formerly called Baby Bottle Tooth Decay) is noted to be very high in Kentucky compared to national studies; the prevalence has increased dramatically from surveys in 1987 to 2001 – particularly among poor and near poor Kentuckians.

What can we do as a public health organization to stem the tide of Early Childhood Caries?

Since ECC begins with the eruption of the first baby (primary) tooth about ages 7 months to one year of age, it makes sense that a prevention intervention should start at the time of the first tooth's eruption. In Kentucky, most family dentists do not see children until after age four or five – their training just does not



Source: Kentucky's Children's Oral Health Profiles 2001, Oral Health Program, Kentucky Department for Public Health in partnership with the University of Kentucky College of Dentistry. "Urgent Care" defined as treatment needed within twenty-four hours. "Early Care" defined as treatment needed within several weeks. Sample of Kentucky 3rd and 6th graders; n = 5962. For more information on the survey design and methods, please contact the Oral Health Program at 502-564-3246.

prepare them to deal with very young children. But, family physicians and pediatricians, as well as health departments and other nurses, do see these very young children several times during the first few years of life – as many as 10 times before a child might see a dentist. The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentists (AAPD) both recommend that children have their first visit to a dentist about age one – the eruption of the first baby tooth.

Starting in FY 03-04 as part of the **KIDS NOW** program for children of early childhood, local health department nurses have had the opportunity to participate in training that would ready them to: twice yearly screen children at their usual visits to health departments, apply a prevention agent (fluoride varnish), provide a preventive oral health message to the caregiver (home care instructions), and make a proper referral to a dentist if necessary. This program is called **KIDS SMILE** and is funded from the tobacco settlement funds for children 0 through 5 years of age. The Kentucky Board of Nursing has declared that the **KIDS SMILE** program is within the scope of practice of Registered Nurses in Kentucky. Once implemented, the activities of **KIDS SMILE** should take only two minutes to administer. At this writing more than 600 health department and other nurses have had the training; more than 4000 children have participated; and evaluation of the clinical outcomes began in April 2006. As time goes on, the hope is that all at-risk children in Kentucky will be able to participate in **KIDS SMILE** to stem the tide of ECC. **This is the second step in preventing toothlessness** – stop the infection before it becomes too bad.

So, why do Kentuckians lose their teeth?

Children usually lose their teeth due to untreatable dental decay – an infection that causes the teeth to cavitate (have a cavity) if the microbes of the infection are constantly nourished with fermentable carbohydrates (sugars, other substances). Dental decay occurs over a long period of time (one to two years or more) and is preventable with good home care, i.e. daily use of fluoride toothpaste and rinses, regular visits to the dentist, and maintaining a balanced diet. **This is step three in preventing toothlessness** – maintain a clean mouth to manage the infection of tooth decay in baby teeth.

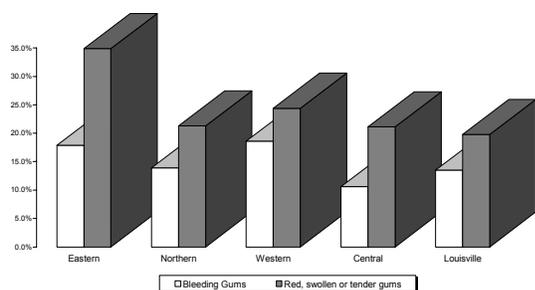
HEALTHY KENTUCKY SMILES: A LIFETIME OF ORAL HEALTH

In Fiscal Year 02-03, the Kentucky Department for Public Health began funding dental sealant programs whereby local health departments would partner with local dentists and hygienists, local elementary schools and provide dental sealants to children in the 2nd, 3rd, and 6th grades. The 6-year and 12-year, adult molars have erupted into the mouth at about these grade levels. The Centers for Disease Control and Prevention list sealants as being an evidence-based prevention intervention that is highly effective in preventing tooth decay in permanent molars – fully 80% of decay in elementary children occurs in the pits and fissures on the top surfaces of permanent molar teeth. So far, 18 local health departments have engaged their communities and are providing sealant programs in their health departments with the collaboration of dentists, hygienists, and schools. **This is the fourth step in preventing toothlessness** – smoothing out the tops of teeth with a painless, simple, plastic coating to keep decay from starting in the pits and fissures of permanent molars.

Adults usually lose their teeth due to periodontal diseases. Periodontal diseases are caused by an infection of several species of microbes that slowly, over a very long period of time (5 plus years), erode the tissues (gums, bone, ligaments) that support the teeth in the mouth. The infection of periodontal disease is insidious, usually painless until late in the disease, is detected by bleeding gums and pocketing around the teeth at the gum line, and causes offensive mouth odors. These diseases can be prevented through good, daily home care (flossing and brushing), use of antiseptic mouth rinses, early intervention by regular visits to and cleanings by a dentist or dental hygienist, and maintaining a balanced diet and lifestyle – everything in moderation. **Step five in preventing toothlessness** – maintaining periodontal health.

If steps one to five are initiated before or at very early stages in the establishment of these oral infections, we can keep our permanent teeth all our natural lives. We do not necessarily need to have a third set of “store bought” plastic teeth. Kentucky not only has a high prevalence of oral infections but access to preventive and restorative oral health care is a challenge.

Percent of Adults with Self-Reported Symptoms of Periodontal Disease by Region: Kentucky 2002

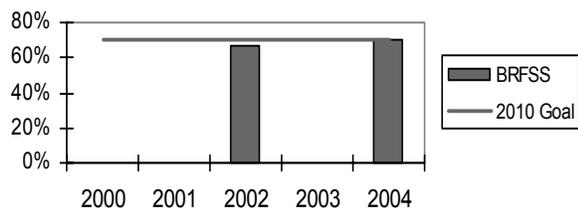


Source: Kentucky Adult Oral Health Survey 2002. Oral Health Program, Kentucky Department of Public Health in partnership with the University of Louisville School of Dentistry. For more information on the survey design and methods, please contact the Oral Health Program at 502-564-3246.

Access to care was highlighted in an issue brief written by Kentucky Youth Advocates in December of 2003, *Open Wide or Lock Jaw? Children's Dental Health Access in Kentucky*. Findings included the fact that only one-third of eligible children received any dental services through Medicaid and the Kentucky Children's Health Insurance Program (KCHIP) in 2002. In that same year, low-income children did not have adequate access to dentists with 2,169 licensed dentists in 2002 and only 871 Medicaid enrolled dentists billing Medicaid for services.

The problem of access to care was also significant for adults. BRFSS data from 2002 and 2004 shows slight improvement with nearly 70% of Kentucky adults visiting the dentist once each year.

**Adult Use of Oral Health Care System - BRFSS
Data 2000 - 2004**



Few of Kentucky's 120 counties are formally designated as Dental Health Professional Shortage Areas although the majority qualifies. Provider shortages are rampant throughout the state with more dentists retiring, relocating to metropolitan areas and reducing their clinic hours each year.

These issues and more were brought before Kentucky's Oral Health Stakeholder Group in a series of meetings over the past two years. The resulting

document, *Healthy Kentucky Smiles: A Lifetime of Oral Health*, highlights the many challenges faced by Kentucky's dental health providers, partners and citizens.

The planners of this document wish to recognize that changing demographics are reconstructing the fiber of Kentucky's citizenry. As the group known as the "Baby-Boomers" age, oral health issues associated with the elder population will become increasingly prominent. Kentucky's racial and ethnic populations are also rapidly diversifying, creating new challenges associated with access to oral health care and cultural competency. Children with special health care needs are in great need of preventive and restorative services, yet few pediatric dentists are available within the state to provide these services. Those that do choose to practice in Kentucky rarely choose to do so in the rural regions. New research regarding possible associations with periodontal disease and preterm birth highlight the need for pregnant women to have access to oral health care, yet this population is affected by a shortage or maldistribution of dental providers.

Cultural sensitivity and humility are values that planners identified as critical to the development of this document. Activities are underway to reach the aforementioned and other special populations because we believe that oral health is an essential component of overall health and that pursuit of health is a right afforded to all citizens of Kentucky.

Following is a description of the process used to develop issues raised by Kentucky's Statewide Oral Health Strategic Plan.

Executive Summary

A lifetime of Healthy Smiles!

Strategic planning for a statewide Oral Health Plan began in 2004 with the identification of stakeholders. These individuals in the community were invited to respond to an online survey about oral health in Kentucky. Over one hundred and fifty people were invited to participate in this process on a web page set up by the University of Kentucky (UK) College of Public Health. Participants were requested to answer the following open-ended questions.

1. What are the strengths in the provision of oral health services in Kentucky?
2. Are there other additional factors that would help us have a positive impact on the achievement of oral health?
3. What can Kentucky do to improve oral health for all citizens?
4. What can Kentucky do to influence the negative factors affecting oral health?
5. What is your vision of oral health in Kentucky?
6. What do you think the purpose or calling of the oral health initiative in Kentucky should be?
7. What are your beliefs, values, or judgments about oral health regarding what is worthy, important or desirable?

Electronic submissions for these questions were collected for approximately one month. Tabulation was completed through the UK College of Public Health. Approximately fifty individuals anonymously completed the survey. Individuals invited to participate were the same group that would be invited to the statewide visioning meeting.

The second step was to conduct a one-day meeting of key oral health leaders within the state on April 16, 2004. During this "Visioning Summit", the Oral Health Strategic Planning Executive Committee met to create a draft vision, mission and values statement that would be presented to the full group for their meeting the next month. Electronic input from the system described above assured inclusion from a variety of community leaders across the Commonwealth.

On May 20 and 21, 2004, Kentucky's initial Oral Health Strategic Planning Meeting was held at the Hilton Suites of Lexington Green. Participating in this two-day event were providers and consumers of oral health care from across the state. Included were representatives from the provider community, academics, business leaders, the faith community and consumers, as well as state and local public health staff. In all, over 100 individuals attended the two-day event.

The primary purpose of this event was to have participants critique and finalize the Mission and Vision Statements, to review the electronic input (SWOT Analysis) and to identify sub-committees, which would form and continue to work on the Strategic Plan. Both the online survey and the first convening of stakeholders sought to prepare a situation analysis of the current status of oral health in Kentucky. Through this process the strengths of the oral health system, opportunities for improvement, and threats were identified.

At the conclusion of the two-day meeting, eight subcommittees formed:

Oral Health Strategic Planning Sub-Committees

- Advocacy
- Economic Development
- Public Health Education
- Funding
- Partnerships and Collaboration
- Prevention and Treatment
- School-based Collaboration
- Workforce

Over the next few months, goals were identified by the members of each workgroup and are provided below. Details as to objectives, critical success factors and potential barriers to success for each of these goals follow this section.

Advocacy

- Develop and administer government policy and programs that address oral health as a full component of overall health for eligible populations
- Elevate the importance of oral health in the public discourse about health status in Kentucky

Economic Development

- Communicate that good oral health has economic value
- Communicate that dentistry is a business and has economic impact on communities
- Build communities with high quality health infrastructures to attract and retain employers
- Increase the number of dental professionals to underserved areas to assure access to care

Funding

- Increase available funding for oral health to increase access to care

Partnerships and Collaboration

- Solicit, develop and nurture relationships with other organizations and associations to expand awareness of and the focus on oral health
- Assist dental professionals to recognize signs of domestic violence observed in their patients and to implement policies and procedures to reduce this burden on both patients and providers

Public Health Education

- Increase oral health wellness through education and disease prevention
- Increase oral health wellness through coordinated state-wide educational activities
- Increase oral health wellness through coordinated state-wide media

Prevention and Treatment

- Provide lifelong maintenance of oral wellness through coordinated, integrated and comprehensive services

School-based Coordination

- Assure that all children receive regular dental education and care as a part of an integrated program

Workforce

- Assess the past, present and future status of the dental workforce in Kentucky and develop a work-plan to address identified needs
- Increase collaboration with and between dental professionals and other medical professionals in Kentucky



Thanks must be given to all participants in the Kentucky Oral Health Strategic Planning Process and to our federal funders. Coordinators would particularly like to thank Mark E. Nehring, D.M.D., M.P.H., Chief Dental Officer, Division of Child, Adolescent and Family Health, Maternal and Child Health Bureau, Health Resources Service Administration, for his dedication to state oral health programs throughout the nation.

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Statewide Oral Health Plan

Healthy Kentucky Smiles: A Lifetime of Oral Health!

Oral disease is a major health problem for Kentuckians. Much of this problem can be prevented through primary prevention efforts, including community water fluoridation, the application of dental sealants and fluoride varnish, oral cancer screenings, and routine dental care as well as oral health education and health promotion.

In 1987, the Office of Oral Health conducted a statewide oral health survey (Kentucky Oral Health Survey - KOHS) consisting of an interview component and a clinical screening component. Findings were alarming.

Dental caries were a significant problem, with 26 percent of adult Kentuckians 18 to 64 years of age having untreated decay, compared to 6 percent on a national survey conducted by the National Institute of Dental Research in the same year. Additionally, KOHS found that 34 percent of Kentuckians had not visited a dentist within the past 12 months. This number became more disturbing when, nine years later, the 1996 BRFSS reported that the measure had increased to 38 percent.

Children fared no better than adults with respect to oral health outcomes. In 1987, 30 percent of children aged 0-4 had caries. In the 5-9 age range, 58 percent of children had a decayed filled surface in a primary tooth (dfs) and 34 percent had a decayed filled surface in a permanent tooth (DFS). Twenty-eight percent of children aged 0-4 had untreated decay while this number rose to 38 percent (dfs) and 27 percent (DFS) for the 5-9 aged children.

Kentucky adolescents proved to have even worse oral health. Eighty-four percent of 14-17 year olds had one or more caries (filled or unfilled), while 67 percent had untreated cavities in primary and permanent teeth.

This information was a catalyst for additional surveys specific to three populations; children, adults and elders, to be implemented in the current decade, described below.

Oral Health Surveys for Children and Adults

While Kentucky can be justifiably proud that ninety percent of all Kentucky's 4.1 million residents receive optimally fluoridated water, oral disease still affects the quality of life of many citizens.

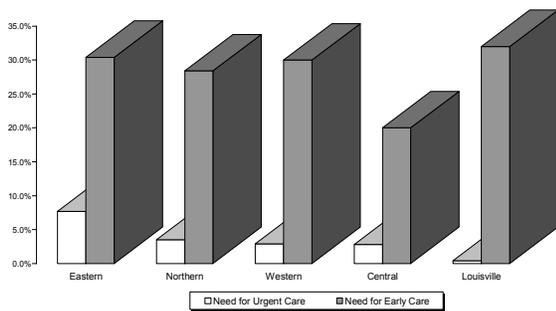
To meet the needs for data acquisition and analysis in the area of oral health, two surveys have been completed during this period; the Kentucky Children's Oral Health Profiles 2001 (University of Kentucky College of Dentistry) and the Kentucky Adult Oral Health Survey 2002 (University of Louisville School of

HEALTHY KENTUCKY SMILES: A LIFETIME OF ORAL HEALTH

Dentistry). A third survey, the Elder Oral Health Survey, is currently near completion (University of Kentucky College of Dentistry) and results will be reported in Spring 2006.

Findings from these two surveys showed some improvement in the oral health of Kentucky's adults and children but significant disparities continue to exist.

2001 Regional Comparison of Urgent and Early Care Needs by Children



Source: Kentucky's Children's Oral Health Profiles 2001, Oral Health Program, Kentucky Department for Public Health in partnership with the University of Kentucky College of Dentistry. "Urgent Care" defined as treatment needed within twenty-four hours. "Early Care" defined as treatment needed within several weeks. Sample of Kentucky 3rd and 6th graders; n = 5962. For more information on the survey design and methods, please contact the Oral Health Program at 502-564-3246.

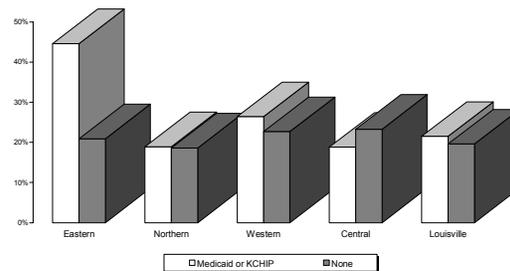
The graph at left demonstrates disparities in the need for urgent or early dental care for children. The need for urgent care was most pronounced in Eastern Kentucky but the area of greatest need for **early** care occurred in Louisville, Kentucky's largest city.

Another interesting result was seen when data was summarized to examine type of insurance utilized by Kentucky families for children's oral care. The graph below illustrates that the penetration of Medicaid/KCHIP enrollees was far greater in Eastern Kentucky than in other areas of the state;

certainly a result of aggressive enrollment over the past decade.

The conundrum that exists is that most of Eastern Kentucky is considered a dental health professional shortage area; even those able to pay for dental care experience barriers to accessing such care. If more dental providers were available to serve Kentucky's most rural areas and if they accepted Medicaid and KCHIP patients, many more children on public assistance might receive regular dental care.

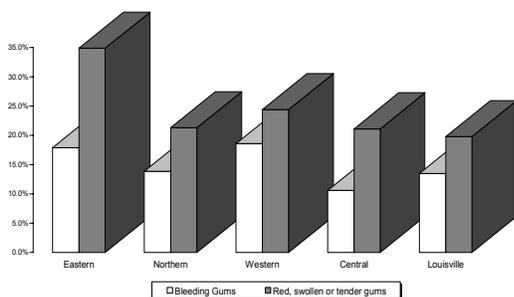
2001 Regional Comparison of Medicaid/KCHIP or "None" as Type of Insurance Used by Children



Source: Kentucky's Children's Oral Health Profiles 2001, Oral Health Program, Kentucky Department for Public Health in partnership with the University of Kentucky College of Dentistry. Sample of Kentucky 3rd and 6th graders; n = 5962. For more information on the survey design and methods, please contact the Oral Health Program at 502-564-3246.

Adults in Kentucky's rural areas have many oral health challenges as well, including periodontal disease, oral pain and untreated decay, dissatisfaction with the appearance of teeth and edentulism.

2002 Regional Comparison of Indicators for Periodontal Disease in Adults



Source: Kentucky Adult Oral Health Survey 2002. Oral Health Program, Kentucky Department of Public Health in partnership with the University of Louisville School of Dentistry. For more information on the survey design and methods, please contact the Oral Health Program at 502-564-3246.

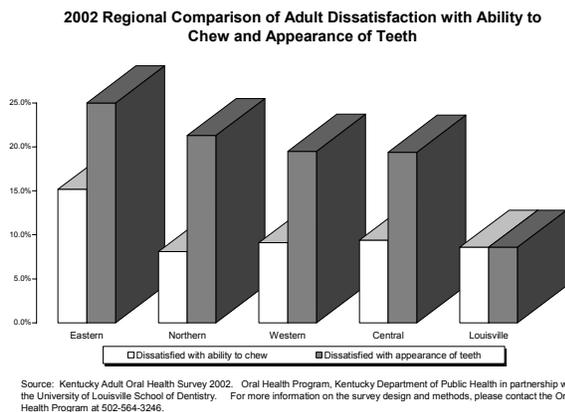
The occurrence of periodontal disease was most pronounced in Eastern Kentucky, where nearly 35 percent of the population indicated red, swollen or tender gums. Western Kentucky followed with nearly 25 percent of its populace indicating the presence of these symptoms.

Untreated pain and decay was a frequently reported problem as well. Again, Eastern Kentucky carried the greatest burden for untreated decay (31.1 percent) while most other regions reported that this oral health problem affected approximately 18 percent of their population.

But untreated pain was consistent in nearly all regions of the state, with totals ranging from a high of 28.5 percent (Eastern Kentucky) to a low of 20.8 percent (Northern Kentucky).

Edentulism, or the loss of teeth without replacement, was again most concentrated in the eastern portion of the state. In that area, 23.7 percent of adults surveyed said that they had not replaced any missing teeth as compared to approximately 16 percent in Northern, Western, and Central Kentucky. The Louisville region had only 6.2 percent of their adult population reporting no replacement.

Finally, dissatisfaction with the ability to chew and with appearance of teeth was measured by the adult oral health survey.



Approximately 15 percent of adults in the eastern part of the state cited dissatisfaction with the ability to chew, with other regions reporting approximately 9 percent for this measure. Data were more consistent between regions for dissatisfaction with the appearance of teeth as illustrated with the table to the left. The Louisville region, however, was again the lowest at 8.6 percent.

This document provides a fraction of the results realized by the two surveys discussed above. For more information about data collected by either of

these surveys or Kentucky's Elder Survey, please contact the Kentucky Department for Public Health, Oral Health Program at 502-564-3246.

Summary of Progress:

While the data presented in the earlier section paints a dire picture of the oral health status of many Kentuckians, particularly those residing in our rural areas, much progress has been made over the past few years in the area of prevention of oral disease. This progress has been achieved through partnerships developed throughout the Commonwealth; partnerships that range from local community health departments to Kentucky's universities, from the medical community and private business to Kentucky's diverse faith communities and schools from Pikeville to Paducah.

First, the "front-line" of public health, Kentucky's local health departments have joined together with the state health department to address some of these concerns at the community level.

The KIDS SMILE Children's Oral Screening and Fluoride Varnish Application Program has increased the number of children (aged 0 to 5) who have received oral health screenings and topical applications of fluoride varnish since its inception in FY04. Certified local health department nurses have provided over 67,000 dental varnish applications and oral screenings throughout the state as of March 2006. Fluoride varnish kits are provided at no charge to local health department partners through a contract with the University of Kentucky, College of Dentistry.

Also in collaboration with local health departments, Kentucky has begun a sealant program for the purpose of encouraging these front-line public health agencies and local dental professionals to work together to combat childhood decay in permanent molars.

In 2003, Kentucky received its first round of funding from the Health Resources Services Administration, Maternal and Child Health Bureau, through the Oral Health Collaborative Systems Grant program, supporting oral health infrastructure activities at the state level.

This funding, currently at \$65,000 per year, has allowed for Kentucky to undertake a Dental Professional Workforce Study, completed in collaboration with the University of Louisville, School of Dentistry and the School of Public Health and Information Sciences. Additional programs funded through this venue include the Children's Oral Health Surveillance System, an on-going visual screening of Kentucky 3rd and 8th graders, providing data not only on oral health status but also including height and weight, providing the ability to calculate Body Mass Index.

Beyond the immediate influence of state government and in partnership with Kentucky's flagship universities, the vision to improve regional access to oral health care throughout the Commonwealth has also enjoyed success. Regional Centers for Oral Health Care are now operational in two Kentucky cities, Hazard and Madisonville. Other sites throughout Kentucky's rural areas are planned for the future. Community support for these ventures has been unprecedented, affirming the need for care that many rural Kentucky communities face and their realization that good oral health care has positive economic benefits.

In addition to providing direct oral health care services, these regional oral health care centers provide cutting-edge preventative, restorative and education programs to community members, addressing issues such as periodontal care during pregnancy and the benefits of regular oral health care for those suffering from early childhood caries, diabetes and cardiovascular disease.

On a smaller scale, local communities have collaborated to bring oral health services to their citizens across the state. Faith communities and local providers have joined together to open clinics in churches, schools and hospitals, during the evening and on the weekends.. Dental professionals have volunteered their time and expertise to serve children and those who have "fallen through" the safety net. And mobile dental units are planned for many communities, bringing the services to the people.

All of these partners came together in 2004 to develop this document which was also made possible through funding provided by Kentucky's Oral Health Collaborative Systems Grant. Bringing together so many of Kentucky's key professionals in the area of oral health, education, rural outreach and strategic planning has been a wonderful process for state oral health staff. We wish to thank all who contributed to this document which will surely make a difference in the health of all Kentuckians.



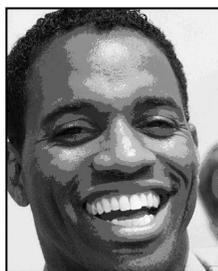
Mission

Assure Oral Health for Kentucky



Vision

Healthy Kentucky Smiles: A Lifetime of Oral Health



Values

We Believe:

1. Oral health is an integral part of an overall preventive health lifestyle.
2. Oral health is an essential component of overall health.
3. Professional oral care is an important part of the health care delivery system.
4. Access to care is essential.
5. The pursuit of health is a right.
6. Oral health is an economic development issue.
7. People have a personal responsibility for their own wellness.
 - a. Individuals are responsible for their own well-being.
 - b. Parents and caregivers have a responsibility.
8. We all (the community) have a responsibility to promote health in our communities.
9. The profession has an obligation to work toward the improvement of oral health for all.
10. Prevention is the “cornerstone” of community health.
11. Oral health is achievable.
12. Oral health education is important in the training of all health care providers and oral health consumer education is imperative.
13. Poverty is a barrier to health (oral) and access.
14. Oral health problems are systemic societal problems.
15. Oral Health primary prevention should start early in life.
16. Children’s oral health is a foundation for a healthy lifetime.
17. Volunteerism is practiced by many Kentucky dentists, through faith-based and non-faith-based venues and by their acceptance of patients with public insurance.
18. Oral Health assessment is a basis to drive scarce resource allocation.



Situation Assessment

The following Strengths, Weaknesses, Threats and Opportunities were identified by the statewide stakeholders.

STRENGTHS

1. Dental Schools and other universities in Kentucky provide outreach and a high quality of care.
2. Early childhood funding through Kentucky's Federal Tobacco Settlement creates numerous opportunities.
3. Partnerships with state/local health departments, faith-based communities, Area Health Education Centers (AHEC), Schools and Colleges of Dentistry and Medicine, dental education programs, various professional healthcare groups and extension services, local clinics, as well as community, civic and local government groups, media, The Kentucky Department for Education, a variety of professional associations, Family Resource Centers, the Kentucky Dental Association (KDA), the Kentucky Dental Health Association (KDHA), private foundations, the Kentucky School of Osteopathic Medicine and more.
4. Water fluoridation levels in Kentucky are among the highest in the nation.
5. State-level programs, including dental sealants, fluoride varnish application, spit tobacco cessation, tobacco cessation and the provision of fluoride supplements.
6. Cross training potential for oral health knowledge (for educators, health providers and through the HANDS Voluntary Home Visitation Program staff)
7. Mobile clinics (in some areas) with portable equipment for outreach care.
8. Quality dental providers and quality dental care in many parts of the Commonwealth.
9. The general supervision of hygienists and expanded function laws.
10. The Children's and Adult's Oral Health Surveys, accomplished in 2001 and 2002 respectively.
11. Kentucky's current administration is willing to talk about taxing for improved health and who personally have interest in health issues.
12. Kentucky's First Lady is supportive and interested in health issues.
13. The existence of Family Resource and Youth Service Centers (FRYSC); an excellent way to provide outreach to communities across Kentucky.

STRENGTHS Cont.

14. Head Start, Healthy Start and other Early Childhood Development initiatives
15. The fact that other health professionals are beginning to see the importance of, and receiving training in oral health issues.
16. Excellent leadership from the State Administrator of the Oral Health Program.
17. Partnership with American Association of Retired Persons (AARP).
18. The ability of nurses (RN's and LPN's) to screen children and apply fluoride varnish in local health departments.
19. The fact that strong state oral health initiatives have led to local initiatives. People are beginning to recognize the problem and want to improve oral health.
20. Existing clinics offer health care to disparate populations but many more are needed.
21. Family orientation and the importance of family in Kentucky offers opportunities for oral health education and advocacy.
22. The existence of the Health Education through Extension Leadership (HEEL) Program – which reaches beyond university walls to improve health outcomes and reduce the burden of chronic disease for all Kentuckians at the local, regional, and state levels.
23. A strong history of collaborations and coalitions on which to build.

CHANGE OPPORTUNITIES/WEAKNESSES

1. Appropriate funding for insurance plan benefits, more appropriate reimbursement for services. (54)
 - a. Medicaid adequately funded
 - b. Parity and private insurance
 - c. Adequate and appropriate funding for local health departments oral health efforts
2. Advocacy for oral health (34)
 - a. Develop strong advocacy groups – local, regional, and state.
 - b. Utilize corporate partnerships to provide visibility to the importance of oral health and increase the opportunities for social marketing and advocacy.

CHANGE OPPORTUNITIES/WEAKNESSES Cont.

3. Workforce Issues: (23)
 - a. Not enough providers for low-income citizens.
 - b. Need for providers in rural areas ‘maldistribution’.
 - c. Dentists may not want to serve children – need for pediatric dentists.
 - d. Need for "provider buy-in" by dental professionals – i.e. sealants as prevention.
 - e. Age of current dental provider cohort who may retire in the next decade or before.
 - f. An updated workforce policy and the need for a dental healthcare workforce plan.
 - g. The need for a healthcare workforce plan for physicians, nurses, nutritionists and health educators, as well as other medical professionals.
 - h. Not enough training for health care providers, misallocation of providers.
 - i. Additional year requirement for dental students (5th year) for the purpose of public service experience.
4. Create mid-level practitioner and increase expanded functions. (22)
 - a. Mid-level practitioner in schools.
5. Cultural issues (20)
 - a. Education, values, disparities in Kentucky with regard to health and health care.
 - b. Education on the importance of oral health is needed (for children, parents, grandparents).
6. Tear down “silos” (provider groups-funding sources). (18)
7. More aggressive prevention strategies (example - varnish, sealants). (18)
8. Regional safety nets are needed. (14)
 - a. Safety net resources.
9. Oral health integrated into overall health – Community Healthcare System. (10)

CHANGE OPPORTUNITIES/WEAKNESSES Cont.

10. Focus public attention on the positive side of oral health. (8)
 - a. Increase public awareness of “healthy” food choices (particularly in schools).
 - b. Impact school nutrition – vending machines.
 - c. Increase public awareness of the negative effects of tobacco use.
 - d. Decrease use and delay onset of tobacco use.
 - e. Spit tobacco education – a real problem for kids in school that are using it.
 11. Utilize under-utilized resources such as: (8)
 - a. AHECs and HANDs staff, (generally more cross-training).
 - b. Need to increase the variety of health providers who are oral health advocates. HANDS, home health, university curriculums (for nurses, physicians, etc.).
 - c. School nurse participation with oral health.
 - d. Community health centers and clinics.
 12. Create interdisciplinary curricula in academic medical centers; impress upon all disciplines the necessity for integrated approach. (5)
 13. Case management – need for a "dental home". (2)
 14. Financial incentives (loans, scholarships, equipment) for distribution of providers;
 - a. to attract providers
 - b. for students in dental school
 - c. county-level advocacy for dental providers to locate in rural areas.
 15. Economic development benefits.
 - a. Community awareness.
 - b. Tie wellness with economic progress and stability.
 16. Dental school link with College of Agriculture and Extension Service.
 17. Impact of oral health on preterm low birth weight infants and periodontal care for pregnant women.
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CHANGE OPPORTUNITIES/WEAKNESSES Cont.

18. Tobacco tax for oral health.
19. Special needs for geriatric population.
20. Lack of access to optimal oral health sources.
21. Lack of statewide oral health infrastructure.
22. Dental education current lacks diversity and needs empathy training. Teaching methods using standardized patients might improve this experience.
23. Educate Medicaid patients on how to be better patients and reduce "red-tape" for dentists to increase provider participation.
24. Too few mobile dental units in areas of need.
25. Need reliable indicators of oral health.
26. Must link strategies to Healthy Kentucky 2010.
27. More data is needed to look at population-based oral health issues. Medicaid and private providers have so much information that we don't have access to.
28. Need focus groups of low income people to determine barriers.
29. Need more oral health educators for health promotion and disease prevention in schools.

(#) indicates the number of priority votes this issue/initiative received from the planning committee.

THREATS

1. Kentucky has a culture of toothlessness – people do not want care because of fear or perceptions.
2. The disease state is often just used to obtain medications.
3. Non-integrated and limited oral health system; Medicaid and dentists oppose each other.
4. Existing manpower is not being used effectively, provider shortages are imminent.
5. Continued economic down-turn pervasive.
6. Attitude toward oral health – public and policy makers.
 - a. Lack of organization which is a barrier to advocacy
 - b. Resulting lack of funding.
 - c. “It’s all about turf”.
7. Shift in funding focus – “whimsy” of categorical funding.
8. Inertia abounds.
9. Lack of “buy-in” as to seriousness of the issue by many people.
10. Discussion becomes divisive.
11. “Splintering” effect of advocates who disagree.
12. Failure to respond to cultural changes in Kentucky.
13. Continuation of unfunded federal mandates.
14. Lack of availability of care for children with special needs.
15. Ignorance of oral mechanisms of disease – need for more education.

THREATS cont.

16. Most Kentucky counties are Dental HPSA's but are not officially delegated as such.
17. Medicaid dental fraud cases are not receiving adequate attention.
18. Lack of public health perspective among dentists.
19. Inaccurate interpretation of provider utilization by payer source.
20. Oral health should be better supported financially by all branches of State Government.



Advocacy

The advocacy work group identified the following goals and objectives for the statewide plan:

Goal 1.0 Develop and administer government policy and programs that address oral health as a full component of overall health for eligible populations.

- Organize an oral health legislative campaign to heighten oral health awareness by January 2007.
- Develop an Oral Health Advocacy Network to enhance the "switchboard effect" for oral health issues.
- Increase oral health state funding from \$ 2 million in 2005 to \$ 6 million by July 1, 2010. *(Funding)**
- Increase Kentucky Medicaid fees from the present levels to the 75th percentile of usual and customary fees by January 1, 2010. *(Funding)*
- Review of public health statutes and policies that may be perceived as barriers to integration of oral health into primary care at the local level. *(Partnerships)*
- Require dental screening upon entry into early care and education by passage of necessary legislation by February 2007. *(School-Based Coordination)*

Goal 2.0 Elevate the importance of oral health in the public discourse about health status in Kentucky.

- Develop a single, strong, powerful message that connects oral health as an important component of overall physical health by October 2007.

* Some objectives will be accomplished by working in conjunction with one or more of the other workgroups as listed in parenthesis.

The Advocacy Workgroup

- Larry Hill, Chair
- Lacey McNary, Co-Chair
- Bob Brooks
- Susan Fister
- Charles Ross
- Katrina Thompson
- Sharon Turner



Strategic Initiative Area ~ Advocacy

Goal 1.0 Develop and administer government policy and programs that address oral health as a full component of overall health for eligible populations.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>1.1 Organize an oral health legislative campaign to heighten oral health awareness by January 2007.</p> <p>Advocacy Workgroup Kentucky Dental Health Coalition Kentucky Dental Association Kentucky Oral Health Program</p>	<ul style="list-style-type: none"> • Kentucky must have a legislature that is willing and able to review oral health issues. • Groups working at the legislative level must approach this collaboratively and in an organized manner. • The plan must be supported by the KDA 	<ul style="list-style-type: none"> • Money • Politics • Economy and war efforts. • Magnitude of the task at hand. • Legislative and public interest. • Funds to lobbying (foundations can not fund this effort).
<p>1.2. Develop an Oral Health Advocacy Network to enhance the “switchboard effect” for oral health issues.</p> <p>Advocacy Workgroup Kentucky Dental Health Coalition Kentucky Dental Association Kentucky Dental Hygienist Association</p>	<ul style="list-style-type: none"> • Various groups must collaborate. • Coordination by lead group for advocacy network management. • Volunteers with diverse backgrounds necessary as advocates. • Various ways to comment (i.e. internet, phone, written) must be available. 	<ul style="list-style-type: none"> • Need a coordinator. • Apathy among volunteers. • Lack of coordination of system. • Lack of support from other advocacy groups.

Strategic Initiative Area ~ Advocacy

<p>Goal 1.0 Develop and administer government policy and programs that address oral health as a full component of overall health for eligible populations. (continued)</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>1.3 Increase the oral health state funding from \$ 2 million in 2005 to \$ 6 million by July 1, 2010.</p> <p>Kentucky Oral Health Program</p>	<ul style="list-style-type: none"> • A legislative sponsor must be identified and oral health education must take place prior to the submission of a bill. • The DPH and Strategic Planning Workgroup must have a business plan for program implementation. 	<ul style="list-style-type: none"> • Major dental associations and coalitions must support this initiative. • Discussion and views must be taken into consideration prior to the legislative session. • Also barriers stated in Objective 1.1.
<p>1.4. Increase Kentucky Medicaid fees from the present levels to the 75th percentile of usual and customary fees (as reported by the American Dental Association for Kentucky's region) by January 1, 2010.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> • Requires additional funding. The legislature must be willing to address this societal problem by providing the adequate funding necessary to support this program. 	<ul style="list-style-type: none"> • Legislative Action Required.
<p>1.5. Review of public health statutes and policies that may be perceived as barriers to integration of oral health into primary care at the local level.</p> <p>Oral Health Program Partnership and Collaboration Workgroup Advocacy Workgroup</p>	<ul style="list-style-type: none"> • Inclusion of crucial professions in review process. • Systematic review including older statutes. 	<ul style="list-style-type: none"> • Unorganized process. • Lack of support from various health professional associations. • General unwillingness to change current statutes, even if inconsistencies are identified.

Strategic Initiative Area ~ Advocacy

Goal 1.0 Develop and administer government policy and programs that address oral health as a full component of overall health for eligible populations. (continued)		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
1.6. Require dental screening upon entry into early care and education by passage of necessary legislation by February 2007.	<ul style="list-style-type: none"> • Gather education and oral health data to document need. • Gather data on benefits of exams as opposed to screens. Also criteria for optimal schedule for screening through the childhood period. • Understand who is affected by the regulation. • Legislation should include language that requires follow-up treatment if indicated. • Identify a sponsor for the bill. 	<ul style="list-style-type: none"> • Efforts should be tied to enhancement of treatment system. • Community control of the “model of care and treatment”. • Is Kentucky’s dental workforce able to provide treatment? • What about counties where few or no providers are located? <p>To ensure success with legislators, the following would be critical:</p> <ul style="list-style-type: none"> • Documentation of need • Explanation of coordinated effort • How screening leads to treatment which then leads to positive outcomes.
Kentucky Dental Coalition Oral Health Program Kentucky Dental Association Kentucky Dental Hygienist Coalition		

Strategic Initiative Area ~ Advocacy

Goal 2.0 Elevate the importance of oral health in the public discourse about health status in Kentucky.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>2.1. Develop a single, strong, powerful message that connects oral health as an important component of overall physical health by October 2007.</p> <p>Advocacy Workgroup Kentucky Dental Health Coalition Kentucky Dental Association Kentucky Dental Hygienist Association Oral Health Program</p>	<ul style="list-style-type: none"> • Integration of mission, vision, and values statements into overall message. • Message must be appropriate for all levels of citizenry and clearly define the importance of optimal oral health. 	<ul style="list-style-type: none"> • Time necessary for discussion and funding to allow for committee meetings. • Facilitator may be necessary to assist group through the process of crafting a statement. • Involvement with communication professionals to assure message clarity.



Economic Development

The economic development work group identified the following goals and objectives for the statewide plan:

Goal 3.0: Communicate that good oral health has economic value.

- Determine the lifetime earning potential based on a healthy, aesthetic dentition; i.e. "A Smile-Value Study" undertaken by the University of Louisville, School of Dentistry by 2008.
- Require oral examination by dentists for welfare-to-work programs and other entitlements related to employment by 2010.
- Provide "Medicaid" or oral rehabilitation services for adults seeking employment by 2010.
- Reduce lost job productivity, secondary to absence from work due to dental disease of employees and/or their family members.

Goal 4.0: Communicate that dentistry is a business and has economic impact on communities.

- Demonstrate that dental offices are also employers in a community.
- Recognize that dentistry has high set-up and operational costs.
- Recognize the importance and value of a maintained and sustainable dental practice to a community.
- Encourage and recruit dental professionals to a community.

Goal 5.0: Build communities with high quality health infrastructures to attract and retain employers.

- Prepare state and local profiles, including oral health providers and services, and make these available to potential employers and the local citizenry.

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- Educate community economic development professionals and business leaders about the value of oral health as an integral part of business recruitment.
- Encourage local economic development efforts to determine health care interests of present and potential employers.

Goal 6.0: Increase the number of dental professionals to underserved areas to assure access to care.

- Call for the expansion of the National Health Service Corps to increase opportunities to additional sites by 2010.
- Reinstigate the National Health Service Corps provision of equipment for commissioned officers opening practices in underserved areas by 2010.
- License foreign-trained dentists that are willing to practice only in underserved areas.
- Create a variety of mid-level dental practitioners for extension of services to underserved areas.
- Complete the Kentucky Oral Health Workforce Analysis Study to determine where the dental manpower needs are by 2007. **(Workforce)*

* Some objectives will be accomplished by working in conjunction with one or more of the other workgroups as listed in parenthesis.

The Economic Development Workgroup

Lee Mayer, Chair
Marybeth Crouch, Co-Chair
Jill Butters
Charlene McGrath
Julie Watts McKee
Marquetta Poynter
Karkie Tackett
David Willis

Strategic Initiative Area ~ Economic Development

Goal 3.0 Communicate that good oral health has economic value.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>3.1 Determine the lifetime earning potential based on a healthy, aesthetic dentition; i.e. "A Smile-Value Study" undertaken by the University of Louisville School of Dentistry by 2008.</p> <p>UL School of Dentistry</p> <p>3.2 Require oral exams by dentists for welfare-to-work programs and other entitlements related to employment by 2010.</p> <p>Kentucky Dental Association Kentucky Dental Hygienists Association Kentucky Oral Health Program</p> <p>3.3 Provide "Medicaid" or Oral Rehabilitation services for adults seeking employment by 2010.</p> <p>Kentucky Dental Association Kentucky Dental Hygienists Association Kentucky Dental Health Coalition</p> <p>3.4 Reduce lost job productivity secondary to absence from work due to dental disease of employees and/or family members.</p>	<ul style="list-style-type: none"> • Base study should relate to earning potential in the same way as educational level attained influences future earning. • Should be structured similarly to current physical and drug exams. • Cooperation from the Kentucky Department of Education-Rehabilitation. (Note: These services were previously provided). • Educate work force on oral health and prevention. • Encourage purchase and use of dental insurance. 	<ul style="list-style-type: none"> • Lack of funding. • Lack of funding. • Cooperation of recipients. • Cooperation of providers. • Lack of funding. • Lack of providers. • No insurance. • Lack of providers.

Strategic Initiative Area ~ Economic Development

Goal 4.0 Communicate that dentistry is a business and has economic impact on communities		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>4.1 Demonstrate that dental offices are also employers in a community and keep dollars at home.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> Present data from the American Dental Association article about the value and impact of the dentistry profession. 	<ul style="list-style-type: none"> Isolation of dentistry from the rest of the business and/or health care community.
<p>4.2 Recognize that dentistry has high set-up and operational costs.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> The local Chamber of Commerce and financial community members must support this project. 	<ul style="list-style-type: none"> Isolation of the profession. The connotation of "rich dentists".
<p>4.3 Recognize the importance and value of a maintained and sustainable dental practice to a community.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> People like to see the "same" dentists, not always a new one. Similarly, they prefer local physicians to ones cycling through. 	<ul style="list-style-type: none"> Finances Quality of Life. Getting graduates to return to rural areas and economically depressed neighborhoods.
<p>4.4 Encourage and recruit dental professionals to a community.</p> <p>Oral Health Program Kentucky Board of Dentistry</p>	<ul style="list-style-type: none"> Give economic incentives to dental professionals practicing in a community with a dental professional shortage. (i.e. loan repayment, Medicaid payments) Create enterprise zones. 	<ul style="list-style-type: none"> Finances Quality of Life. Living conditions. Legislation required.

Strategic Initiative Area ~ Economic Development

Goal 5.0 Build communities with high quality health infrastructures to attract and retain employers.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>5.1 Prepare state and local profiles, including oral health providers and services, and make these available to potential employers and the local citizenry. Monitor changing demographics of Kentucky counties.</p> <p>Oral Health Program Economic Development Workgroup Kentucky Dental Association</p>	<ul style="list-style-type: none"> Requires a combined effort of all local and state agencies, providers. Employees want services and employers want healthy employees. Utilize Kentucky State Data Center for on-going monitoring activities of target populations. 	<ul style="list-style-type: none"> Lack of interest. No one assigned to take on this project. May never have been thought of as a recruitment tool.
<p>5.2 Educate community economic development professionals and business leaders about the value of oral health as an integral part of business recruitment.</p> <p>Oral Health Program Economic Development Workgroup Kentucky Dental Association</p>	<ul style="list-style-type: none"> Provide training using materials developed from previous objective (5.1). 	<ul style="list-style-type: none"> Must communicate value and importance of oral health as a part of overall health.
<p>5.3 Encourage local economic development efforts to determine health care interests of present and potential employers.</p> <p>Economic Development Workgroup Oral Health Program Kentucky Dental Association</p>	<ul style="list-style-type: none"> Area development districts and recruiters should check such interests. 	<ul style="list-style-type: none"> Can the community provide the required benefits? If the reason for this question is not clear to employers, this could be a barrier to an accurate response.

Strategic Initiative Area ~ Economic Development

Goal 6.0 Increase the number of dental professionals to underserved areas to assure access to care.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>6.1 Call for the expansion of the National Health Service Corps to increase opportunities to additional sites by 2010.</p> <p>Kentucky Dental Association Workforce Development Workgroup Kentucky Oral Health Program</p>	<ul style="list-style-type: none"> Dental Health Professional Shortage Area designations need to be updated to reflect the true access-to-care needs across Kentucky. Guarantee recruitment to high-need locations through loan repayment offers upon sign-up. History of success in Kentucky, particularly for very rural practices. Two dental operatories and start-up equipment used to be provided. 	<ul style="list-style-type: none"> Bureaucracy Lack of funding for staffing to work on HPSA designations. Politics associated with HPSA designations.
<p>6.2 Reconstitute the National Health Service Corps provision of equipment for commissioned officers opening practices in underserved areas by 2010.</p>	<ul style="list-style-type: none"> Some states allow this now, especially for particular populations and localities. 	<ul style="list-style-type: none"> Lack of funding.
<p>6.3 License foreign trained dentists that are willing to practice only in underserved areas.</p> <p>Kentucky Dental Association</p>		<ul style="list-style-type: none"> Legislation necessary. American Dental Association. Are credentials sufficient? Adequate training in foreign schools?

Strategic Initiative Area ~ Economic Development

<p>Goal 6.0 Increase the number of dental professionals to underserved areas to assure access to care. (continued)</p>		
<p>Objective Who, What, When</p>	<p>Critical Success Factors and Activities</p>	<p>Barriers to Success</p>
<p>6.4 Create a variety of mid-level dental practitioners for extension of services to underserved areas.</p> <p>Kentucky Dental Association University of Kentucky College of Dentistry University of Louisville School of Dentistry</p>	<ul style="list-style-type: none"> • This has occurred in other countries and in remote areas of Alaska. • ADA and ADHA would have to be cooperative. 	<ul style="list-style-type: none"> • Internal politics/scope of practice issues. • Training, supervision, sanctioning practice locations. • Public interpretation.
<p>6.5 Complete the Kentucky Oral Health Workforce Analysis Study to determine where the needs are by late 2007.</p> <p>Oral Health Program University of Louisville School of Dentistry University of Louisville School of Public Health and Information Sciences</p>	<ul style="list-style-type: none"> • Commissioned by the Department for Public Health and undertaken by the University of Louisville, College of Dentistry starting Fall of 2004. 	<ul style="list-style-type: none"> • Needs to be completed within the three-year period of the HRSA grant supporting the project (Oral Health Collaborative Systems Grant).

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Funding

The funding work group identified the following goals and objectives for the statewide plan:

Goal 7.0: Increase available funding for oral health to increase access to care.

- Carve out dental Medicaid Program and establish a single payer system for dental services by December 2006.
- Increase Kentucky Medicaid fees from the present levels to the 75th percentile of usual and customary fees by January 1, 2010.
- Increase oral health state funding from \$ 2 million in 2005 to \$ 6 million by July 1, 2010.
- Investigate additional federal grants specific to oral health access to care and collaborative partnerships annually; particularly for special populations.
- Investigate private foundation funding opportunities in oral health improvement for disparate populations.

The Funding Workgroup

Fred Howard, Chair
Tim Feeley, Co-Chair
Mary Sue Flora
Cliff Maesaka
Mike Porter

Strategic Initiative Area ~ Funding

Goal 7.0 Increase available funding for oral health to increase access to care.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>7.1. Carve out dental Medicaid Program and establish a single payer system for dental services by December 2006.</p> <p>Oral Health Program</p>	<ul style="list-style-type: none"> • Support of Governor, Secretary of Health and Human Services and State Legislature. • Support of the profession. 	<ul style="list-style-type: none"> • Lack of support of Governor, Secretary of Health and Human Services and State Legislature.
<p>7.2. Increase Kentucky Medicaid fees from the present levels to the 75th percentile of usual and customary fees (as reported by the American Dental Association for Kentucky's region) by January 1, 2010.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> • Requires additional funding. The legislature must be willing to address this societal problem by providing adequate funding necessary to support this program. 	<ul style="list-style-type: none"> • Legislative action required.
<p>7.3. Increase in oral health state funding from \$ 2 million in 2005 to \$ 6 million by July 1, 2010.</p> <p>Kentucky Dental Association Oral Health Program</p>	<ul style="list-style-type: none"> • The Department for Public Health and Strategic Planning Workgroup must have a solid plan for utilization of the additional funding and a business plan for program implementation. 	<ul style="list-style-type: none"> • Major dental associations and coalitions must go into the legislative session supporting this initiative.

Strategic Initiative Area ~ Funding

Goal 7.0 Increase available funding for oral health to increase access to care. (continued)		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>7.4. Investigate federal grants specific to oral health access to care and collaborative partnerships annually; particularly for special populations.</p> <p>Oral Health Program Kentucky Dental Association</p>	<ul style="list-style-type: none"> • Adequate state dental program that can direct these programs. 	<ul style="list-style-type: none"> • Lack of a central resource that can pursue and direct these efforts.
<p>7.5. Investigate private foundation funding opportunities in oral health improvement for disparate populations.</p> <p>Oral Health Program</p>	<ul style="list-style-type: none"> • Utilization of an organization such as the Kentucky Dental Health Coalition to find these resources and to direct their use. 	<ul style="list-style-type: none"> • Kentucky Dental Health Coalition lacks adequate staff to carry out this function.

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Partnerships and Collaboration

The Partnerships and Collaboration work group identified the following goals and objectives for the statewide plan:

Goal 8.0: To solicit, develop and nurture relationships with other organizations and associations to expand awareness of and expand the focus on oral health.

- Determine what organizations are currently providing (and interested in providing) regarding oral health care in Kentucky. Publish this assessment by September 2007.
- Identify agencies and organizations not currently involved but whose involvement would be beneficial to the provision of oral health services or advocacy efforts by September 2007.
- Establish at least five local and regional strategic oral health partnerships to develop coordinated oral health efforts by January 1, 2010.
- Identify potential community partners throughout Kentucky who are willing to invest in oral health wellness and disease prevention initiatives by March 2007.
- Develop a curriculum for the provision of basic oral health education, screening techniques and referral skills for non-dental professionals in Kentucky.* (*Workforce*)
- Review public health statutes and policies that may be perceived as barriers to integration of oral health into primary care at the local level.
- Provide multicultural oral health wellness resources to community partners by Fall 2007. (*Public Health Education*)
- Encourage community partners to coordinate oral health educational activities at established state-wide regional and local programs by July 2007. (*Public Health Education*)

Goal 9.0: To assist dental professionals to recognize signs of domestic violence observed in their patients, and to implement policies and procedures to reduce this burden on both patients and providers.

- Development and implementation of a continuing education program and resource materials to increase the recognition of domestic violence by dental professionals by December 2006. *(DPH Special Initiative)*

* Some objectives will be accomplished by working in conjunction with one or more of the other workgroups as listed in parenthesis.

The Partnerships and Collaboration Workgroup

David Bolt, Chair
Baretta Casey, Co-Chair
Morris Norfleet, Co-Chair
Mike Byrne
Sandy Cleveland
Dudley Conner
Sandy Goodlett
Bob Henry
David Hinson
Judy McCrackin
Loretta Maldaner
Rosie Miklavcic
Carol Phebus
Linda Grace Piker
Bonnie Tanner



Strategic Initiative Area ~ Partnerships and Collaboration

<p>Goal 8.0 To solicit, develop and nurture relationships with other organizations and associations to expand awareness of and expand the focus on oral health.</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>8.1 Determine what organizations are currently providing (and interested in providing) regarding oral health care in Kentucky and to publish this assessment and directory by September 2007.</p> <p>Oral Health Program Partnership and Collaborations Workgroup</p>	<ul style="list-style-type: none"> • Staff or contractor time to complete the assessment and publish the directory. • Funding is necessary for this project. 	<ul style="list-style-type: none"> • Lack of funding. • Lack of personnel. • Lack of volunteer and staff time to accomplish this task.
<p>8.2. Identify agencies and organizations not currently involved but whose involvement would be beneficial to the provision of oral health services or advocacy efforts by September 2007.</p> <p>Oral Health Program Partnership and Collaborations Workgroup</p>	<ul style="list-style-type: none"> • Coordination with other health services must be maintained. • Agencies must be willing to work with oral health improvement efforts and realize the importance of their role in the initiative. 	<ul style="list-style-type: none"> • Knowledge of oral health by other providers must be improved and the will to work cooperatively must be present.
<p>8.3. Establish at least five local and regional strategic oral health partnerships to develop coordinated oral health efforts by January 1, 2010.</p> <p>Oral Health Program Partnership and Collaborations Workgroup</p>	<ul style="list-style-type: none"> • Must start with local support. • Commitment is necessary from the local directors and organizations. • Dentists and auxiliary staff must be involved. 	<ul style="list-style-type: none"> • Belief or realization of dental needs by dentists in communities as well as local policy makers. • The will to improve oral health status in the community must exist.

Strategic Initiative Area ~ Partnerships and Collaboration

Goal 8.0 To solicit, develop and nurture relationships with other organizations and associations to expand awareness of and expand the focus on oral health. (continued)

Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>8.4. Identify potential community partners throughout Kentucky who are willing to invest in oral health wellness and disease prevention initiatives by March 2007</p> <p>Public Health Education Workgroup DPH Oral Health Program Student Intern (TBD)</p>	<ul style="list-style-type: none"> • Obtainment of email addresses of health educators in local county health dept's as well as universities, AHEC's, and other community educators. • Partner with KDHC, KDHA, KDA. • Partner with HEEL program. 	<ul style="list-style-type: none"> • Satisfying stakeholders. • Lack of funding. • Lack of manpower. • Few partners with needed expertise.
<p>8.5. Develop a curriculum for the provision of basic oral health education, screening techniques and referral skills for non-dental professionals in Kentucky.</p> <p>Oral Health Program University of Kentucky College of Dentistry</p>	<ul style="list-style-type: none"> • Cooperation between dental professional organizations and medical professionals. • Inclusion in the curriculum development process by providers in various professions. 	<ul style="list-style-type: none"> • Lack of participation by other medical professionals. • Curriculum must be inclusive in nature • Continuing Education Credits for various professions must be secured.

Strategic Initiative Area ~ Partnerships and Collaboration

<p>Goal 8.0 To solicit, develop and nurture relationships with other organizations and associations to expand awareness of and expand the focus on oral health. (continued)</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>8.6 Review of Public Health Statutes and policies that may be perceived as barriers to integration of oral health into primary care at the local level.</p> <p>Oral Health Program Partnership and Collaboration Workgroup Advocacy Workgroup</p>	<ul style="list-style-type: none"> • Inclusion of crucial professions in review process. • Systematic review including older statutes. 	<ul style="list-style-type: none"> • Disorganized process. • Lack of support from various health professional associations. • Unwillingness to change current statutes if inconsistencies identified.
<p>8.7. Provide multicultural oral health wellness resources to community partners by Fall 2007</p> <p>DPH Oral Health Program</p>	<ul style="list-style-type: none"> • Identify community workers working on diversity projects. • Identify leaders in multicultural community. 	<ul style="list-style-type: none"> • Satisfying stakeholders. • Lack of funding. • Lack of manpower. • Few partners with needed expertise.
<p>8.8. Encourage community partners to coordinate oral health educational activities at established state-wide, regional and local programs by July 2007.</p> <p>Public Health Education Workgroup DPH Oral Health Program</p>	<ul style="list-style-type: none"> • Major programs include Children’s Dental Health Month, Special Olympics and Kentucky State Fair. • Involvement of state dental health-educator crucial. 	<ul style="list-style-type: none"> • Lack of enthusiasm. • Time – sacrifice • Lack of manpower. • Possible problem with incentives for partners – what are they?

Strategic Initiative Area ~ Partnerships and Collaboration

<p>Goal 9.0 To assist dental professionals to recognize signs of domestic violence observed in their patients, and to implement policies and procedures to reduce this burden on both patients and providers.</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>9.1. Development and implementation of a continuing education program and resource materials to increase the recognition of domestic violence by dental professionals by December 2006.</p> <p>University of Kentucky College of Dentistry Kentucky Oral Health Program Kentucky Domestic Violence Association Kentucky Justice and Public Safety Cabinet Kentucky Dental Association</p>	<ul style="list-style-type: none"> Continuing education workshops and supporting educational materials will be offered annually to Kentucky professional dental associations. Oral health/domestic violence toolkits (including a resource directory) will be developed and disseminated to dental professionals. Continuation of funding. 	<ul style="list-style-type: none"> Dental associations and coalitions must support this initiative. Dental professionals may not recognize their role in identifying the signs and symptoms of domestic violence. Currently, there are no mandatory domestic violence continuing education requirements for Kentucky dental professionals. Lack of adequate funding for material and course development.



Prevention and Treatment

The prevention and treatment work group identified the following goals and objectives for the statewide plan:

Goal 10.0: Provide lifelong maintenance of oral wellness through coordinated, integrated, and comprehensive services.

- Change perceptions of oral health by providing information and training to all health providers and health provider educators beginning in January 2007.
- To reduce oral disease, increase the percentage of Kentucky children who have an identifiable dental home and who have been seen by their dentist before age three by 50% by December 31, 2010.
- Develop criteria for provider ownership of oral health care.
- Reduce incidence of oral disease by increasing the use of fluoride varnishes by 25% in children aged 6 to 72 months in Kentucky by December 31, 2007.
- Reduce the incidence of oral disease by increasing the use of sealants applied to permanent molars in children by 25% in Kentucky by December 31, 2007.
- Develop pilot communities for children's oral health coalition building activities by January 1, 2007.
- Include oral health clinical guidelines in Kentucky's Medicaid Oral Health Benefit by Fall of 2007, for the purpose of the prevention of preterm birth and the management of diabetes as well as cardiovascular disease, through improved oral health care.

The Prevention and Treatment Workgroup

Steve Wrightson, Chair Bertie Salyer, Co-Chair
Jo Comley
Kathy Fields
Stephanie Poynter
Cris Sparks
Garland VanZant

Strategic Initiative Area ~ Prevention and Treatment

<p>Goal 10.0 Provide lifelong maintenance of oral wellness through coordinated, integrated, and comprehensive services.</p>		
<p>Objective Who, What, When</p>	<p>Critical Success Factors and Activities</p>	<p>Barriers to Success</p>
<p>10.1 Change perceptions of oral health by providing information and training to health providers and health provider educators beginning in January 2007.</p> <p>Kentucky Oral Health Program Kentucky Dental Association Kentucky Dental Hygienists Association University of Kentucky College of Dentistry University of Louisville School of Dentistry Kentucky Pediatric Society Area Health Education Centers Local Health Departments</p>	<ul style="list-style-type: none"> • Assure that health providers understand the importance of good oral health as a part of overall health of their patients and communicate this to their patients. • Obtain lists of potential providers and target educational sessions. • Local health departments may play a role in this outreach to local providers. • Pilot sessions with continuing education units (CEU's) to be developed by September 2006. 	<ul style="list-style-type: none"> • Need to operationalize ownership and perceptions.

Strategic Initiative Area ~ Prevention and Treatment

Goal 10.0 Provide lifelong maintenance of oral wellness through coordinated, integrated and comprehensive services (continued)		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>10.2 To reduce oral disease, increase the percentage of Kentucky children who have an identifiable dental home and who have been seen by their dentist before age three by 50% by December 31, 2010.</p> <p>Kentucky Oral Health Program Kentucky Dental Association Kentucky Dental Hygienists Association University of Kentucky College of Dentistry University of Louisville School of Dentistry Kentucky Pediatric Society Area Health Education Centers Local Health Departments</p>	<ul style="list-style-type: none"> • Create a system to identify and track the number of children who go to a dentist by age 3. 	<ul style="list-style-type: none"> • Funding • Staffing • The records of private providers are not currently accessible.

Strategic Initiative Area ~ Prevention and Treatment

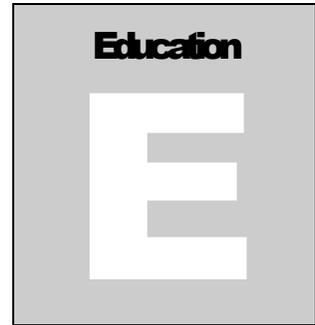
Goal 10.0 Provide lifelong maintenance of oral wellness through coordinated, integrated and comprehensive services (continued)		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>10.3 Develop criteria for provider ownership of oral health care.</p> <p>Kentucky Oral Health Program Kentucky Dental Association Kentucky Dental Hygienists Association University of Kentucky College of Dentistry University of Louisville School of Dentistry Kentucky Pediatric Society Area Health Education Centers Local Health Departments</p>	<ul style="list-style-type: none"> Criteria to include that the provider see children, educate children and parents and work in other areas of disease prevention or health maintenance. 	<ul style="list-style-type: none"> None identified.
<p>10.4 Reduce incidence of oral disease by increasing the use of fluoride varnishes by 25% in children aged 6 to 72 months in Kentucky by December 31, 2007.</p> <p>Kentucky Oral Health Program Kentucky Dental Association Kentucky Dental Hygienists Association University of Kentucky College of Dentistry University of Louisville School of Dentistry Kentucky Pediatric Society Area Health Education Centers Local Health Departments</p>	<ul style="list-style-type: none"> The application of fluoride varnish is currently underway through the KDPH Data tracking system in place and monthly reports for statewide fluoride varnish applications available. Public/Private Partnerships are necessary to achieve goal. 	<ul style="list-style-type: none"> Oral Health Program staffing must be maintained to coordinate programs and maintain data. Fluoride Varnish is currently funded through federal tobacco settlement dollars. Cooperation between health providers can increase the scope of provider ability.

Strategic Initiative Area ~ Prevention and Treatment

Goal 10.0 Provide lifelong maintenance of oral wellness through coordinated, integrated and comprehensive services (continued)		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>10.5 Reduce the incidence of oral disease by increasing the use of sealants applied to permanent molars in children by 25% in Kentucky by December 31, 2007.</p> <p>Oral Health Program Kentucky Dental Association and Partners</p>	<ul style="list-style-type: none"> • Currently underway through the KDPH. • Selected local health departments will receive funding for sealant applications. • Public/Private Partnership necessary to achieve fluoride varnish application goal. • Improve oral health care access by selecting three urban and three rural communities for oral health coalition-building activities to benefit children and families. 	<ul style="list-style-type: none"> • Funded currently through State General Fund dollars. Funding must be maintained and increased. • Cooperation necessary from local dentists and local health departments who receive the funding for this program.
<p>10.6 Develop pilot communities for children's oral health coalition building activities by January 1, 2007.</p> <p>Oral Health Program Kentucky Dental Association and Partners</p>	<ul style="list-style-type: none"> • Improve oral health care access by selecting three urban and three rural communities for oral health coalition-building activities to benefit children and families. 	<ul style="list-style-type: none"> • Longevity of the coalition. • Competing priorities for coalition members. • Health illiteracy.

Strategic Initiative Area ~ Prevention and Treatment

<p>Goal 10.0 Provide lifelong maintenance of oral wellness through coordinated, integrated and comprehensive services (continued)</p>		
<p>Objective Who, What, When 10.7 Include oral health clinical guidelines in Kentucky's Medicaid Oral Health Benefit by Fall of 2007, for the purpose of the prevention of preterm birth and the management of diabetes as well as cardiovascular disease, through improved oral health care. Oral Health Program University of Kentucky College of Dentistry University of Louisville School of Dentistry Kentucky Dental Association Kentucky Dental Hygienists Association Kentucky Primary Care Association Kentucky Federal Community Health Centers The HEEL Program Area Health Education Centers</p>	<p>Critical Success Factors and Activities</p> <ul style="list-style-type: none"> As of Spring 2006, a taskforce has been established and a draft protocol created for the prevention of preterm birth through the management of periodontal disease. Implementation of these clinical guidelines has not yet begun. Diabetes and Cardiovascular disease management will include the creation of respective taskforces and the development of draft clinical guidelines with the expectation of implementation in late 2007. 	<p>Barriers to Success</p> <ul style="list-style-type: none"> Reduction in the level of Medicaid Funding for Oral Health services. Lack of support by Kentucky's Dental Community.



Public Health Education

The public health education work group identified the following goals and objectives for the statewide plan:

Goal 11.0: Increase oral health wellness through education and disease prevention.

- Identify through an informal survey oral health wellness curriculums and programs currently being utilized in Kentucky by March 2007.
- Identify potential community partners throughout Kentucky who are willing to invest in oral health wellness and disease prevention initiatives by March 2007.
- Provide multicultural oral health wellness resources to community partners by Fall 2007.

Goal 12.0: Increase oral health wellness through coordinated state-wide educational activities.

- Review and update the Kentucky Smile Curriculum to be redistributed to Kentucky Schools and community partners by Fall 2005.
- Develop a state-wide reporting system at the Kentucky Department for Public Health for all oral health educational activities being conducted by community partners by Fall 2006.
- Encourage community partners to coordinate/incorporate oral health educational activities at established state-wide, regional and local programs by July 2006.

Goal 13.0: Increase oral health wellness through coordinated state-wide media.

- Strengthen parent involvement in oral health effort through public education and social marketing at the community level.* (*School-Based Coordination*)
- Encourage community partners to use media outlets to promote oral health educational activities to at the state and local level by Fall 2006.
- Seek support to plan and develop a statewide oral health media campaign by Fall 2007.

* Some objectives will be accomplished by working in conjunction with one or more of the other workgroups as listed in parenthesis.

Public Health Education Workgroup

Sharlee Shirley Burch, Chair

Dedra DeBerry, Co-Chair

Allison Gray

Libby Ritchie



Strategic Initiative Area ~ Public Health Education

Goal 11.0 Increase oral health wellness through education and disease prevention.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>11.1. Identify through an informal survey oral health wellness curriculum and programs currently being utilized in Kentucky by March 2007.</p> <p>Public Health Education Workgroup DPH Oral Health Program Student Intern (TBD)</p>	<ul style="list-style-type: none"> Obtain email addresses of health educators in local county health departments. Obtain contact information for universities, AHEC's, and other community educators. 	<ul style="list-style-type: none"> Satisfying stakeholders. Lack of funding. Lack of manpower. Few partners with needed expertise.
<p>11.2. Identify potential community partners throughout Kentucky who are willing to invest in oral health wellness and disease prevention initiatives by March 2007</p> <p>Public Health Education Workgroup DPH Oral Health Program Student Intern (TBD)</p>	<ul style="list-style-type: none"> Obtain email addresses of health educators in local county health dept's as well as universities, AHEC's, and other community educators. Partner with KDHC, KDHA, KDA. Partner with HEEL program. 	<ul style="list-style-type: none"> Satisfying stakeholders. Lack of funding. Lack of manpower. Few partners with needed expertise.
<p>11.3. Provide multicultural oral health wellness resources to community partners by Fall 2007.</p> <p>DPH Oral Health Program</p>	<ul style="list-style-type: none"> Identify community workers working on diversity projects. Identify leaders in multicultural community. 	<ul style="list-style-type: none"> Satisfying stakeholders. Lack of funding. Lack of manpower. Few partners with needed expertise.

Strategic Initiative Area ~ Public Health Education

Goal 12.0 Increase oral health wellness through coordinated state-wide educational activities.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>12.1. Review and update the Kentucky Smile Curriculum to be redistributed to Kentucky Schools and community partners by Fall 2005.</p> <p>University of Kentucky College of Dentistry DPH Oral Health Program</p>	<ul style="list-style-type: none"> Completed by Sharlee Shirley Burch and HEEL Program – available for use February 2006. 	NONE
<p>12.2. Develop a state-wide reporting system at the Kentucky Department of Public Health for all community oral health educational activities by Fall 2006.</p> <p>DPH Oral Health Program</p>	<ul style="list-style-type: none"> May already exist through PSRS reporting system. Involvement of state dental health educator crucial. 	<ul style="list-style-type: none"> Inability to attain information from community partners. Lack of funding. Lack of manpower.
<p>12.3. Encourage community partners to coordinate/incorporate oral health educational activities at established state-wide, regional and local programs by July 2006.</p> <p>Public Health Education Workgroup DPH Oral Health Program</p>	<ul style="list-style-type: none"> Major programs include Children’s Dental Health Month, Special Olympics Special Smiles and Kentucky State Fair. Involvement of state dental health educator crucial. 	<ul style="list-style-type: none"> Lack of enthusiasm. Time – sacrifice Lack of manpower. Possible problem with incentives for partners – what are they?

Strategic Initiative Area ~ Public Health Education

Goal 13.0 Increase oral health wellness through coordinated state-wide media.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>13.1 Strengthen parent involvement in oral health effort through public education and social marketing at the community level.</p> <p>Oral Health Program Department of Education Department for Medicaid Services</p>	<ul style="list-style-type: none"> • Address access/treatment needs of families who fall between K-CHIP and private care plans. • Team with already trusted 0-4 early childhood community programs (HANDS, Early Head Start, etc). • Team with primary school and school communities (PTA, PTO). 	<ul style="list-style-type: none"> • “Income Gap” harmful to treatment effort. • Enlightened self-interest of parents is necessary to the success of this effort.
<p>13.2. Encourage community partners to use media outlets to promote oral health educational activities at the state and local level by Fall 2006</p> <p>Public Health Education Workgroup DPH Oral Health Program</p>	<ul style="list-style-type: none"> • Explore funding opportunities for media campaign. • Explore web for free to use media for partners. 	<ul style="list-style-type: none"> • Lack of manpower. • Lack of funding. • Lack of enthusiasm/buy-in by partners.
<p>13.3. Seek support to plan and develop a statewide oral health media campaign by Fall 2007.</p> <p>Public Health Education Workgroup UK College of Public Health UL School of Information Sciences DPH Oral Health Program</p>	<ul style="list-style-type: none"> • Explore possibility of private foundation or corporate funding. • Identify existing campaigns in other states. • Partner with academic institutions • Plan, develop, design, create and evaluate potential campaigns. 	<ul style="list-style-type: none"> • No federal grant exists for this. • Manpower shortage for this type of research.

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School-Based Coordination

The school-based coordination work group identified the following goals and objectives for the statewide plan:

Goal 14.0: Assure that all children receive regular dental education and care as a part of an integrated program.

- Require dental screening upon entry into early care and education by passage of necessary legislation by February 2007.
- Develop curriculum and materials for use in early care and education by February 2007.
- Strengthen parent involvement in the oral health effort through public education and social marketing at the community level.

The School-Based Coordination Workgroup

Earl Trevor, Chair
Keith Sanders, Co-Chair
Phyllis Berry
Carol Blethen
Eileen Deren
Paul Dominique
Tammy Gay
Kelly Goins
Carrie Janszen
Jack Morris
Rita Moya
Christine Weyman



Strategic Initiative Area ~ School-Based Coordination

<p>Goal 14.0 Assure that all children receive regular dental education and care as a part of an integrated program.</p>		
<p>Objective Who, What, When</p> <p>14.1 Require dental screening upon entry into early care and education by passage of necessary legislation by February 2007.</p>	<p>Critical Success Factors and Activities</p> <ul style="list-style-type: none"> • Gather education and oral health data to document need. • Gather data on benefits of exams over screens and criteria for schedule for screening through the childhood period. • Understand who is affected by the regulation (who is early care and who is education?). • Legislation should include language that requires follow-up treatment if indicated. • Identify a sponsor for the bill. 	<p>Barriers to Success</p> <ul style="list-style-type: none"> • Efforts should be tied to enhancement of treatment system. • Community control of the “model of care and treatment”. • Is Kentucky’s dental workforce able to provide treatment? • What about counties where few or no providers are located? <p>To ensure success with legislators, the following would be critical:</p> <ul style="list-style-type: none"> • Documentation of need. • Explanation of coordinated effort. • How screening leads to treatment which then leads to positive outcomes.
<p>Kentucky Dental Coalition Oral Health Program Kentucky Dental Association Kentucky Dental Hygienist Coalition</p>		

Strategic Initiative Area ~ School-Based Coordination

<p>Goal 14.0 Assure that all children receive regular dental education and care as a part of an integrated program. (continued)</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>14.2 Develop curriculum and materials for use in early care and education by February 2007.</p> <p>Oral Health Program University of Kentucky College of Dentistry</p>	<p>Necessary to match research-based curricula to:</p> <ul style="list-style-type: none"> • Early childhood standards. • Head Start outcomes. • Program of studies (i.e. how is oral health reflected in CATS test?) 	<ul style="list-style-type: none"> • Barrier in possible poor match between curricula and standards, outcomes and program of studies.
<p>14.3 Strengthen parent involvement in oral health effort through public education and social marketing at the community level.</p> <p>Oral Health Program Department of Education Department for Medicaid Services</p>	<ul style="list-style-type: none"> • Address access/treatment needs of families who fall between K-CHIP and private care plans. • Public advocacy through social marketing to “build demand” for oral health care services. • Team with already trusted 0-4 early childhood community programs (HANDS, Early Head Start, etc). • Team with primary school and school communities (PTA, PTO). • Encourage parent to parent education and support. • Coordination with other health professions who serve children. 	<ul style="list-style-type: none"> • “Income Gap” harmful to treatment effort. • Enlightened self-interest of parents is necessary to the success of this effort.

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Workforce

The workforce work group identified the following goals and objectives for the statewide plan:

Goal 15.0: Assess the past, present and future status of the dental workforce in Kentucky and develop a work-plan to address identified needs.

- Complete a workforce study of oral health capacity and publish the results by June 30, 2007.
- Assess results and develop a work plan to address identified needs by December 2007

Goal 16.0: To increase collaboration with and between dental professionals and other medical professionals in Kentucky.

- Develop a curriculum which will provide basic oral health education, screening techniques and referral skills for non-dental professionals in Kentucky.
- Provide continuing education on oral health issues to health professionals throughout the Commonwealth.

The Workforce Workgroup

Beverly Largent, Chair

Raynor Mullins, Co-Chair

Linda M. Asher

Pam Burch

Sue Derouen

John Hensley

Dan Martin

Gina Miller

Gary Munsie

Connie Richmond

Kayla Rose

Strategic Initiative Area ~ Workforce

<p>Goal 15.0 To assess the past, present and future status of the dental workforce in Kentucky and develop a work-plan to address identified needs.</p>		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>15.1. To complete a workforce study of oral health capacity and publish the results by June 30, 2007.</p> <p>University of Louisville School of Dentistry University of Louisville School of Public Health and Information Sciences Oral Health Program</p>	<ul style="list-style-type: none"> Demographics (age, gender, professional degree); current and projected future practice profile, retention issues including out-of-state licensure and patient flow across county lines. Funding through HRSA/MCHB Oral Health Collaborative Systems Grant. U of L School of Dentistry study coordinator with support from U of L School of Public Health and Information Sciences. 	<ul style="list-style-type: none"> Funding continuation from HRSA/MCHB critical to study.
<p>15.2. To assess results and develop a work plan to address identified needs by December 2007.</p> <p>Kentucky Dental Association Kentucky Dental Hygienists Association Board of Dentistry Oral Health Program</p>	<ul style="list-style-type: none"> HPSA Dental Shortage area designations Planning for the retention and recruitment of teaching professionals and researchers. Funding opportunities and surveillance projects. Level of care for specific populations (i.e. pediatrics and geriatric). Additionally, midlevel practitioner issues include new role duties, year of training and licensure. 	<ul style="list-style-type: none"> Staffing limitations at the Department for Public Health critical to HPSA designation expansion efforts. Coordination with other groups such as Kentucky Dental Association and the Kentucky Oral Health Coalition.

Strategic Initiative Area ~ Workforce

Goal 16.0 To increase collaboration with and between dental professionals and other medical professionals in Kentucky.		
Objective Who, What, When	Critical Success Factors and Activities	Barriers to Success
<p>16.1. To develop a curriculum for the provision of basic oral health education, screening techniques and referral skills for non-dental professionals in Kentucky.</p> <p>Oral Health Program University of Kentucky College of Dentistry</p>	<ul style="list-style-type: none"> • Cooperation between dental professional organizations and medical professionals (including physicians, osteopaths, nurses and nurse practitioners as well as nutritionists and health educators.) • Inclusion in the curriculum development process by providers in various professions. 	<ul style="list-style-type: none"> • Lack of participation by other medical professionals. • Curriculum must be inclusive in nature and a variety of professionals must be tapped to contribute to the development process. • Continuing Education Credits for various professions must be secured.
<p>16.2. To provide continuing education on oral health issues to health professionals throughout the Commonwealth.</p> <p>Oral Health Program University of Kentucky College of Dentistry University of Louisville School of Dentistry</p>	<ul style="list-style-type: none"> • Important to keep oral health in front of medical and public health personnel as a part of on-going continuing education. This may include publishing articles in peer-reviewed journals (national and local) as well as other venues. 	<ul style="list-style-type: none"> • Need dental professionals to write articles and maintain a listing of possible publications regularly viewed by Kentucky medical and public health professionals.

Kentucky Oral Health Stakeholder Group

Strategic Planning Executive Committee	
Name	Title/Affiliation
David Bolt, MA	Chief Operating Officer/Director of Planning and Business Development, Lewis County Primary Care Center
James C. Cecil, DMD, MPH	Administrator, Kentucky Department for Public Health, Oral Health Program
Gerald A. Ferretti, DDS, MS, MPH	University of Kentucky College of Dentistry
Suzanne W. Hubbard, DDS	Director, State of Tennessee, Oral Health Services
Carrie Janszen, RDH, BSEd	Northern Kentucky Health Department
Julie Watts McKee, DDS	Director, WEDCO District Health Department
Morris Norfleet, PhD	Mountain Mission Development Corporation
Lyle B. Snider, PhD, MPH, RN	Regional Public Health Epidemiologist for the Big Sandy Region
Charles Ross, MPS	Director, Purchase District Health Department
Sharlee Shirley Burch, RDH, MPH	University of Kentucky, College of Dentistry
David Willis, DMD, MBA	University of Louisville, School of Dentistry

Strategic Planning Stakeholder Group	
Name	Title/Affiliation
David Aker	Director, Mountain Missions/Kentucky Baptist Convention
Linda Asher	University of Kentucky, Kentucky Area Health Education Center
Lois Baker	CEO, Mountain Comprehensive Care Center
Greg Bausch	Northeast Kentucky Area Health Education Center
Phyllis Berry	Associate Executive Director, Children Inc.
Harry Bickel, DMD, MPH	Training and Technical Assistance Services, Western Kentucky University
Carol Blethen	Kentucky Child Now!
Robert Brooks	Vice President, Trover Foundation
Pam Burch	Purchase Area Health Education Center
Representative Thomas Burch	Kentucky State House of Representatives
Jill Butters, RDH, MPH, EdD	University of Louisville, School of Dentistry
Michael E. Byrne	University of Louisville, School of Medicine Area Health Education Center
Baretta R. Casey, MD	Vice Chair, East Kentucky Campus; University of Kentucky Department of Family and Community Medicine
C. Lawrence Chiswell, DMD	Lexington Community College, Dental Hygiene Program

HEALTHY KENTUCKY SMILES: A LIFETIME OF ORAL HEALTH

Strategic Planning Stakeholder Group (continued)	
Name	Title/Affiliation
Sandy Cleveland, RN	Kentucky Department for Public Health, Maternal and Child Health Branch
Jo Comley, BA	Kentucky Department for Public Health, Early Childhood Development Branch, HANDS Quality Assurance
Dudley J. Conner	Kentucky Public Health Association
Julia Costich, JD, PhD	Director, Kentucky Injury Prevention and Research Center
Marybeth Crouch, RDH	Doral Dental Services of Kentucky, LLC
James S. Davis, MD	Director, Division of Adult and Child Health, Kentucky Department for Public Health
Larry Davis	Director, Marshall County Health Department
Dedra DeBerry	Northwest Area Health Education Center, Health Education Training Center
Senator Julie Denton	Kentucky State Senate
Eileen M. Deren, RN	Louisville Metro Health Department
Cindy Derer, DMD	Ronald McDonald House Charities of the Bluegrass, Inc.
Sue Derouen, RN	Operations Manager, Kentucky Board of Nursing
Paul Dominique, DMD	University of Kentucky, College of Dentistry
Charles Douglass	Kentucky Department for Medicaid Services
Leigh England	Trover Foundation Education Division
Sue Feeley, DDS	Private dental practice, Past President, KY Board of Dentistry
The Honorable Timothy E. Feeley	Family Court Judge – 12 th Judicial Circuit
Kathy Fields, RN	Cumberland Valley District Health Department
Susan Fister, PhD, RN	Bluegrass Farm-worker Health Center
Mary Sue Flora	Kentucky Department for Medicaid Services, EPSDT Special Services
Eric Friedlander	Director, Commission for Children with Special Health Care Needs
David Gardner	Proctor and Gamble
Tammy Gay	Family Resource Youth Services Center, Richmond, Kentucky
Chris Goddard	CEO, HealthPoint Family Care, Inc.
Kelly Goins	University of Kentucky, College of Dentistry
Robert D. (Sandy) Goodlett, PhD	Office of Family Resource and Youth Service Centers, Cabinet for Health and Family Services
Allison Gray	Marshall County Health Department
Lawrence Hager	President and Founder, The Hager Foundation
David Hardison, DMD, MBA	Oral Health Resources International, University of Kentucky, College of Dentistry
Robert G. Henry, DMD, MPH	Veterans Administration, Department of Veteran Affairs and University of Kentucky College of Dentistry
John Hensley	Kentucky Department for Public Health, Health Care Access Branch
Lawrence F. Hill, DDS, MPH	Cincinnati Health Department/Greater Cincinnati Oral Health Council
David K. Hinson, PhD	First Baptist Church, Frankfort, Kentucky
Fred Howard, DMD	Kentucky Dental Health Coalition
Rick Hulefield	Executive Director, Children's Inc.
Lucy Jewett	South Central Kentucky Area Health Education Center
Herman Johnson	Director, Cumberland Valley District Health Department
Judy Jones, JD	Director, University of Kentucky Center for Rural Health
Rice C. Leach, MD	Commissioner, Kentucky Department for Public Health

HEALTHY KENTUCKY SMILES: A LIFETIME OF ORAL HEALTH

Strategic Planning Stakeholder Group (continued)	
Name	Title/Affiliation
Beverly Largent, DMD	Private Dental Practice
Clifford Maesaka, DDS	Delta Dental Plan of Kentucky
Loretta Maldaner	Director, Purchase Area Health Education Center
Marie Markesbery	Colgate-Palmolive
Dan A. Martin, MD	Hopkins County Health Department/Trover Foundation
Representative Marylou Marzian	Kentucky State House of Representatives
Samuel Matheny, MD	Kentucky Clinic, Family Medical Center
Lee S. Mayer, MS, DMD	University of Louisville, School of Dentistry
Judy McCrackin, RN	Commission for Children with Special Health Care Needs, Cabinet for Health and Family Services
William McElwain, MD	Director, Rockcastle Hospital & Respiratory Care Center
Charlene McGrath	South East Kentucky Area Health Education Center
Lacey McNary, MSW	Kentucky Youth Advocates
Rosie Miklavcic, MPH	Director, Franklin County Health Department
Debra Miller	Kentucky Youth Advocates
Gina Miller, RDH, BSDH	President, Kentucky Dental Hygienists Association
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Senator Ernesto Scorsone	Kentucky State Senate
Sherry Senters, DMD	Whitehouse Dental Clinic
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