



Division of Health Promotion

Idaho Oral Health Summit - 2001
Shaping the Future, Improving Access

Friday, November 16, 2001
Center on the Grove - Boise, Idaho

Convened by
The Idaho Oral Health Alliance

Summit Facilitation and Proceedings
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Introduction and Summary

Introduction

This proceedings document is summary of discussions from the November 16, 2001 Idaho Oral Health Summit in Boise, Idaho. This document includes a section that covers the Idaho Oral Health Alliance (IOHA), highlights from the November 16th Summit, and Proposed Strategic and Closing comments by the facilitators of the Summit, Community Health Development Specialists.

Also included is an attachment section with pre-summit telephone interviews feedback, detailed chronological notes from the Summit, and Internet web-links to Idaho foundations and other helpful web links.

Summary

Many Idaho oral health issues, ideas, opinions, and strategies were presented during the November 16th Summit, along with the identification and solidification of collaborative opportunities and partners. Below is a summary list of the Idaho oral health issues, ideas, opinions, and strategies as observed by the facilitators of the Summit:

- Defining the problem and finding the solution(s).
- Adopting a broader determinants of health strategy can expand the universe of participants in the development of oral health improvement strategies (cast a wider net to bring-in other stakeholders).
- Access, affordability/income, availability/capacity, knowledge, responsibility, population and relationships are key areas of consideration and focus.
- Plan, develop, implement and evaluate a systems approach that links policy, funding, education, training, prevention, best practices, recruitment and retention, reimbursement and public/private partnerships.
- The observations and advice offered by Summit participants be used as the foundation of an Idaho oral health improvement plan.
- State-level partnerships are critical, among and between the State Dental and Medical Associations, Dental Hygienists Association, Public Health and elected and appointed officials.
- Some solutions can be reached using or reordering existing resources, and other solutions may require new/different thinking, commitments and resources.

The overarching theme from both the pre-meeting telephone interview process and the November 16th Summit was: It is time to raise the bar regarding oral health in Idaho. A particular focus on creating a shared vision and a plan to address Idaho's oral health needs. Key components of this plan, according to pre-Summit telephone interviews and the November 16 Summit are:

- Financing/Policy
- Prevention and Education
- Infrastructure (Access)
- Recruitment and Retention (Access)

Community Health Development Specialists proposes a series of planning meetings of Idaho oral health stakeholders with the charge to develop an **Idaho Oral Health Plan**. The Idaho Oral Health Plan process will create the forum for issues to be clarified and ordered, and strategies to be developed in a coordinated and implementable fashion. The Idaho Oral Health Plan itself will be a product of a collaborative effort, highlighting previous and existing efforts to address oral health issues and will provide the context for improved or new Idaho oral health improvement strategies.

Based on input from Summit participants and experience with other state oral health improvement efforts, Community Health Development Specialists (CHDS) proposed the following general components for the **Idaho Oral Health Plan**:

- Overall policy goals that reflect the framework for action suggested by the Surgeon General's Report on Oral Health in America.
- National objectives related to each policy goal drawn from Healthy People 2010, a second major initiative of the Surgeon General's Office and the Center for Disease Control and Prevention, which set and tracked goals for the nation's health beginning in 1990. Oral Health is a priority area in Healthy People 2010.
- Idaho specific priorities for each goal area relative to the Surgeon General's Report on Oral Health in America.
- Idaho specific priorities for national objectives related to each policy goal drawn from Healthy People 2010.
- Idaho specific priorities that are unique and deserve attention outside of the realm of the Surgeon General's report and Healthy People 2010.
- Recommendations and action steps to meet all priorities identified. These recommendations should include the implementation components needed, required or desired for each priority strategy.

In order to develop an **Idaho Oral Health Plan**, Community Health Development Specialists recommends:

1. Expanding the Idaho Oral Health Access Coalition
2. Forming work groups in the following areas
 - a. Financing/Policy
 - b. Prevention and Education
 - c. Infrastructure (Access)
 - d. Recruitment and Retention (Access)
 - e. A work group that focuses on drafting the **Idaho Oral Health Plan**
3. Implementing community input process
4. Conducting a strategic planning session
5. Convening the 2nd Annual Idaho Oral Health Summit

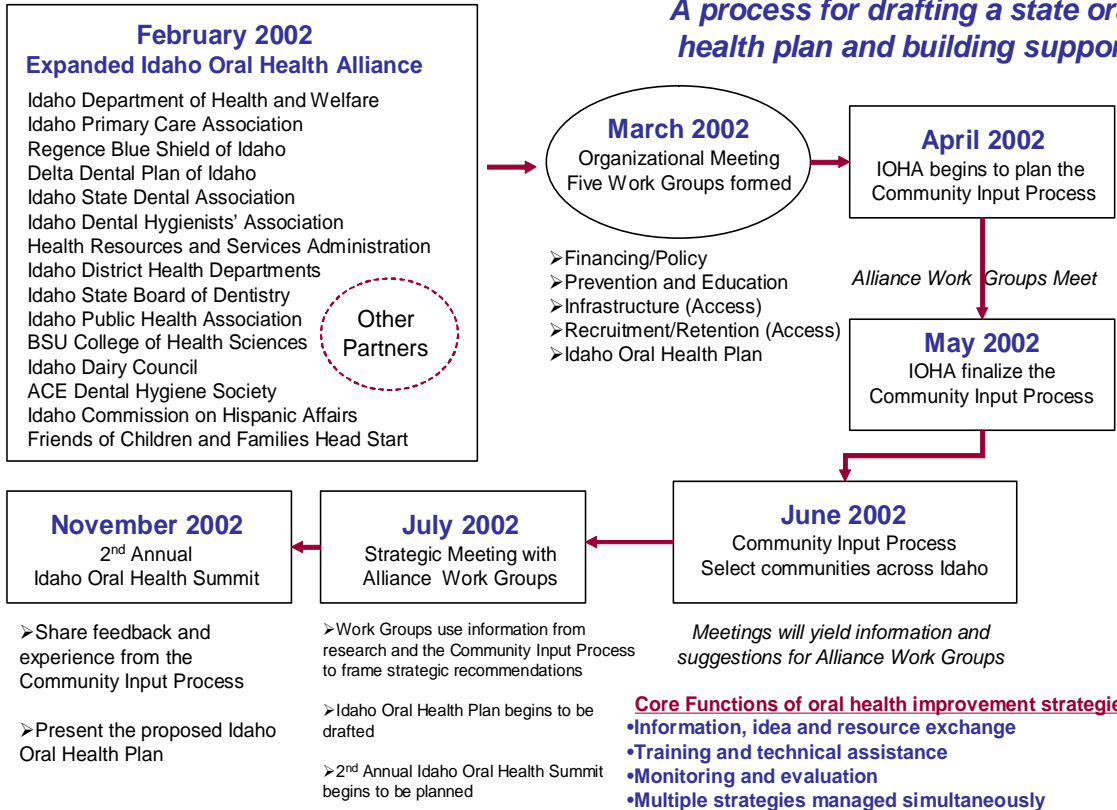
To sustain Idaho oral health improvement efforts, CHDS recommends the development of a mechanism or a process that allows the performance of the following core functions of any health improvement effort (these functions get defined as the health improvement effort is initiated and evolves):

- Information, idea and resource exchange
- Training and technical assistance
- Monitoring and evaluation
- Multiple strategies managed simultaneously

The figure on the following page animates this recommendation.

Idaho Oral Health Alliance

A process for drafting a state oral health plan and building support



The Idaho Oral Health Alliance

The Idaho Oral Health Alliance (IOHA) was formed in May 1998 by individuals and organizations with an interest in improving oral health of Idaho children and adults. Members include representatives of State and District Health Departments, private and public health insurers, dentist and dental hygienist associations, other medical, nursing and health professional organizations, education programs and others. Membership is open to any individual or group with an interest in promoting oral health and improving access to dental care for Idaho citizens.

The **Mission** of the Idaho Oral Health Alliance is:

“To improve the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.”

The Idaho Oral Health Alliance has two **key accomplishments** since its inception in 1998. These accomplish are:

1. In 1999 the Idaho Legislature allocated \$2.2 million to increase Medicaid dental reimbursement rates. The fee increases were implemented July 1, 1999.
2. Seal Idaho 2000, a collaborative effort involving IHOA members, was introduced by the Governor in his 2000 State of the State Address. The largest volunteer community dental service project ever conducted in Idaho, Seal Idaho 2000 provided free dental sealants worth \$227,094 to 2,804 Idaho second grade students and reached 19,139 children and their parents with a message about the value of sealants and early preventive dental care.

In March 2001, the IOHA members identified the following **Priority Areas**:

- Early childhood caries prevention
- Access to primary dental care
- Community water fluoridation
- Dental public health infrastructure funding
- Grassroots advocacy

November 16, 2001 Idaho Oral Health Summit

This section will highlight the history of the Idaho Oral Health Summit 2001 and the main discussions and decisions from the November 16, 2001 Summit. A chronological listing of the “minutes” as transcribed by the facilitators is located in the attachments section of this proceedings document.

Summit History

The Idaho Oral Health Alliance decided to convene Idaho’s First Oral Health Summit as an initial step to improve access to dental services for Idaho children and families. The goal of the Summit was to **create a shared vision** for action among public and private stakeholders. The Summit was convened to **provide a forum** for collaboration and development of solutions focused on policy and funding, access to care, and prevention/education. Anticipated outcomes of the Summit include:

- State policy recommendations to increase access;
- Creation of a comprehensive state dental public health plan; and
- Increased support and funding for dental public health programs and clinics.

The joint planning and problem solving process generated by the Summit could result in the implantation of short and long-term strategies that could:

- Increase access to primary dental care; and
- Reduce oral health diseases and disparities.

Responsibility for the follow-up process will be shared by the stakeholders and coordinated by the Idaho Oral Health Alliance members, including the Oral Health Program of the Idaho Department of Health and Welfare, and the Idaho Primary Care Association. Funding for Summit and follow-up activities is from the Title V Maternal and Child Health Block Grant and a special grant from the Department of Health and Human Services, Health Resources and Services Administration, Region X Seattle Field Office, and the Maternal and Child Health Bureau.

The Summit

Convening Remarks

Lisa Penny, Oral Health Program Manager for Idaho Department of Health and Welfare convened the First Idaho Oral Health Summit.

Lisa shared her appreciation for the attendance of over 150 individuals to this important Summit. In particular, Lisa wanted to thank the following Summit sponsors, contributors and supporters who made this historic Summit possible:

Major Summit Sponsors	Summit Contributors and Supporters
Idaho Department of Health and Welfare Idaho Primary Care Association Regence Blue Shield of Idaho Delta Dental Plan of Idaho Idaho State Dental Association Idaho Dental Hygienists' Association Health Resources and Services Administration	Idaho District Health Departments Idaho State Board of Dentistry Idaho Public Health Association BSU College of Health Sciences Idaho Dairy Council ACE Dental Hygiene Society Idaho Commission on Hispanic Affairs Friends of Children and Families Head Start

Lisa provided an overview of the Idaho Oral Health Alliance and referred to the IOHA insert in the registration packet for Summit participants to review at their convenience.

Lisa then introduced **Michael R.J. Felix** of Community Health Development Specialists, as the facilitator of the Idaho Oral Health Summit.

Michael shared his appreciation for being asked to co-facilitate the meeting with **Charles J. "Chuck" Wiltraut** from Community Health Development Specialists, and **Sherry G. Dyer** from Pacific West Training.

Michael noted the efforts of the Idaho Oral Health Alliance, sponsors, contributors and the individuals who cleared their calendars to be present for such an important event regarding oral health in Idaho.

Michael reviewed the following **Summit Agenda:**

7:30 a.m.	Registration and Continental Breakfast
8:00 a.m.	Welcome - <i>Summit Organizers and Facilitators</i>
8:15 a.m.	Opening Remarks - <i>Karl B. Kurtz, Director, Idaho Department of Health and Welfare</i>
8:30 a.m.	Opening Remarks - <i>Rep. Mike Simpson, U.S. House of Representatives</i>
8:45 a.m.	Keynote - Making Oral Health a Priority: Call to Action - <i>Lt. Governor Jack Riggs, MD</i>
9:15 a.m.	Keynote - U.S. Surgeon General's Framework for Action and Best Practices <i>Peter Milgrom, DDS, Professor, Department of Dental Public Health Sciences, University of Washington</i>
9:45 a.m.	Break
10:00 a.m.	Panel - Perspectives on Oral Health and Access to Care Public Health Perspective <i>Lisa Penny, RDH, State Oral Health Program Manager Idaho Department of Health and Welfare</i> Provider Perspective <i>Scott H. Kido, DDS, President, Idaho State Dental Association Julie Slee, RDH, Immediate-Past President, Idaho Dental Hygienists' Association</i> Primary Care Perspective <i>Erin Ostteen, DDS, Dental Director, Terry Reilly Health Services</i> Medicaid Perspective <i>Joe Brunson, Administrator, Idaho Division of Medicaid</i> Government/Legislative Perspective <i>Rep. Margaret Henbest, Idaho State Legislator</i> Business Perspective <i>Hart Beal, Benefits Analyst, Micron Technology, and President, Employers' Health Coalition of Idaho</i>
11:15 a.m.	Break
11:30 a.m.	Facilitated Group Discussion - Key Issues and Objectives to Improve Oral Health of Idaho Children and Families - <i>Michael R.J. Felix and Charles J. "Chuck" Wiltraut, Community Health Development Specialists</i> (Summit participants will have an opportunity to share their perspectives on the key issues, present strategies and solutions that work, and discuss what they would like to see happen to improve oral health and access to care in Idaho.)
12:15 p.m.	Lunch (provided)
1:15 p.m.	Facilitated Breakout Sessions - Strategies and Recommendations to Meet Objectives <i>Michael R.J. Felix, Charles J. "Chuck" Wiltraut and Sherry Dyer, Facilitators</i> (Summit participants are asked to choose one breakout session to attend.) Breakout Session A: Policy and Funding Breakout Session B: Access to Care Breakout Session C: Prevention and Education
3:00 p.m.	Break
3:15 p.m.	Reports from Breakout Sessions
3:45 p.m.	Next Steps and Commitment to Summit Follow-up - <i>Summit Organizers</i>
4:00 p.m.	Adjourn

Michael then shared some of the input received via the pre-Summit telephone interview process, highlighting meeting expectations and desired outcomes with a particular focus on creating a shared vision and a plan to address Idaho's oral health needs. Key components of this plan, according to pre-Summit telephone interviews were:

- Legislative/policy
- Prevention and education
- Access to oral health services
- Reduction of oral health disease and disparities

Michael emphasized that the Summit, if embraced properly, would be facilitated toward these desired outcomes. Michael asked all participants to consider the following question for the Summit, and perhaps for work conducted outside of the realm of the Summit, and that is: ***“Will my action or inaction today inhibit or enhance oral health status?”***

Michael introduced **Karl B. Kurtz**, Director of the Idaho Department of Health and Welfare to provide the opening remarks.

Special Note: Full excerpts of the speakers' comments can be viewed in the Attachment section of this proceedings document.

Highlight from Karl's opening remarks:

Everyone holds a portion of the answer, holds a piece of the solution, today we need to put all the pieces together and make the commitments to form the partnerships to create the solutions. @

Karl noted that we are all convened here at this historic Summit because of the oral health need: a growing concentration of oral health. In particular, Karl mentioned that poorer people suffer disproportionately worse than people with higher incomes. Karl noted, according to statistics he made available that:

- 26% of Idaho 3rd grades have untreated tooth decay
- 32% attending lower income school shave untreated cavities (15% attending the highest income schools)
- 32% - 12% are in need of urgent care

Karl also mentioned:

- We do not have a real organized constituency advocating for oral health.
- The public is largely unaware unaware of the connection of good oral health to good overall health.
- Over 1/3 of the country does not have dental health insurance.

Solutions are not as easily identifiable as the issues. Karl shared what he believes are some of the critical issues regarding oral health:

- Capacity is an issue
 - Average age of a practicing dentist in Idaho is 50
 - 32 of 44 counties are designated dental shortage areas
- Low reimbursement rates
 - 716 dentists submitted Medicaid claims in December 2000
 - Around 400 submitted for this December (2001)

Michael then introduced the Keynote speaker, **Lieutenant Governor Jack Riggs, MD.**

Highlight from Lieutenant Governor Riggs Keynote:

America received a C-Minus on oral health status and addressing oral health status needs; is Idaho happy with this? Are you happy with a C-Minus? These grades are simply not good enough. You have an opportunity today to raise the bar. @

Lieutenant Governor Jack Riggs noted that it was an honor and a pleasure to serve Idahoans as Lieutenant Governor. Lieutenant Governor Jack Riggs welcomed those from outside of Idaho who attended. Everyone does bring their experience and expertise.

Lieutenant Governor Jack Riggs shared that he believes that the fundamental problem regarding oral health is that the oral health message is not getting out and to the right audiences: the general public, stakeholders, and elected and appointed officials.

Our health care system is segregated

- Doctors may not fully understand and appreciate the connection/relationship between oral health and medical health.
- Physicians are trained that everything else is connected . . . do not worry about the mouth, which is the dentists' realm.
- Potential advocates are out because they do not know.

Use the purpose of today's summit as your charge: make oral health a priority.

Lieutenant Governor Jack Riggs provided some data:

- Tooth decay is 5 times more than asthma; 7 times more than hay fever
- 18% of 2 - 4 year olds; 25% of 8 year olds have had a sealant
- 7% of teens have lost a permanent tooth
- 69% of adults have lost a permanent tooth
- 65 - 74 over a 25% have lost all of their natural teeth
- Throat cancer - 7th cancer

- \$54 billion spent on dental care
- 50 million school hours of school time are lost a year due to poor dental health. The implication of this alone is staggering.
- People who cannot afford access to dental care are 12 times as likely to miss school compared to those who do have access; studies have shown that if you cannot read as appropriate by 3rd grade, you are already placed at a disadvantage in terms of brain development and scholastic performance.

Some steps have been taken that could use additional efforts:

- \$54 billion spent on dental care
- Medicaid reimbursement rates increase (legislators are the critical people that need to be educated - contact them, get them involved, but do it in an organized, coordinated fashion); take advantage of our democratic system: get behind the issue and get the issue in front the policy makers; increase your legislative activities – I will be very supportive. Be realistic and be specific.
- Do not just increase Medicaid reimbursement rates, make this only part of a larger, more creative and comprehensive plan.

Michael shared his appreciation for Lieutenant Governor Jack Riggs comments and summarized what all of the guest speakers shared up to this point of the Summit: systemic issues and solutions; definition and adoption of health; education; training; continued research; partnerships; broader connection; evaluation; and the need to work the policy process.

Michael introduced Peter Milgrom, DDS and Professor in the Department of Dental Public Health Sciences, University of Washington.

Highlights from Peter Milgrom's remarks:

Science has determined the connection of oral health to overall health of individuals, populations and communities, now is the time for the thinking and action to connect with the science. . .set quantitative goals. . .do not get engaged in territory, who's to blame, and that increasing Medicaid reimbursement rates will solve the problem: instead focus on the goal and then determine the process to achieve it. . .prenatal care presents a great opportunity. @

Peter suggested Summit participants take pieces of the solution to work-on, to not wait until you can address the whole problem. Need the momentum to be created to address the issues.

He covered the following in his presentation:

- U.S. Surgeon Generals Report: this is the first one on oral health
- Whose problem is it?

- What are the oral health issues impacting rural Idaho?
- What works in addressing oral health issues and needs?
- Role of the dental practice

Special Note: Peter Miglrom offered, upon request, his Power Point presentation to interested individuals.

Peter highlighted the following oral health points of interest to emphasize points made earlier in the Summit and provide additional context:

- 25% of children have more than 80% of tooth decay; pay for sealant program now (prevention) or later (acute).
- Oral health is everybody's problem.
- Dentists are retiring and dying faster than they are being replaced; rural communities will be the communities that suffer first and probably the hardest.

What works:

- Preventive dental care for children requires the redefining of prenatal care to include oral health.
- Tooth decay is an infectious disease transmitted from mother to child just after birth.

In addition, Peter shared that, "Waiting for damaged teeth is like specializing in amputations for diabetes care."

Set quantitative goals, think solution and place focus on thinking and action (not who's territory, who's to blame, increase Medicaid. . .focus on the goal and then determine the process to achieve):

- For all pregnant women assess the risk of her infecting the child
- For high risk mothers: chlorhexidine mouth rinse; xyltiol chewing gum; basic dental care

Michael thanked Peter Milgrom for his presentation and proposed taking the Summit's first break prior to the Panelist portion of the Summit.

BREAK

Panel

A panel was assembled to provide various perspectives on oral health across Idaho. Many of the panelists had note cards and speaker notes available. Below are highlights from their panel presentations. Full excerpts of the panelists' comments can be viewed in the Attachments section of this proceedings document.

Lisa Penny, RDH, State Oral Health Program Manager for the Idaho Department of Health and Welfare.

Lisa shared that the United States Surgeon General's Report on Oral Health served as the basis for her comments. Lisa indicated that data tells the story of oral health needs across the United States.

Lisa also shared that in order to address these issues, partnerships (traditional and non-traditional) are critical. Opportunities to have a positive impact do exist including the fluoridation of water and collaborating for the support and establishment of comprehensive clinics.

Scott H. Kido, DDS, President of the Idaho State Dental Association.

Scott shared that, in terms of addressing oral health issues, perfection should not be a goal, improvement should be and that, "Our society has a responsibility to help those who are underserved."

Scott noted how millions of dollars are being committed to a preventable disease. Part of this is the fact that states and dentists are losing money, which in turn causes a strong resentment toward treating oral health, particularly for low-income and uninsured individuals.

Dentists are willing to help. In some capacity, dentists have always been here to help; however, the relationship needs to be nurtured through training, and financial support.

Julie Slee, RDH, Immediate Past-President of the Idaho Dental Hygienists' Association.

Julie shared that she believes that, at the heart of the oral health problems in Idaho, there are two key factors: capacity and policy issues.

As it relates to capacity, Julie noted that the existing base of dentists is shrinking and not being replenished at an appropriate pace. In addition, the underutilization of existing resources such as dental hygienists and dental assistance is also a contributing factor to the capacity issue.

Regarding policy issues, Julie stated that hygienists are not empowered enough to make their contributions, and that policy changes at the state level (legislative and associations) would be needed to tap this existing resource.

Erin Ostten, DDS, Dental Director of Terry Reilly Health Services.

Erin shared that in order to positively impact oral health in the State of Idaho, strengthening the safety net of all health services for the low income and uninsured could serve as the overarching goal/strategy.

Erin shared the following statistics she prepared for the Summit:

- Less than 30% of our children with Medicaid and CHIP are not receiving any dental services.
- Idaho Care Lines fields 500 requests a month seeking a dentist to service Medicaid patients.
- Only 73 dentists are accepting new Medicaid patients under strict parameters; may have enough providers enlisted, but not enough serving.

Joe Brunson, Administrator of the Idaho Division of Medicaid.

Joe noted that, “We are talking about a disease that is impacting all, but particularly the poor who are children, women, minority and disabled.”

Joe shared what he believes the factors are that influence the systems set in place to help people: perceptions and stigma~~s~~, and the multiple understandings or mis-understandings.

In particular, Joe stated, “If we cannot influence or move the policy makers along the line of change, we will not be as successful as we need to be because policy impacts the finance and delivery of oral health services.”

Joe presented the following scenario:

- Paying a dentist 75% of usually and customary cost for treating Medicaid patients; OR
- Taking a different focus: increasing access and incorporating private primary care physicians.

Similarly, Joe noted that workforce development is a critical issue: Idaho dentists are getting older and not being replenished at a rate to serve the existing patient base. Joe believes that rural populations will be impacted more severely than the general population.

Joe provided a “check-list” of possible ideas/activities to improve oral health in Idaho:

- Look at integrating oral health at the macro level
- Health education and promotion
- Have folks from Medicaid, physicians and dentists and other workforce personnel involved in oral health improvement activities
- Integrate into a primary care case management model

- Getting the system to move along to get us the support to do what we need to do

The Honorable Margaret Henbest, Idaho State Representative.

Representative Henbest stated that oral health is, “A deep and broad problem that will not be solely solved by one individual or one individual group: it will require multiple groups.”

Representative Henbest shared some opportunities she believes are worth considering to improve oral health in Idaho:

- Deal with the dental shortage itself: need to increase supply; reach future dentists early and often (high school).
- Expand pool of providers: stronger functioning relationships with primary care physicians and dentists (could potentially double efforts).
- Dealing with compliance (keeping appointments and presentation); need a better understanding and shared responsibility.
- Work with the Department of Education: points of care and curriculum opportunities.
- Engage local communities in this effort.
- Local Public Health are critical partners.

Representative Henbest noted that government has a responsibility to help the address oral health issues by facilitating the process through legislative action. Some legislative opportunities presented by Representative Henbest:

- Eliminate bureaucracy
- Appropriate reimbursement rates
- Tax credits
- Use billing practices that are manageable and appropriate
- Explore insurance product that looks more like a street product as opposed to a Medicaid product (flow and perception)

Hart Beal, Benefits Analyst for Micron Technology and President of the Employers’ Health Coalition of Idaho.

Hart noted that businesses are dealing with competitiveness in a difficult market and in order to get the best and brightest employees – since they make the company profitable – dental care is used as a recruitment and retention tool.

Hart shared findings from a sampling of 22 companies that provide dental coverage. These companies provide:

- 100% coverage for preventative care
- 80% coverage for basic care (filings, extractions root canals)
- 50% coverage for major (crowns and dentures)
- Annual maximum per member per year \$1000 to \$2000
- \$25 to \$55 a month for family coverage

These benefits cost the employers money and share the following concerns:

- People put off their dental care because of fear/stigma; not good for production.
- Dental costs are overshadowed by medical costs, focus is still on medical, dental is overlooked.

Hart shared some possible oral health improvement ideas:

- Best tool is education, know the problem, who it impacts, who is playing a role in oral health care.
- Education around better oral health care.
- Employers sponsor health fairs on and off-site.
- Free dental care is not the answer; some employers offer free dental, even then, people do not take advantage of it: need to influence the mind-set of individuals (people, providers and policy makers).

Michael thanked all of the panelists for providing their perspectives on and ideas on how to address oral health issues in Idaho.

Michael mentioned that, “We have heard a lot regarding oral health issues and the opportunities to improve oral health. Issues at the health system, policy, community and individual levels.”

Michael also noted that there are opportunities to collaborate around oral health improvement ideas including informing individuals, providers and policy makers about the status of oral health in Idaho, what is currently being done to address the improvement needs that exist and the ideas to provide oral health care better or differently.

Facilitated Group Discussion

Michael facilitated Summit participants in a group discussion. He focused on challenges in addressing oral health issues in Idaho, and ideas and opportunities to address oral health issues in Idaho. In a summary fashion, here is what some Summit participants shared:

Challenges

- Competing with other well-funded and organized interest groups who already have the attention of policy makers;
- Manpower/capacity;
- Dental/oral health care is not on the total health radar screen;
- 2.4% of total Medicaid budget goes towards Medicaid dental; SPECIAL NOTE: as a point of clarification, Medicaid sets aside an amount based on billing, poor utilization of Medicaid billing represents the 2.4% (reflects only what is billed);
- A primary care provider is writing prescriptions for fluoride tablets? Why not dentists? Why not fluoridate the water?;

- How can we spread the burden/responsibility of serving people who have oral health needs?;
- 20% of the safety net has the bulk of the problem; need to address this; and
- What about the consumer perspective?

Ideas and Opportunities

- Define the full range of players in oral health;
- Influence the mind-set of individuals through interactions and curriculum;
- More partnerships;
- America's Promise and Idaho Association of Cities focusing-in on community improvement where oral health could be a part of: point is, do not duplicate existing efforts; coordinate activities;
- Dental/oral health must be a priority: a reflection of this is in state, county and local budgets;
- Work with what we have: expand our current functions; need some policy changes (law is not allowing us to serve); and
- Understand and respect realms of knowledge and experience.

Michael thanked the Summit participants for sharing their thoughts regarding challenges in addressing oral health issues in Idaho, and for the ideas and opportunities to address these issues. Michael noted that it was time to break for lunch and then reconvene at 1:15 p.m.

LUNCH BREAK

Michael reconvened the Summit and reviewed the purpose of the facilitated breakout sessions.

Facilitated Breakout Sessions

The purpose of each breakout session is 1) to brainstorm ideas and solutions, and 2) to identify strategies to develop and implement these ideas and solutions.

The Surgeon General's Framework for Action outlines the components of an Oral Health Plan and provided reference points for consideration as each breakout session group developed their ideas, solutions and strategies:

- Change Perceptions of Oral Health
- Build Effective Health Infrastructure
- Remove Barriers to Oral Health Services
- Accelerate Building and Application of Science

The brainstorming of ideas and the development of strategies was endeavored as time allowed. Strategies were developed along the following manner:

1. Desired Outcomes

- a. What will be done/accomplished with this idea or solution?

2. **Process**
 - a. What strategies/actions are needed to accomplish the desired outcome?
3. **Challenges**
 - a. What factors could impact carrying the idea or solution forward?
4. **Who**
 - a. Who are the individuals and organizations who must be involved to successfully move the idea forward?
5. **Next Steps**
 - a. What are the next steps and the time frame for moving the idea(s) forward?
6. **Future Involvement**
 - a. Who in the breakout group is willing to be involved following the Summit to help move these solutions and strategies forward?

Summit participants reconvened to provide a 10 minute presentation around their recommended solutions and strategies. The following paragraphs are summaries of the report-out portion of the Facilitated Breakout Sessions. These notes are ordered as listed on the Summit Agenda. These notes were transcribed from flip chart pages. Apologies are extended for unintentional errors and omissions.

Special Note: Full excerpts of the speakers' comments can be viewed in the Attachments section of this proceedings document.

Policy and Funding

The Policy and Funding breakout group wanted to see dialogue of linkages between the Idaho Medical Association and the Idaho Dental Association and the supporting, enhancement or development of a pilot program that incorporates the key components of access, reimbursement and a "home" for oral health care (Terry Reilly Clinic replication).

The development of recruitment and retention strategies and seeking the appropriate legislative and financial support was also mentioned as a key idea or opportunity.

Other suggestions included:

- Establishing a process in which primary care providers could bill for dental procedures.
- Maximizing the use of resources to ensure prompt payment.
- Modifying the Idaho Dental Practice Act; begin with dialogue first (avoid turf and focus on the issues: better oral health).
- Instituting a policy for schools with soda pop machines to also offer alternatives such as water (particularly with fluoride), milk and appropriate fruit juices.

Access to Care

The Access to Care breakout group reported out on one implementation idea, that is: The Expanded Functions of Existing Dental Providers.

The desired outcomes of this idea, as expressed by the Access to Care group were improved access to oral health services and improved oral health outcomes (reduced disease and disparities) services by increasing capacity of existing resources and developing new capacity to meet the oral health needs of Idaho.

Various functions that could be performed under an expanded role include, but are not limited to: Education; Training; Diagnosis; Treatment; Restorative and Preventive Treatment (fluoride varnish and sealants).

Key players in this idea of expanded functions of existing dental providers are: Dentists (should have license reciprocity; the ability to work in at least two states); Dental Hygienists; Dental Assistants; and potentially Primary Care Physicians; Pediatricians; Licensed Nurse Practitioners; Physicians Assistants; and Registered Nurses.

Lobbying and advocacy would be the process for implementing this idea, that is, to strategically approach the State Board of Dental Examiners; Key elected and appointed officials, and candidates; Partner with the Idaho Dental Association; Idaho Dental Hygienists Association; Community; and other stakeholders with the prospect and plan of expanding the roles of existing dental health providers.

Prevention and Education

The Prevention and Education breakout group noted that good advice for prevention and education strategies is to avoid being bogged down in over collaboration and overzealous goals.

The Prevention and Education group had many ideas. Here is a partial listing of some of the ideas:

- Dental health written into school curriculum;
- Pre and post-natal oral health care for all pregnant women (receive an oral health exam) and the reduction of each childhood carriers;
- 80% fluoridation community water systems across Idaho; 3 targeted counties over the next thirty-six months (Bannock; Bonneville; and Farmingway (Sp?));
- Fully funded preventative program in all 7 health districts and coordinated by a full time dental hygienist; and
- Integrate child prevention oral health services with the well-child exam; professionally trained in varnish applications, risk assessment, and screening.

Suggestions for how to move forward on these ideas included:

- Keep the process simple; collaborations can get cumbersome and unrealistic; keep the process manageable and pragmatic;
- Dentists and hygienists get together to address the expanded functions idea;
- Develop a plan so potential partners can determine how to be involved, and their appropriate role and contribution;
- Share today's outcomes and learning with oral health constituents, providers and other stakeholders (primary care providers, etc.); and
- Call our legislatures.

The following individuals noted their interest in continued involvement regarding prevention and education strategies: Lisa Penny; Lalani Ratnayake; Roxanne Joyner; Tina Fisher; and Kathy Tuller.

Proposed Strategies

Many Idaho oral health issues, ideas, opinions, and strategies were presented during the November 16th Summit, along with the identification and solidification of collaborative opportunities and partners.

A general list of ideas, strategies, and oral health partner relationships to support, enhance or develop is listed below:

Support

- The Idaho Advanced General Dentistry program in Pocatello
- Seal Idaho 2000
- The Terry Reilly Health clinic in Caldwell

Enhance

- Weekly fluoride rinse program-19 schools (children rinse once a week with fluoride rinse and can expect 30 percent fewer cavities)
- Working relationship with the Idaho State Dental Association
- Medicaid reimbursement rates
- Oral health prevention and education programs
- The role dental hygienists and dental assistants play in the delivery of oral health care

Develop

- A Governor's Task Force on Oral Health, with broad representation assembled to for solution development and planning
- A dental school in Idaho
- State water fluoridation (80% fluoridation community water systems across Idaho)
- Credential hygienists to provide more care
- Tax relief programs for dentists, hygienists and practices
- Allow physician offices to provide dental screenings to children ages 0-2
- Specific goals
 - Instead of 23% of the CHIP population getting dental services, 75% should be the goal
 - 80% of all of the dentists in Idaho treating a reasonable amount of Medicaid patients in their mix

While many opportunities were presented during the November 16th Summit, participants shared that they were interested in a formal process to ensure that these ideas and opportunities would be further developed and implemented.

In the spirit of one of the opportunities mentioned by Summit participants: the formation of a Governor's Task Force on Oral Health, Community Health

Development Specialists proposes a series of planning meetings of Idaho oral health stakeholders with the charge to develop an **Idaho Oral Health Plan**.

The Idaho Oral Health Plan process will create the forum for issues to be clarified and ordered, and strategies to be developed in a coordinated and implementatble fashion. The **Idaho Oral Health Plan** itself will be a product of a collaborative effort, highlighting previous and existing efforts to address oral health issues and the **Idaho Oral Health Plan** will provide the context for improved or new Idaho oral health improvement strategies.

Based on input from Summit participants and experience with other state oral health improvement efforts, Community Health Development Specialists proposed the following general components for the **Idaho Oral Health Plan**:

- ↪ Overall policy goals that reflect the framework for action suggested by the Surgeon General's Report on Oral Health in America.
- ↪ National objectives related to each policy goal drawn from Healthy People 2010, a second major initiative of the Surgeon General's Office and the Center for Disease Control and Prevention, which set and tracked goals for the nation's health beginning in 1990. Oral Health is a priority area in Healthy People 2010.
- ↪ Idaho specific priorities for each goal area relative to the Surgeon General's Report on Oral Health in America.
- ↪ Idaho specific priorities for national objectives related to each policy goal drawn from Healthy People 2010.
- ↪ Idaho specific priorities that are unique and deserve attention outside of the realm of the Surgeon General's report and Healthy People 2010.
- ↪ Recommendations and action steps to meet all priorities identified. These recommendations should include the implementation components needed, required or desired for each priority strategy.

This Proceedings document could be used to initiate and facilitate the Idaho Oral Health Plan process. Integral to the planning process is the Idaho vision of oral health and key components as expressed by Summit participants and pre-Summit interviewees. The following figure is provided to animate the vision.

Idaho Oral Health Alliance

Idaho Oral Health Vision

- Increased access to oral health system and services -
- Decrease in oral health disease and disparities -

Collaborative Strategies Resource and Community Levels

1. Financing/Policy
2. Prevention and Education
3. Infrastructure (Access)
4. Recruitment/Retention (Access)

United States Surgeon General's Framework For Action

- ✓ Change Perceptions
- ✓ Remove Barriers
- ✓ Accelerate Science
- ✓ Build Effective Infrastructure

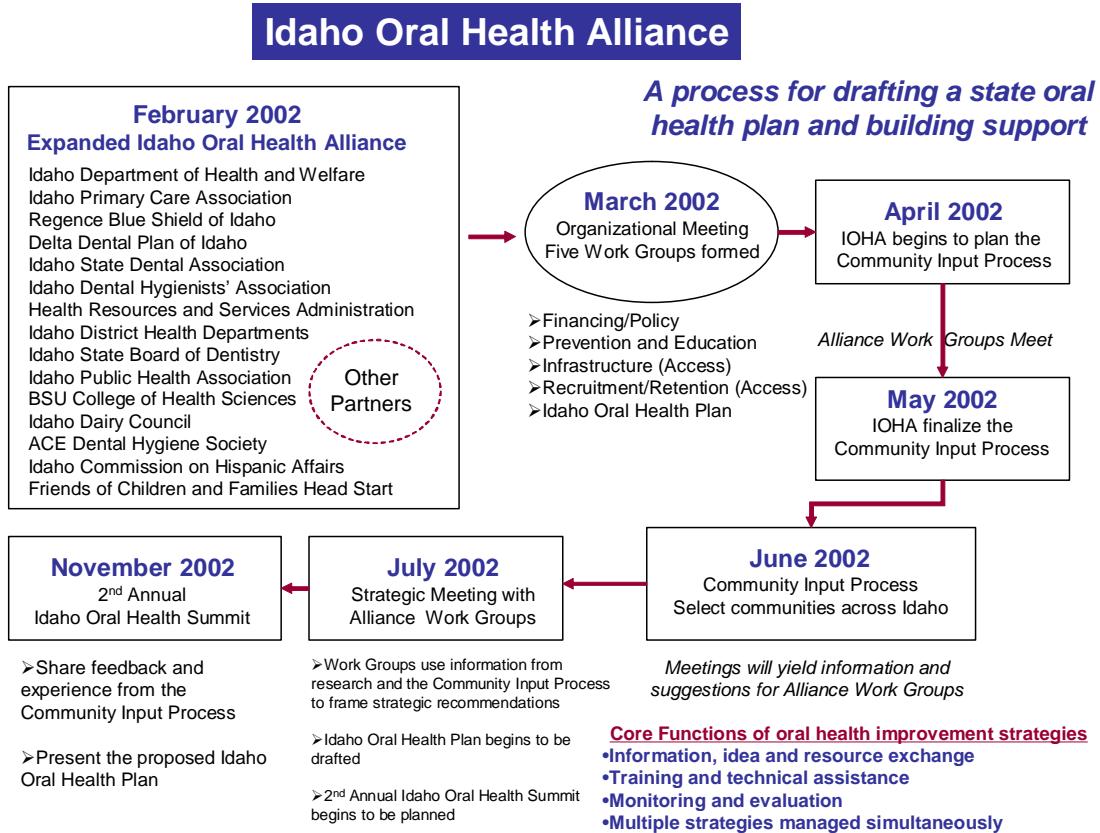
In order to develop an Idaho Oral Health Plan that incorporates the Idaho vision of oral health and its key components, Community Health Development Specialists recommends:

1. Expanding the Idaho Oral Health Access Coalition
2. Forming work groups in the following areas
 - a. Financing/Policy
 - b. Prevention and Education
 - c. Infrastructure (Access)
 - d. Recruitment and Retention (Access)
 - e. A work group that focuses on drafting the **Idaho Oral Health Plan**
3. Implementing community input process
4. Conducting a strategic planning session
5. Convening the 2nd Annual Idaho Oral Health Summit

To sustain Idaho oral health improvement efforts, CHDS recommends the development of a mechanism or a process that allows the performance of the following core functions of any health improvement effort (these functions get defined as the health improvement effort is initiated and evolves):

- Information, idea and resource exchange
- Training and technical assistance
- Monitoring and evaluation
- Multiple strategies managed simultaneously

The following figure animates this recommendation:



Closing

While the Idaho Oral Health Alliance is challenged to “Raise the Bar” as an alliance, and as stakeholders in increasing access to oral health services and reducing oral health disease and disparities, the Idaho Oral Health Alliance has demonstrated its ability to collaborate to address these issues in the past. Through continued efforts at the alliance, state and community levels, the Idaho Oral Health Alliance, can once again, come together to prioritize oral issues and ideas, and ***develop sustainable strategies*** to improve the oral health status and the safety net of oral health services in Idaho.

ATTACHMENTS

Pre-Summit Telephone Interviews

In preparation for the November 16, 2001 Summit, Idaho Oral Health Alliance Members and selected individuals to gather the following information, thoughts, perceptions and advice around oral health in the state of Idaho:

1. What are the most-pressing **oral health issues** impacting Idaho;
2. **What is working** in terms of addressing oral health issues;
3. **Ideas** for the future (immediate, short and long-term); and
4. **“Tips”** for the November Summit.

The detailed findings are provided on the following pages.

How to Read These Responses: Responses are listed in the following manner: frequency equals placement. That is, the more times a response was given the higher it is placed. In descending order, from most frequently mentioned to least mentioned. General issues are always listed first. Some categories and responses could cut across one another (which is acceptable), however, for pragmatic organizational purposes, categories and responses were developed and placed on the basis of most appropriate or direct name and fit/placement.

Birds Eye View

What do you believe are the most-pressing oral health issues impacting/affecting Idaho?

Access for Populations

General

- Cost of Dental Care in general which in turn makes access to care so difficult for low income, no-income and Medicaid patients.

Medicaid and Children

- Perception of Medicaid population as individuals who are lazy and do not value opportunities; not the case, largely out of circumstance not out of choice to be on Medicaid
- Too few dentists will accept Medicaid patients
- Dentists who accept Medicaid patients do not understand emergency dental care, you need treatment in 30 minutes not 30 days
- Perception of Medicaid population as individuals who are lazy and do not value opportunities; not the case, largely out of circumstance not out of choice to be on Medicaid
- Number of dentists who accept Medicaid patients (new or existing); and the number of dentists who operate on a sliding fee scale or payment schedule, regardless of insurance status
- Dental professionals are not seeing children ages 0-2 for examinations
- Access for Medicaid/CHIP children

- Access to a dentist or dental provider; particularly for those on Medicaid or uninsured
- The Medicaid and CHIP population is lumped together in one group and shouldn't be. Medicaid has a stigma attached to it. CHIP kids are children of working poor.
- Children living in our communities, attending school, who have parents working in our country are not eligible for CHIP, if they were not born in this country. If all children can be educated in our country why aren't they eligible for health care? Other states (17) provide coverage to all children residing within their boundaries. (Kids Count)
- Children are often unable to verbalize their oral pain. Children may behave badly but no one realizes the connection between oral pain and behavior problems. Some effects of pain; anxiety, fatigue, irritability, withdrawal and distraction. Some children grow up with tooth problems and do not know any different. Very few people are available to assess children and advocate for them. Dental health professionals can be perceived as self-serving. School nurses are aware of the oral health problem and would utilize dental hygienists if there were more available.
- Many children have Medicaid but few dentists take Medicaid clients or limit them in their practices. Low reimbursement vs. the high cost of staff and materials are contributing factors. Once a child has problems parents cannot afford care to get cavities filled.
- Too much untreated, preventable disease in the children from lower socio-economic populations
- Access to oral health care, particularly for kids on Medicaid or CHIP; providers not honoring these insurance
- Lack of access to care for the Medicaid and CHIP children
- Medicaid: dentist do not accept Medicaid; some have to travel hundreds of miles to access a dentist
- Lack of training/knowledge for dental office staff on assisting families using Medicaid/CHIP
- Too few dentists are accepting Medicaid patients for a variety of reasons

Low-Income, Uninsured, Disabled and Minority

- Low-income people have a low-dental IQ and need education on how to be responsible consumers of dental services. (Be on time for appointments, call if unable to make scheduled appointment, brush before dental exam and so on)
- The lack of access of care for dental needs of that segment of the population that comprise of non-insured, minority and elderly groups
- The low-income population, especially children and the elderly are not receiving adequate dental care
- Oral health care needs of those who do not have any private insurance; access is incredibly poor
- Underprivileged individuals including low income, children, elderly are not receiving care

- The level/quality of care that the uninsured received is perceived to be of a lesser degree than that of a private insurance patient and even Medicaid; sometimes perception is reality
- Taking care of people in our state that are not currently receiving dental care because of inability to pay for services.
- ACCESS for financially underprivileged families
- Access especially for low-income working families
- Accessing specialty care is even more difficult, even if it is medically necessary
- The number of non-insured residents: people put-off their dental care
- Oral health for the disabled; virtually does not exist; such a small amount of attention and dollars dedicated toward this; those that do see disabled children are in either one of two categories: a new dentist that want to build a business; others cannot keep clients (rookies or desperate practitioners); Very limited to what can be obtained; Have to travel some 60 miles to seek services
- Migrant workers (have a culture I do not understand) have serious dental/oral health needs
- Access to services for lower socioeconomic groups

The Oral Health System

General

- Limited funding
- Weak data base for some care decisions

Coordination

- The lack of a central, coordinating office to focus individuals and groups towards a common goal. Thus we have several different programs and agencies via for the "donated" time of the providers who are already very busy
- Disjointed and fragmented oral health care system
- Rural provider access to specialty services as well as limited diagnostic and treatment decision making information in some instances

Utilization and Capacity

- Dental hygienists are underutilized due to lack of public health funding and outdated supervision laws. The Idaho Dental Practice Act prevents hygienists from practicing independently in collaboration with a dentist, unless they work in public health.
- Idaho is losing its best and brightest because even when there is an opening in public health dentistry in our state, the pay is so low compared to private industry, health agencies cannot compete and many do not want to because they do not appreciate the value of an oral health program.
- There is a shortage of dentists, so a dentist could fill their schedule with paying patients; demand is there

- Feel that many of the dentists are busy enough with paying patients to think about incorporating non-paying patients in the mix; with the manpower shortage, dentists are a commodity and paying patients will wait
- Specialty care is even tougher to access; travel 40 plus miles one way to access a specialist who sees Medicaid patients only one day a week for a 3 hour block of time (transportation and time off of work becomes another issue)
- Lack of dentists trained specifically in dealing with young children and the overuse of surgery with general anesthetic for dental procedures
- I have never understood the unanimous decision of the dentists in to never take call nights or weekends, and to never have time for emergency visits. Probably 5% of ER patients don't need a doctor, they need a dentist; a doctor can only give them an antibiotic and analgesic in the meantime. Money is not the problem; our county has a system for underwriting care for acute cases.
- Not enough dentist coming-out of dental school to replace those retiring
- Maldistribution of dentists; rural areas affected
- Very, very rural Idaho, needs more dentists; the very few dentists have hard and fast rules: only so many hours in the day; only deal with cash and does not deal with Medicaid
- Utilization is poor
- Capacity issue

Reimbursements and Administration

- 55% to 59% of cost reimbursement rate for Medicaid dental services; dentists felt slighted, cannot trust Medicaid program or patients
- Medicaid reimbursement for dental is too low
- Medicaid has paid dentists very unfairly
- Inaccessibility to dentist; lack of dentists who accept Medicaid (for children and adults); get 30-cents on the dollar
- Medicaid billing is too cumbersome. Dentists complain EDS service is poor

Knowledge, Awareness and Perceptions

- Early prevention education i.e. baby bottle tooth decay
- Access to care/public education on oral hygiene
- Stigma associated with dental health in general; people do not like to go to the dentists (all people)
- Idaho not fully into the concept of a broader definition of health: the connection between medical and dental health
- The general population does not realize tooth decay is infectious and can spread from mother to infant and spread from tooth to tooth. The general population underestimates the importance of oral health. I have seen children unable to eat and feel so bad they could not attend school. The

surgeon general report estimates that 52 million school hours are lost due to oral pain. I know of a child who died in Notus, ID, as a result of three abscessed teeth. The crying shame is, it can all be prevented. Idaho could do a better job at helping kids get and stay healthy

- Dentists do not seem interested/vested in care as opposed to physicians

Disease, Condition and Lifestyle

- Statewide, Idahoans have poor access to optimally fluoridated water. For my District, 30 percent drink optimally fluoridated water but for other areas of the state it is much lower. There is natural fluoride in many of the water systems in southwest Idaho.
- High numbers of children with decayed teeth. Parents are not going to dentists for preventive methods, such as, early exams, education, fluoride varnish or sealants
- Lack of focus on the preventive and maintenance
- Water fluoridation (water is not fluoridated; a good, easy preventive measure not being taken advantage of)
- High disease rate, especially among the young and elderly

Policy

- State policy makers and the general public do not understand the value of oral health as an important component of health care. Without oral health public health experts employed by state and local health agencies, which specialize in health promotion and disease prevention, how do people become informed and who is available to write grants to fund programs? Who is available to advocate for water fluoridation? No one.
- Medicaid: policy does not make sense; more of an incentive not to work and have assets
- The public health infrastructure in Idaho is weak with little funding for oral health programs.

Making Strides

What oral health strategies are you aware of or are involved in that seem to be making a difference, making strides to improve oral health in Idaho and its communities?

General

- No idea
- District Health has had a tremendous response to a social marketing campaign for fluoride varnish. A dental hygienist working for the District has been providing screening and fluoride varnish one day a week. District requests Medicaid, other insurance, or payment on a sliding fee scale depending on family income.

Private and Other Programs

- Dental hygiene clinics, two days a week, Early Childhood Caries, ECC, prevention clinics at pre-schools, and Southwest District Health (this is a preventive program and targets 1-3 year children for fluoride varnish application and parent education, 4-18 year old children for preventive dental care like cleanings and sealants and targets pregnant women for therapeutic treatment of gingival infection (gums) assessment and referral. Again the demand is great and we must turn away patients, much like the situation at TRHS.
- Some practices have up built up to a practice where one-third of the patient mix is Medicaid; treat those that are already in the mix; real good management (excellent scheduling; keeping appointments; broken appointment policy; structure 2 to 3 appointments to get all the necessary work done in a humane manner; all patients are on the same playing field; respectful attitude; staff and patients are geared this way)
- I attended a great conference in Washington (Roots of Oral Health) about implementing the ABCD Medicaid program and another Oral Health program called **AWatch Your Mouth@**
- Idaho Women's Network: Advocacy for Medicaid access to dental health services; educate consumers on issues and access; discuss issues and impact with dentists
- Volunteer dental clinic in Boise; run by a CHC; recruiting dentists and offers a sliding-fee scale
- Partnership with Ohio State University Residency Program (placing dentist in rural areas; seeing uninsured and Medicaid patients); in two towns; would like to expand
- Looking into a mobile dental van to services children at schools; screenings and preventive dentistry; working with The Ronald McDonald House (will purchase van; need operational capital)
- Rural Health Care Access Program; provides grants to communities and organization to improve access to care recruit and retain providers and other clinicians; medical focus; would like to expand focus to include dental

- Columbia Dental: first managed care dental association in the state; only two offices in Idaho (Boise); based out of Washington and Oregon; take a different approach – plan on having patients long-term; focus on disease; different philosophy (make money if they are able to prevent major dental problems)
- Full time public health dental hygienists in the past were hired in each of the 7 health districts to provide fluoride rinse programs in schools, conduct DMF surveys to assess needs and refer children for dental treatment, provide preventive education. Funding is no longer provided for these programs to exist at an adequate level to meet the needs
- The Idaho Advanced General Dentistry program in Pocatello is helping provide services that are focused on and primarily directed toward lower socioeconomic groups when they provide treatment opportunities corresponding to the educational needs of the dental residents

School-Based Programs

- School based sealant program- one school (Portable dental equipment is set up on the school premise and preventive care is delivered at school. Children are away from class for a shorter time than if they have to be driven to an appointment and the dental staff at school is productive because unlike off site dental offices, there are no missed appointments at school.)
- Weekly fluoride rinse program-19 schools (children rinse once a week with fluoride rinse and can expect 30 percent fewer cavities)
- Classroom plaque control education-19 schools (schools who participate in the weekly fluoride mouth rinse program are eligible to receive education on oral health, disclose plaque, learn proper brushing and flossing.)
- Head Start mandates that each child have an oral screening and helps the family get any follow up care that is needed. A long-term goal of our program is to work with local pediatricians to get them to look for caries during well child exams.
- Our school district is involved in the fluoride program; once a week for kids in 1 – 5 grade, who's parents sign permission forms; also benefits migrant and seasonal farm workers
- Mobile Dental Van Project: visit schools; provide services to kids who receive free or reduced lunches
- In the last few years, seen some grants going to public health agencies regarding oral health, particularly with schools (i.e., varnishing)

State Programs

- Consult to Medicaid, coordinate with the ISDA Board of Trustees, consult to the State Health Promotions organization
- Central Health District Office (sealant program; for kids at no cost)
- Establishing a working relationship with the Idaho State Dental Association
- Seal Idaho
- Changing Medicaid payment structure to prioritize prevention and children's services
- Some school fluoride rinse programs, but limited
- Expansion of Dental Residency: Indigent dental clinic; could it be expanded to the Boise area?

The Caring Foundation

- Caring Foundation sponsors a program (very limited) to individuals who are not covered by any insurance program
- The Caring Foundation Program; working in the Treasure Valley; provides dental care to individuals who do not have insurance and are not on Medicaid; will help the uninsured population; came on board several months ago; done in conjunction with Regents Blue Shield
- Caring Foundation for Children; collaboration with Blue Cross of Idaho; raising money to provide dental programs for uninsured children
- The Caring Foundation, recently launched; not sure of impact, but sounds good

Idaho Oral Health Alliance

- Sit on the Oral Health Alliance group and attempt to focus on issues and how to address them.
- Working on the summit
- Idaho Oral Health Alliance: brings to gather so many different voices

Terry Reilly Clinic

- Terry Reilly's Dental Clinic; offers a sliding fee scale
- Terry Reilly Health Services Low Income Dental Clinics in Boise and Nampa. Caring Foundationworking with Columbia Dental in Boise and Nampa to provide dental care for low income children.
- The Terry Reilly Health clinic in Caldwell and a new clinic in Boise provide some dental and dental hygiene services at a reduced cost or for no cost to patients but these are also not adequate to fulfill demand

Ideas, Opportunities and Advice

What are some of your ideas to improve oral health in/for Idaho?

State and Policy-Level

General

- Involve policy makers in the process
- Don't give an illusion of coverage if it will not be honored; having insurance is not access; need to hold dentists accountable to honor Medicaid
- Work to form an Oral health czar position for the state that is not overseen by a physician.
- Get a dental school in Idaho
- State water fluoridation.
- Idaho Dental Association should have more input opportunities for people to provide their thoughts; you can lodge a complaint, but it seems that it is set-up to protect the dentists more so than the consumer; Need a more objective dental association; more of a presence of the American Dental Association; Need more self check's and balances form within (dental association); control your own ranks or will be controlled form the outside; People taking legal action because of displeasure with the Idaho Dental Association

Dental Hygienists

- Board of Dentistry: Credential hygienists to provide more care. Model the Oregon Limited Access permit for dental hygienists which allows hygienists to practice in collaboration with a dentist when serving special populations, working in certain institutions like long term care facilities, hospitals, public health agencies, community clinics, public schools and federal or state programs. This allows hygienists to work independently under general orders. Take this recommendation to the legislature. The dental hygienist should be permitted to perform dental hygiene services without first having to have a patient examined by a dentist. The hygienist can prioritize patients and facilitate a referral. The hygienist working in a collaborative practice arrangement can be held to the same standards dentists are. The Board of Dentistry, Medicaid, can conduct random site reviews; the general supervising dentist can conduct chart reviews for quality assurance and set protocols. Hygienists, who have been trained in expanded functions, placement of restorations, should be permitted to practice in this manner with a dentist. The BOD could issue dental hygiene licenses with expanded functions. With 6000 dentist retiring every year and only 4000 graduating from dental school, I would think the dentists would be grateful for some hygienists who can extend their hands a bit further.
- Explore developing a career ladder for dental hygienists who want to learn and apply more skills. Canada has a midlevel dental professional much like a dental hygienist who restores and extracts primary teeth. The

dentist could still supervise this care but it would extend the dentist's hands and more children could be served.

- Allow hygienists to provide more basic services independent of dental supervision
- Allow hygienists to do restorative care; Washington State Law allows this (good model); Spread the responsibility to increase access and reduce costs and poor oral health outcomes; need to modernize (i.e., primary care utilizes nurse practitioners and physicians assistance, why not dentistry)
- Allow dental hygienists to work under standing orders in special care facilities; i.e., schools, long term care, hospitals, community clinics, etc.
- Make use of dental hygienists who have bachelor degrees and are licensed by the state but still must operate under strict supervision requirements. If more education is required, develop the continuing education courses needed to satisfy those requirements.
- Expand the practice act so that dental hygienists that choose to do so could perform some limited restorative procedures.
- Dental hygienists should be allowed to provide restorative care for individuals in order to increase access to care for the population, especially children and the underprivileged.
- Utilization of Public Health Hygienists: service as triage and educator
- Hygienists should be permitted to practice independently, in collaboration with dentists as they do in Oregon, Washington, California, New Mexico and Colorado.

Medicaid Reimbursements and Program

- Medicaid: increase reimbursement rates for dental services and improve customer service so more dentists will participate. Please not at the expense of dropping adult Medicaid.
- Medicaid and Private insurance: recognize dental hygienists as a specialty that can bill for dental hygiene services. Recognize physicians, nurse practitioners, and physician assistants as specialties who can bill for topical fluoride application to 1-3 year old children.
- Medicaid should be easier to use and payments should be higher.
- Increase Medicaid reimbursement. Get the dental association behind a goal to have all dentists accept an agreed upon percentage of Medicaid or low charge services.
- Consumer Price Index (CPI) added to formula for dental reimbursement
- Increase Medicaid reimbursement rates to providers
- Improving Medicaid reimbursements
- Increasing Medicaid Reimbursement Rates
- Better payment structures for Medicaid patients (reimbursements to the providers)
- Expand Medicaid eligibility

- To expand Medicaid to 200% of poverty for all populations; adults currently tied to TANF; children (CHIP), is currently at up to 150% of the federal poverty level
- Implement ABCD Medicaid program

Funding and Grants

- The state should look at funding and staffing some public clinics to relieve the load in some of their more difficult areas to serve. But they need coordination
- Fund an Idaho Oral Health Program. The legislature could appropriate 2 million dollars to fund, 1FTE dentist dental director, 1 FTE water fluoridation supervisor, 1FTE dental hygienist manager and 7 full time oral health program coordinators at the district health departments. Set money aside for projects to fund community based initiatives that will significantly impact children's access to dental care and prevent dental disease in children. Washington State set aside 5 million for this purpose in 1995.
- More grants to primary care facilities that offer dental services (SB 1183)
- More stable funding for residency programs; working on a one-time small grant; more permanent and expanded funding
- Fund public oral health programs in each of the 7 districts in the state, realizing that efforts in prevention will save dollars later on (the state legislature should consider this a wise investment).

Tax Relief, Loan Forgiveness, Licensure and Other Incentives

- Tax relief programs for dentists, hygienists and practices
- State reduce loan re-payment by serving a certain amount of Medicaid; assists in establishing good operating principles for practitioners (great work ethic; diverse exposure and experience; here to serve/practice/lead)
- Some type of incentive program to make it acceptable to dentists (not just increasing reimbursement rates); forgiving educational loans for new dentist if they accept a certain number or percentage of Medicaid patients into their mix (i.e., Minnesota licensing requirements; look at other states; Oregon's Stand for Children and the mobile van model)
- The Board of Dentistry is giving CE credit to dentists who provide volunteer dentistry...I believe we need to promote the concept of volunteer dentistry within or outside the dentist's own office.

Prevention and Education

- Best way to address this problem is prevention; we are spending millions on treating a preventable condition; need to re-focus; prevention seems to work well in the middle-class and upper-class population; low-income does not benefit (why? - research indicates that we simply do not know why)
- Physician based early childhood prevention: having the most merit; something we can do now; something that is effective (used to serve on a CHC Board of Directors)

- Has to be a multi-prong approach: start at birth; focus on children early and often
- Consumers need to be educated and experienced to the point where they can do self-advocacy or have well-trained advocates for them
- Preventive public health programs
- Educate Primary care providers about the importance of Oral Health and their role in protecting it
- Become culturally aware to better address needs of all oral health consumers
- Oral health plays a major role in many systemic diseases. For example, in individuals with plaque in their arteries, arteriosclerosis, cardiovascular disease, six microorganisms can be found and their origin can only be traced to the mouth. Periodontal disease is a risk factor, like tobacco use and high cholesterol for stroke and MI. Sixty percent of the adult population has periodontal disease.
- Education to reduce the stigma of dental health, reduce bottle baby
- Focus on prevention; cheaper to do the annual check-ups and routine oral health care as compared to paying for the root canal
- The children, if cared for at a young age, will avoid pain, tooth loss, problems associated with malocclusion etc. Adults will be better able to function and will recover necessary self-esteem if their dental needs are met and teeth are restored and periodontal infections treated
- Prevention education in all groups will save the patient in time and money
- Educating people about the importance of oral health
- Idaho Oral Health Alliance and the American Dental Association and other key partners convene regional health summits; general themes or specific themes (i.e., the impact of substance and alcohol abuse on oral health; population specific issues, etc.)

Capacity

Providers

- The private practitioners, especially the local leadership, are not tuned into public health. It just seems like one organization after another asking them to give of their services.
- Dentists should come out of the dark ages and pay more attention to how professionals can work together instead of only worrying about their income and protecting their turf.
- Allow physician offices to provide dental screenings to children ages 0-2
- Work closely with oral health professionals, specifically the dental profession to develop a solution to finding an oral health home for all people in Idaho
- Dentists who do accept Medicaid, drop the attitude; we are not second-class citizens; we are not white trash

- Attorney's do pro-bono work; can dentists do some pro-bono work, or determine what is the number of Medicaid then can afford to take into their mix
- Educate and certify dental assistants so they may also offer help and services to meet the needs of the underserved people in our state. Bring water fluoridation levels up to optimal levels in all areas of the state.
- If a dental assistant is properly educated, he/she could be a greater contributor also.
- Capacity: Are there adequate numbers of willing providers?

Recruitment, Retention and Residency Programs

- Would like to see more recruitment of dentists; could use more competition; access would open up
- Creating incentives to attract female practitioners to diversify the workforce
- Establishing residency programs that brings dentists into communities and schools; more of a dental presence at the schools (reach kids early and often); schools co-op with dentists
- Expansion of the residency training program to other areas of the state, thus providing a combination of education and service to the presently underserved populations. In making that statement, it needs to be recognized that the primary mission of the dental residency program is education, but that a strong secondary component is and a continue to be service of the underserved

Community

- State public health dollars should be reinstated to pay for personnel to conduct school fluoride/sealant programs throughout the state, not limited to certain schools.
- Fluoridate more of the water supplies
- District Health can help with fluoride varnish and sealants for low-income children but dentists need to be open to hygienist working under consultant protocols.
- More grant writing skills
- Establish school based dental clinics
- Establish community health clinics (increase the number and distribution of)
- Operate low income dental clinics in several areas around the state with hired dental staff as well as allowing for some volunteer opportunities
- More charity work or being open to a reasonable amount of charity work

Data

- Data is key: need better research on populations of poverty

One year from now, what kind of a statement would you like to make about Idaho and how it is addressing oral health? What about 5 years or 10 years?

General

- I do not think Idaho can turn this around in one year

1 Year Statements

General

- Stakeholders have implemented at least one collaborative strategy to improve oral health outcomes.
- There has been come coming together
- All of the kids who have coverage have access to a provider
- That the disabled are given a fair chance to see good, competent oral health care services
- A year from now: the development of a Governor's Task Force with broad representation assembled to for solution development and planning
- So what I'd like to see after one year is dentists getting some kind of act together to handle emergencies after hours.
- A plan is in place and starting to show results
- Idaho reinstated their oral health program in 2002.
- In any of the above time frames: that dental hygienists regulate their own profession; that dentists are more concerned about the oral and general health of their patients than they are with their income; that they are less concerned about control of dental hygienists.
- Legislative commitment to implement the strategies established at the Summit; grows from year-to-year
- Idaho was on the lower half of the list in terms of providing oral health care in 2001, in 2002, they are now on the upper half and moving ahead
- People are valuing and taking responsibility for good oral health care
- All the major players at the table agreeing and committing to a set of comprehensive solutions; no fragmentation, collaboration; plan for the state
- Oral health is part of the definition of health in Idaho; this new definition is adopted and incorporated as part of the mind-set and activities of all Idahoans (individuals, communities and institutions)
- More collaboration among and between Idahoans (individuals, communities and institutions)

Medicaid

- 75 percent of the dentists in Idaho accept Medicaid patients.
- Instead of 23 percent of the CHIP population getting dental service 75 percent now receive dental services.
- I would like to see 80% of all of the dentists in Idaho treating a reasonable amount of Medicaid patients in their mix

- Idaho is addressing oral health by improving Medicaid reimbursement rates to providers so that service is available to all who need it.
- When someone has a Medicaid card (especially a child) that they have unrestricted access to dental care
- Would like to see the Medicaid stigma taken away, gone
- I would hope to see more DDS taking Medicaid pts and doing volunteer dentistry.

5 Year Statements

- An integrated physical and dental health system exists in which all children regardless of income or insurance status can access and receive services.
- Dental hygienists can now practice in underserved areas, unsupervised in collaboration with a dentist; ISU is piloting the first Master level advance practice dental hygiene degree (like the nurse practitioner degree) which would permit a hygienist to extract primary teeth, restore primary teeth, write prescriptions for fluoride and prophylactic antibiotics and deliver local anesthetic under general supervision. The school would be charged with teaching evaluation and differential diagnostic skills, human behavioral sciences, infection control, health promotion, disease prevention, and epidemiology.
- 5 to 10 years change the present-day case of only 2.4% of Idaho State Health Budget goes to Medicaid Oral Health
- 5-10 years from now: well on the way to improving access to dental care for people in Idaho
- Things are better, we can see the light at the end of the tunnel; we can get children and families into a provider
- Dental Hygienists in Public Health Depts fully funded
- If more preventive services are rendered in the near future then in 5 or 10 yrs there should be less chronic dental problems.
- I would like to be able to say that all of the dental education programs in the state provide us with culturally sensitive and willing partners in the dental care of all citizens and that the educational programs have continued to contribute to significant reduction in the oral health problems of the state on several different fronts

10 Year Statements

- Improved long-term health outcomes have been demonstrated as to the importance of oral health and improved access to services.
- Caries have all but been eliminated.
- The problem is solved
- Idaho cares about their children enough that there are either clinics or pediatric dentists available to all children (accessible, affordable and reimburses well)

- I would like to be able to say by 2010 that we fulfilled the above “wish-list” and that all people with oral pain, suffering and disease have a place to receive good care.

What advice would you offer to us in preparation for the November Summit?

General

- We all need to own the problems to solve them. Please no pointing of fingers to point out what "they" are doing badly or should do.
- Be careful that it is not too laden with government ideology
- The private industry is not yet very supportive of this summit
- Stress the importance of oral health as it relates to total health.
- Talk to the Idaho State Oral Health Board and asked them to consider changing the dental health practice act to allow dental hygienists to do restorative procedures
- Use as much of the Surgeon General's report on oral health as you can- focusing on rural/frontier/low-income challenges for care delivery/access
- Invite people from the region, especially Washington, who have already taken some of the steps I mentioned above.
- Keep in mind that not everyone is an expert in every thing; a lot of people do not know the perspective of the working poor and vice-versa. . .managed the discussion well. . .be mindful of everyone’s realm of knowledge and experience
- Enthusiasm and optimism in planning and expectations.
- Understanding that Idaho is a different political environment; not much state leadership and support for oral health and Medicaid (conservative politics; introducing progressive ideas); Proud to be one of the states that spends the least on Medicaid
- Doctors run the town; managed care has failed to bring the rates down; Lots of attention and legislation on medical care; dental health just barely making the radar screen
- I’m glad to see this “pre-survey” so that you know where people stand. There are people in this state who have a lot of knowledge on the subject but it seems oral health has not been a high priority.
- Just be aware that there are strong feelings in the dental community about “turf” and who will be allowed to provide certain services. There is much hypocrisy on the part of organized dentistry.
- Seem like you have the expertise

Moving Forward

- Help us move from ideas to implementation
- Work on creating an atmosphere of mutual respect and team building.
- A well facilitated open-forum
- Be good facilitators: keep us on track

- Try to get dentists to understand that dental hygiene is not a threat to their practice, but instead, could make it grow and produce a higher level of care.

What would make this Summit worth your time. . .what would you like to cover, do, accomplish?

General

- Make things happen
- Would like to see some honest input and work by everybody in pursuit of reaching equitable solutions
- Do not just meet for the sake of meeting
- I just wish people would consider looking at things in a new light and try not to get defensive when a few hygienists talk about alternative practice settings or “independence.” I have been told independence is a bad word and will anger many dentists. I do not express myself much because dentists have been so rude to me and I like to try to get along with everyone. But for the children, I will try to express myself and I will attend because this issue is very important to me
- That I was heard and my ideas were incorporated into the process

Shared Vision, Priorities and Plan

- I would like to come out of it with clear action plans and some commitment from people in authority that we will follow through with the plans. I have been involved with a lot of planning committees and not much ends up happening.
- Establishing measurable outcomes
- Work on creating a shared vision and establishing working relationships.
- Produce a prioritized plan of action to accomplish the goals that are identified at the summit
- I would like to see some concrete strategies for improving accessibility to poor families and action plans for implementing them and buy-in from the key stakeholders.
- Clear, do-able plans with time frames
- What are the next steps
- Even if it just a sketch, a list of ideas and strategy components
- Everyone needs to work toward a system of dental care that provides education, prevention methods and treatment to all of Idaho's citizens
- Would like to see do-able plans with people committed to moving the plans forward (assignments and timelines)
- A concrete outcome that is focused on solving the problem, not complaining about; get from problem and information to commitment and implementation (at least a step toward implementation)
- Establishing a starting-point or several do-able starting points (i.e., kids, policy, etc.)

- The Summit will produce some strong working agendas in the different areas that can bring fruitful results in the next few years.

Informing and Influencing

- A realization by the government that they have to depend on the provider and quit belittling them must because they don't see it their way
- Recognize that oral health is “our” problem not “your” problem or “my” problem
- Catch the attention of the ill-informed legislature
- Inform health improvement activities and policy makers about the real means to address health issues
- Develop educational pieces on need/access for Governor's Office, State Legislature
- That the powers to be – the people who possess the ability to change things – be present and engaged
- Participants leave the Summit with a different appreciation of the business or fiscal aspects of dental health care
- I get to take away knowledge and examples to use in my community

Continuity and Sustainability

Commitment to follow-up status report/check-in type of process

- I get to take away knowledge and examples to use in my community
- Measure our progress
- Discussion of barriers and opportunities
- Modify process
- Keep momentum

Any additional advice/comments you would offer the Idaho Oral Health Alliance, or in general . . .parting words of wisdom?

General

- Good luck
- Not at the moment, thanks for the opportunity to offer my Head Start input.
- Be mindful of policy and budget implications, Medicaid budget has potential to increase, will the state be willing to accept this?
- I think that it is great that IOHA found facilitators that are as knowledgeable and energetic as possible

Process

- Getting some legislative support is important, however, do not overlook the power of grassroots efforts
- Find out what pieces of data people have to contribute to the whole picture of what oral health looks like for Idaho
- Do not set false expectations

- Make the process more accessible: rotate locations, use of technology (i.e., video conferencing)
- Could we phase-out the process, establish time lines?

Outcomes

- Idaho thinks of indigent children and does the right thing. There is an abundance of dentistry to be done. Let's not argue over who looks in the mouth first. Let's give Idaho children the best chance at a better and healthier life and start by addressing oral health.
- Cheaper to treat people early and often than later in life when it costs more

Detailed Chronological Summit Notes

This section provides the detailed chronological notes from the November 16, 2001 Idaho Oral Health Summit. These notes are ordered based on the Summit Agenda. These notes were based on the observation of the Summit facilitators with portions being transcribed from flip chart pages. Apologies are extended for unintentional errors and omissions.

The Summit

Convening Remarks

Lisa Penny, Oral Health Program Manager for Idaho Department of Health and Welfare convened the First Idaho Oral Health Summit.

Lisa shared her appreciation for the attendance of over 150 individuals to this important Summit. In particular, Lisa wanted to thank the following Summit sponsors, contributors and supporters who made this historic Summit possible:

Major Summit Sponsors	Summit Contributors and Supporters
Idaho Department of Health and Welfare Idaho Primary Care Association Regence Blue Shield of Idaho Delta Dental Plan of Idaho Idaho State Dental Association Idaho Dental Hygienists' Association Health Resources and Services Administration	Idaho District Health Departments Idaho State Board of Dentistry Idaho Public Health Association BSU College of Health Sciences Idaho Dairy Council ACE Dental Hygiene Society Idaho Commission on Hispanic Affairs Friends of Children and Families Head Start

Lisa provided an overview of the Idaho Oral Health Alliance and referred to the IOHA insert in the registration packet for Summit participants to review at their convenience.

Lisa commented that, what she envisioned for the Summit was the opportunity for Idahoans to create a shared vision of oral health in Idaho.

Lisa acknowledged representatives from the national office Maternal and Child Health, and from the Seattle, Washington Health Resources and Services Administration Field Office.

Lisa then introduced **Michael R.J. Felix** of Community Health Development Specialists, as the facilitator of the Idaho Oral Health Summit.

Michael shared his appreciation for being asked to co-facilitate the meeting with **Charles J. "Chuck" Wiltraut** from Community Health Development Specialists, and **Sherry G. Dyer** from Pacific West Training.

Michael noted the efforts of the Idaho Oral Health Alliance, sponsors, contributors and the individuals who cleared their calendars to be present for such an important event regarding oral health in Idaho.

Michael reviewed the following **Summit Agenda**

7:30 a.m.	Registration and Continental Breakfast
8:00 a.m.	Welcome - <i>Summit Organizers and Facilitators</i>
8:15 a.m.	Opening Remarks - <i>Karl B. Kurtz, Director, Idaho Department of Health and Welfare</i>
8:30 a.m.	Opening Remarks - <i>Rep. Mike Simpson, U.S. House of Representatives</i>
8:45 a.m.	Keynote - Making Oral Health a Priority: Call to Action - <i>Lt. Governor Jack Riggs, MD</i>
9:15 a.m.	Keynote - U.S. Surgeon General's Framework for Action and Best Practices <i>Peter Milgrom, DDS, Professor, Department of Dental Public Health Sciences, University of Washington</i>
9:45 a.m.	Break
10:00 a.m.	Panel - Perspectives on Oral Health and Access to Care
	Public Health Perspective <i>Lisa Penny, RDH, State Oral Health Program Manager Idaho Department of Health and Welfare</i>
	Provider Perspective <i>Scott H. Kido, DDS, President, Idaho State Dental Association Julie Slee, RDH, Immediate-Past President, Idaho Dental Hygienists' Association</i>
	Primary Care Perspective <i>Erin Ostteen, DDS, Dental Director, Terry Reilly Health Services</i>
	Medicaid Perspective <i>Joe Brunson, Administrator, Idaho Division of Medicaid</i>
	Government/Legislative Perspective <i>Rep. Margaret Henbest, Idaho State Legislator</i>
	Business Perspective <i>Hart Beal, Benefits Analyst, Micron Technology, and President, Employers' Health Coalition of Idaho</i>
11:15 a.m.	Break
11:30 a.m.	Facilitated Group Discussion - Key Issues and Objectives to Improve Oral Health of Idaho Children and Families - <i>Michael R.J. Felix and Charles J. "Chuck" Wiltraut, Community Health Development Specialists</i> (Summit participants will have an opportunity to share their perspectives on the key issues, present strategies and solutions that work, and discuss what they would like to see happen to improve oral health and access to care in Idaho.)
12:15 p.m.	Lunch (provided)
1:15 p.m.	Facilitated Breakout Sessions - Strategies and Recommendations to Meet Objectives <i>Michael R.J. Felix, Charles J. "Chuck" Wiltraut and Sherry Dyer, Facilitators</i> (Summit participants are asked to choose one breakout session to attend.) Breakout Session A: Policy and Funding Breakout Session B: Access to Care Breakout Session C: Prevention and Education
3:00 p.m.	Break
3:15 p.m.	Reports from Breakout Sessions
3:45 p.m.	Next Steps and Commitment to Summit Follow-up - <i>Summit Organizers</i>
4:00 p.m.	Adjourn

Michael then shared some of the input received via the pre-Summit telephone interview process, highlighting meeting expectations and desired outcomes with a particular focus on creating a shared vision and a plan to address Idaho's oral health needs. Key components of this plan, according to pre-Summit telephone interviews were:

- Legislative/policy
- Prevention and education
- Access to oral health services
- Reduction of oral health disease and disparities

Michael emphasized that the Summit, if embraced properly, would be facilitated toward these desired outcomes.

Michael then asked how many practicing dentists, dental hygienists, oral health educators, primary care physicians, and other providers were present. Each group stood-up accordingly with a respectable representation in each category.

Michael introduced **Karl B. Kurtz**, Director of the Idaho Department of Health and Welfare to provide the opening remarks.

Highlight from Karl's opening remarks:

Everyone holds a portion of the answer, holds a piece of the solution, today we need to put all the pieces together and make the commitments to form the partnerships to create the solutions.@

Karl thanked Michael and Chuck for coming to Idaho to help and lend their expertise.

Karl then thanked everyone in the room for coming to Idaho's first oral health summit.

Karl expressed that he hopes that smiles are a little brighter today to brighten the smile of others in Idaho.

Karl noted that we are all convened here at this historic Summit because of the oral health need: a growing concentration of oral health. In particular, Karl mentioned that poorer people suffer disproportionately worse than people with higher incomes. Karl noted, according to statistics he made available that:

- 26% of Idaho 3rd grades have untreated tooth decay
- 32% attending lower income school have untreated cavities (15% attending the highest income schools)
- 32% - 12% are in need of urgent care

Even though dental disease is the most common chronic disease in children, it is also the most preventable.

Oral health has been taking a back seat to other health issues.

Good oral health impacts how we eat, interact, performance our jobs, do in school, how we sleep, how we function . . . a key role in personal success (esteem and activities).

Karl also mentioned:

- We do not have a real organized constituency advocating for oral health.
- The public is largely unaware unaware of the connection of good oral health to good overall health.
- Over 1/3 of the country does not have dental health insurance.

Solutions are not as easily identifiable as the issues. Karl shared what he believes are some of the critical issues regarding oral health:

- Capacity is an issue
 - Average age of a practicing dentist in Idaho is 50
 - 32 of 44 counties are designated dental shortage areas
- Low reimbursement rates
 - 716 dentists submitted Medicaid claims in December 2000
 - Around 400 submitted for this December (2001)

Phone lines taking requests for dentists who serve Medicaid patients

Everyone holds a portion of the answer, holds a piece of the solution, today we need to put all the pieces together and make the commitments to form the partnerships to build the solutions.

Personal thanks for the commitments already made and noted that, “What you accomplish today will hopefully brighten the smile of Idahoans for decades to come.”

Michael then introduced the Keynote speaker, **Lieutenant Governor Jack Riggs, MD.**

Highlight from Lieutenant Governor Riggs Keynote:

America received a C-Minus on oral health status and addressing oral health status needs; is Idaho happy with this? Are you happy with a C-Minus? These grades are simply not good enough. You have an opportunity today to raise the bar. @

Lieutenant Governor Jack Riggs noted that it was an honor and a pleasure to serve Idahoans as Lieutenant Governor.

Lieutenant Governor Jack Riggs welcomed those from outside of Idaho who attended. Everyone does bring their experience and expertise.

Lieutenant Governor Jack Riggs shared that he believes that the fundamental problem regarding oral health is that the oral health message is not getting out and to the right audiences: the general public, stakeholders and elected and appointed officials.

Personal experience as a medical doctor, while a medical student, really did not get the exposure to oral health . . . literally only hours devoted to it over the course of years of medical school.

Our health care system is segregated

- Doctors may not fully understand and appreciate the connection/relationship between oral health and medical health.
- Physicians are trained that everything else is connected . . . do not worry about the mouth, which is the dentists' realm.
- Potential advocates are out because they do not know.

Opportunity is to get the medical community, the doctors connected to oral health.

Use the purpose of the summit as your charge: make oral health a priority.

Lieutenant Governor Jack Riggs provided some data:

- Tooth decay is 5 times more than asthma; 7 times more than hay fever
- 18% of 2 - 4 year exp; 25% of 8 year olds have had a sealant
- 7% of teens have lost a permanent tooth
- 69% of adults have lost a permanent tooth
- 65 - 74 over a 25% have lost all of their natural teeth
- Throat cancer - 7th cancer
- \$54 billion spent n dental care

Poor dental health is a link to poor physical health growth of children, growth of the fetus, base for poor overall health status. Other data provided by Lieutenant Governor Jack Riggs:

- 50 million school hours of school time are lost a year due to poor dental health. The implication of this alone is staggering.
- People who cannot afford access to dental care are 12 times as likely to miss school compared to those who do have access; studies have shown that if you cannot read as appropriate by 3rd grade, you are already placed at a disadvantage in terms of brain development and scholastic performance.

Today, there is an opportunity to tie-in oral health to physical health and to overall quality of life.

- Oral health is connected to disease, development, and performance, mentally, physically, socially and economically . . . make the connection and develop strategies
- Strategic opportunities: focus on education various audiences; prevention (early and often); fluoridation, sealants, and supplements;

Some steps have been taken that could use additional efforts:

- \$54 billion spent on dental care
- Medicaid reimbursement rates increase (legislators are the critical people that need to be educated - contact them, get them involved, but do it in an organized, coordinated fashion); take advantage of our democratic system: get behind the issue and get the issue in front the policy makers; increase your legislative activities - I will be very supportive. Be realistic and be specific.
- Do not just increase Medicaid reimbursement rates, make this only part of a larger, more creative and comprehensive plan.

Systemic issues: health system, legislative/policy system, and community system

A summit such as this is critical because it ties all three systems together: make it effective, clear outcomes. Increase awareness, increase activities, and increase access.

Lieutenant Governor Jack Riggs shared, “My challenge to those dentists that do not accept Medicaid, I challenge you to do so. For those that are presently seeing Medicaid patients, consider taking more.”

In addition, Lieutenant Governor Jack Riggs noted, “We can do better. This summit is an indication that it can be done. You can come-up with some plans that will be effective. I pledge to help. Together we can make it better for Idahoans.”

Michael shared his appreciation for Lieutenant Governor Jack Riggs comments and summarized what all of the guest speakers shared up to this point of the Summit: systemic issues and solutions; partnerships; broader connection, definition and adoption of health; and the need to work the policy process.

Michael introduced Peter Milgrom, DDS and Professor in the Department of Dental Public Health Sciences, University of Washington.

Highlights from Peter Milgrom's remarks:

Science has determined the connection of oral health to overall health of individuals, populations and communities, now is the time for the thinking and action to connect with the science. . .set quantitative goals. . .do not get engaged in territory, who's to blame, and that increasing Medicaid reimbursement rates will solve the problem: instead focus on the goal and then determine the process to achieve it. . .prenatal care presents a great opportunity. @

Peter Miglrom shared his appreciation for the opportunity to be part of the Summit.

Peter noted that he would like to put some meat on the bones on what we heard so far this morning, would really like to focus on ideas and solutions and conceptualize the ideas a little differently than before.

Take pieces of the solution to work-on, do not wait until you can address the whole problem. Need the momentum to be created to address the issues.

Covered the following in his presentation:

- U.S. Surgeon Generals Report: this is the first one on oral health
- Whose problem is it?
- What are the oral health issues impacting rural Idaho?
- What works in addressing oral health issues and needs?
- Role of the dental practice

Special Note: Peter Miglrom offered, upon request, his Power Point presentation to interested individuals.

Peter highlighted the following oral health points of interest to emphasize points made earlier in the Summit and provide additional context:

- 25% of children have more than 80% of tooth decay; pay for sealant program now (prevention) or later (acute).
- Oral health is everybody's problem.
- Dentists are retiring and dying faster than they are being replaced; rural communities will be the communities that suffer first and probably the hardest.

What works:

- Preventive dental care for children requires the redefining of prenatal care to include oral health.
- Tooth decay is an infectious disease transmitted from mother to child just after birth.

Peter noted that there are known strategies: treatment of dental care must be part of well baby care.

In addition, Peter shared that, "Waiting for damaged teeth is like specializing in amputations for diabetes care."

Science has determined the connection of oral health to overall health of individuals, populations and communities, now is the time for the thinking and action to connect with the science in order to improve oral and overall health status.

Set quantitative goals, think solution and place focus on thinking and action (not who's territory, who's to blame, increase Medicaid. . .focus on the goal and then determine the process to achieve):

- For all pregnant women assess the risk of her infecting the child
- For high risk mothers: chlorhexidine mouth rinse; xylitol chewing gum; basic dental care

Michael thanked Peter Milgrom for his presentation and proposed taking the Summit's first break prior to the Panelist portion of the Summit.

BREAK

Panel

A panel was assembled to provide various perspectives on oral health across Idaho. Many of the panelists had note cards and speaker notes available. Below are highlights from their panel presentations.

Lisa Penny, RDH, State Oral Health Program Manager for the Idaho Department of Health and Welfare

- U.S. Surgeon General's Report on Oral Health as the basis for comments
- Data tells the story of oral health needs
- Partnerships are critical
- Opportunities to have a positive impact do exist: fluoridation of water
- Comprehensive clinics

Scott H. Kido, DDSA, President of the Idaho State Dental Association

- Organized dentistry perspective
- Perfection should not be a goal, improvement should be
- Our society has a responsibility to help those who are underserved
- Offered task force recommendations
- Millions of dollars on a preventable disease: state and dentists are losing money; causing a strong resentment
- Various populations with equally various problems and expectations. Not a one size fits all problem or solutions

- Dentists will help, need more resources in terms of knowledge, understanding and financial

Julie Slee, RDH, Immediate Past-President of the Idaho Dental Hygienists' Association

- Noted insert in folder regarding dental hygienists training and reviewed slides sharing the caliber of dental hygienists: schooling, years of experience, qualifications
- Capacity and policy issues
- Hygienist not empower enough to make their contributions to better oral health

Erin Ostten, DDS, Dental Director of Terry Reilly Health Services

- Strengthening the safety net of all health services for the low income and uninsured
- Less than 30% of our children with Medicaid and CHIP are not receiving any dental services
- Idaho Care Lines fields 500 requests a month seeking a dentist to service Medicaid patients
- Terry Reilly Clinic considered a **Best health practice model**, however still has a large waiting list of individuals seeking oral health services
- Recruitment and retention of dentists is a priority; public health dentists work on average 40 hours a week, unheard of in private practice; licensure issues; public health dentist get paid less than private practice dentist
- Prevention is a major challenge
- Community Health Centers (CHCs) are facing a forest fire of toothaches and severe needs
- Only 73 dentists are accepting new Medicaid patients under strict parameters; may have enough providers enlisted, but not enough serving

Joe Brunson, Administrator of the Idaho Division of Medicaid

- Talking about a disease that is impacting all, but particularly the poor who are children, women, minority and disabled.
- What are the factors that influence the systems set in place to help people
 - Perceptions and stigmas
 - Understanding or mis-understanding
- If we cannot influence or move the policy makers along the line of change, we will not be as successful as we need to be because policy impacts the finance and delivery of oral health services
- In health care, we are a group of ethical people: we come in to it to do good; we need to have that ethical influence re-charged and transferred to other systems: policy and community

- Medicaid and oral health care: almost a \$900 million dollar program
 - What are the consequences when individuals do not get the preventive and routine care that they need, look at our budget
 - Those that do receive adequate care: the cost of disabled child: \$250,000 a year
 - Could pay a dentist 75%, but will this influence the market? Emphasis should be on appropriate costs
 - A different focus would be on increasing access and incorporating private primary care physicians; be involved in oral health care (i.e., diagnosis, referral; possible varnishing)
- Workforce development is a critical issue: Idaho dentists are getting older and not being replenished at a rate to serve the existing patient base; rural populations will be impacted severely
- Look at integrating oral health at the macro level
- Health education and promotion
- Have folks from Medicaid, physicians and dentists and other workforce personnel involved in oral health improvement activities
- Integrate into a primary care case management model
- Getting the system to move along to get us the support to do what we need to do

The Honorable Margaret Henbest, Idaho State Representative

- A deep and broad problem that will not be solely solved by one individual or one individual group: it will require multiple groups
- Poor children are twice as likely as having an untreated cavity as opposed to those with higher income
- Government has a responsibility to help the poor by facilitating the process through legislative action:
 - Eliminate bureaucracy
 - Appropriate reimbursement rates
 - Tax credits
 - Use billing practices that are manageable and appropriate
 - Explore insurance product that looks more like a street product as opposed to a Medicaid product (flow and perception)
- Other opportunities
 - Deal with the dental shortage itself: need to increase supply; reach future dentists early and often (high school)
 - Expand pool of providers: stronger functioning relationships with primary care physicians and dentists (could potentially double efforts)
 - Dealing with compliance (keeping appointments and presentation); need a better understanding and shared responsibility
 - Work with the Department of Education: points of care and curriculum opportunities
 - Engage local communities in this efforts
 - Local Public Health are critical partners

Hart Beal, Benefits Analyst for Micron Technology and President of the Employers' Health Coalition of Idaho

- Businesses dealing with competitiveness in a difficult market
- Get the best and brightest employees: they make the company profitable
- Dental care costs money, dental care is a recruitment and retention tool
- A sampling of 22 companies showed that they provide dental coverage; of these, here is what they provide:
 - Waiting times
 - 100% coverage for preventative care
 - 80% coverage for basic care (fillings, extractions root canals)
 - 50% coverage for major (crowns and dentures)
 - Annual maximum per member per year \$1000 to \$2000
 - \$25 to \$55 a month for family coverage
- Concerns from employers
 - People put off their dental care because of fear/stigma; not good for production
 - Dental costs are overshadowed by medical costs, focus is still on medical, dental is overlooked
- A few ideas
 - Best tool is education, know the problem, who it impacts, who is playing a role in oral health care
 - Education around better oral health care
 - Employers sponsor health fairs on and off-site
 - Free dental care is not the answer; some employers offer free dental, even then, people do not take advantage of it: need to influence the mind-set of individuals (people, providers and policy makers)

Michael thanked all of the panelists for providing their perspectives on and ideas on how to address oral health issues in Idaho.

Michael mentioned that, "We have heard a lot regarding oral health issues and the opportunities to improve oral health. Issues at the health system, policy, community and individual levels."

Michael also noted that there are opportunities to collaborate around oral health improvement ideas including informing individuals, providers and policy makers about the status of oral health in Idaho, what is currently being done to address the improvement needs that exist and the ideas to provide oral health care better or differently.

Facilitated Group Discussion

Michael facilitated Summit participants in a group discussion. He focused on challenges in addressing oral health issues in Idaho, and ideas and opportunities to address oral health issues in Idaho. In a summary fashion, here is what some Summit participants shared:

Challenges

- Competing with other well-funded and organized interest groups who already have the attention of policy makers;
- Manpower/capacity;
- Dental/oral health care is not on the total health radar screen;
- 2.4% of total Medicaid budget goes towards Medicaid dental; SPECIAL NOTE: as a point of clarification, Medicaid sets aside an amount based on billing, poor utilization of Medicaid billing represents the 2.4% (reflects only what is billed);
- A primary care provider is writing prescriptions for fluoride tablets? Why not dentists? Why not fluoridate the water?;
- How can we spread the burden/responsibility of serving people who have oral health needs?;
- 20% of the safety net has the bulk of the problem; need to address this; and
- What about the consumer perspective?

Ideas and Opportunities

- Define the full range of players in oral health;
- Influence the mind-set of individuals through interactions and curriculum;
- More partnerships;
- America's Promise and Idaho Association of Cities focusing-in on community improvement where oral health could be a part of: point is, do not duplicate existing efforts; coordinate activities;
- Dental/oral health must be a priority: a reflection of this is in state, county and local budgets;
- Work with what we have: expand our current functions; need some policy changes (law is not allowing us to serve); and
- Understand and respect realms of knowledge and experience.

Michael thanked the Summit participants for sharing their thoughts regarding challenges in addressing oral health issues in Idaho, and for the ideas and opportunities to address these issues. Michael noted that it was time to break for lunch and then reconvene at 1:15 p.m.

LUNCH BREAK

Michael reconvened the Summit and reviewed the purpose of the facilitated breakout sessions.

Facilitated Breakout Sessions

The purpose of each breakout session is 1) to brainstorm ideas and solutions, and 2) to identify strategies to develop and implement these ideas and solutions.

The Surgeon General's Framework for Action outlines the components of an Oral Health Plan and provided reference points for consideration as each breakout session group developed their ideas, solutions and strategies:

- Change Perceptions of Oral Health
- Build Effective Health Infrastructure
- Remove Barriers to Oral Health Services
- Accelerate Building and Application of Science

The brainstorming of ideas and the development of strategies was endeavored as time allowed. Strategies were developed along the following manner:

1. **Desired Outcomes**
 - b. What will be done/accomplished with this idea or solution?
2. **Process**
 - a. What strategies/actions are needed to accomplish the desired outcome?
3. **Challenges**
 - a. What factors could impact carrying the idea or solution forward?
4. **Who**
 - a. Who are the individuals and organizations who must be involved to successfully move the idea forward?
5. **Next Steps**
 - a. What are the next steps and the time frame for moving the idea(s) forward?
6. **Future Involvement**
 - a. Who in the breakout group is willing to be involved following the Summit to help move these solutions and strategies forward?

Summit participants reconvened to provide a 10 minute presentation around their recommended solutions and strategies. The following paragraphs are summaries of the report-out portion of the Facilitated Breakout Sessions. These notes are ordered as listed on the Summit Agenda. These notes were transcribed from flip chart pages. Apologies are extended for unintentional errors and omissions.

Policy and Funding

- Dialogue of linkages between the Idaho Medical Association and the Idaho Dental Association
 - Education of professionals could translate into support
 - Diffusion of ownership and change practice programs

- Incorporate the participation of:
 - The hospital association and primary care organizations
 - Idaho Dental Hygienists Association
 - Idaho Nurses Association
 - Indian Health Services
 - National Education Association, Idaho Department of Education, and Head Start programs
 - Consumer input (wide-spectrum: pre-natal to geriatric)
- Support, enhance or develop a pilot program that incorporates the key components of access, reimbursement and a “home” for oral health care (Terry Reilly Clinic replication)
- Develop recruitment and retention strategies and seek the appropriate legislative and financial support
- Work with Medicaid to look at other “best health practice models”
 - Investigate a Medicaid dental best health practice model/a policy effort in Arkansas that increased Medicaid reimbursement rates. Mr. Billy Tarpley, Executive Director of the Arkansas State Dental Association; 2501 Crestwood Drive, Suite 205; North Little Rock, Arkansas 72116; P: 501-771-7650; F: 501-771-1016 ; Web and E-mail: www.dental-asda.org and asda@aristotle.net
- Establish a process in which primary care providers could bill for dental procedures
- Maximize use of resources to ensure prompt payment
- Modify the Idaho Dental Practice Act; begin with dialogue first (avoid turf and focus on the issues: better oral health)
- Define dental prevention and determine who could be trained to deliver it
- At the school-based level (primary, middle and high) have an individual responsible for implementation of preventive and basic treatment services: assess what is currently working
- Develop a strategy for DDS to be reimbursed for dental education
 - Must be worded carefully for the federal government
 - Follow medical template “face to face consultation” and “disease consultation”
- Investigate ways to increase access: pro-bono options (need a gatekeeper), mobile vans, new partners, etc.
- State loan repayment and scholarship programs
 - Increase funding
 - Make access easier
- Establish “charitable” values in early graduates and students
- Address water fluoridation
 - Educate the public
 - Develop state policy
- Establish tax breaks, credits or incentives for dental practitioners
- Establish oral health outcome measures
- Establish a special fund dedicate to children’s dental prevention
- Enhance oral health grant writing capacity

- Partner with Idaho high learning institutions (technical schools, universities and colleges) and communities to better define oral health problems and develop solutions
- Look at DDS reimbursement and consider tying the reimbursement to the cost of living or consumer price index
- If Medicaid dental reimbursements come in lower than budget, divide remainder between Medicaid DDS's
- Institute a policy for schools with soda pop machines to also offer alternatives such as water (particularly with fluoride), milk and appropriate fruit juices

Access to Care

- Issues
 - Providers
 - Capacity
 - Scope of practice and services
 - Specialists
 - Licensing issues
 - Role of dental hygienists and dental assistants
 - Replenishing the person power/our base
 - Where to refer people to?
 - Transportation
 - Oral health consumers not intellectually armed with the knowledge that they ought to have to appropriately access and navigate the oral health system (access points, eligibility, programs and services)
 - Reimbursement rates
 - The uninsured, working poor
- Ideas
 - General
 - Oral health access could be define as chair time (time in a dentists chair receiving services)
 - Need to partner for a better standard of oral health care
 - Get to people often and early
 - Good case management
 - Broad view
 - Payment plans – offer a sliding fee payment schedule
 - Emphasis on prevention
 - Humane access to emergency care for those without a medical or dental home; emergency room should not serve as a medical or dental point of care
 - Expand the function of auxiliary staff
 - Need to change the laws regarding dental hygienists and dental assistants to allow them to do – appropriately – more than what they currently are; underutilization of a resources is a disservice

- Conduct a service inventory to learn who is doing what and what is working
 - Partner with private dental and medical practitioners
 - Hospitals and health departments as key partners
- Expansion of education/teaching, training and residency programs
 - National Health Services Corps SEARCH model (Students Experiences and Rotations in Community Health)
 - Area Health Education Centers
 - Private practice dentists and universities
- Our Ideal Dental health System
 - Public Health Departments and Hospitals
 - Faith community
 - Head Start
 - Schools
 - Local Philanthropies
 - United Way
 - Private
 - Dentists
 - Dental Hygienists
 - Dental Assistants
 - Primary care providers
 - Pediatricians
 - Education component for professionals, consumers, and policy makers and resource holders
 - Legislative focus: adequate reimbursement rates
 - Global enough that the stigma would be reduced: oral health is a key part of overall health
- Other ideas
 - ABCD – replicate it
 - Licensed professionals working in medical clinic settings (public or private)
 - License reciprocity
 - For new dentists, mandatory pro-bono or Medicaid cases
 - On-going training for non-dental providers geared toward identification and potential treatment of oral health issues as part of treating the entire individual
 - Resources development to secure funds to shore-up the oral health safety net of services and providers
 - Increased activity from the dental society; encourage local chapters and members to think more broadly and engage in collaborative endeavors that will improve oral health
 - The role of parents in their own oral health care and the role that parents play in their children's oral health care; train parents around good oral health behavior/habits, maintenance and routine oral health care; WIC is a good model to build on

- Implementation Idea: Expanded Functions of Existing Dental Providers
 - Desired outcome is improved access to oral health services and improved oral health outcomes (reduced disease and disparities) services by increasing capacity of existing resources and developing new capacity to meet the oral health needs of Idaho
 - Functions
 - Education
 - Training
 - Diagnosis
 - Treatment
 - Restorative
 - Preventive Treatment
 - Fluoride varnish
 - Sealants
 - Parent/patient education
 - Non-dental and medical components of preventions
 - Screenings and assessments
 - Prescription or pharmacy capacity (arrangements)
 - Who
 - Dentists (should have license reciprocity; the ability to work in at least two states)
 - Dental Hygienists
 - Dental Assistants
 - Potentially
 - Primary Care Physicians
 - Pediatricians
 - Licensed Nurse Practitioners
 - Physicians Assistants
 - Registered Nurses
 - How
 - Lobby/advocate
 - State Board of Dental Examiners
 - Key elected and appointed officials, and candidates
 - Partners
 - Idaho Dental Association
 - Idaho Dental Hygienists Association
 - Community
 - Other stakeholders

Prevention and Education

- Challenges
 - Quick action
 - Avoid being bogged down in over collaboration
- Streamline
 - Limitations in the law for dental hygienists and dental assistants

- Political barriers between dental and medical professionals – turf issues
- Funding – a limited pool and competing priorities; perception that when general funds are short, dental health loses support
- Reimbursement barriers
- Need full system of family health well-being (coordination of service providers)
- Dental health has not been in the top five family health issues
- Time, patience and long-term commitments are required for making the necessary changes needed for improved oral health in Idaho
- Evidence shows that increased scope of practice will expand the longevity of hygienists working and increase the efficiency of a dental office
- Ideas and opportunities
 - Dental health written into school curriculum
 - Remove soda pop and candy machines from schools
 - Educate school boards on importance so it will be written into standards
 - Strategy at the local level
 - Investigate current standards related to oral health (in Idaho and across the United States)
 - Allow dental hygienists to teach
 - Grant development – provide materials to teach
 - Pre and post-natal oral health care for all pregnant women (receive an oral health exam) and the reduction of each childhood carriers
 - Parents assisted in being responsible for their own dental health, and the dental health of their children
 - Integrate with well child visits
 - Varnish for WIC, Head Start and Early Head Start
 - Rinses and gums; Medicaid reimbursement and private insurance
 - Sealant, varnish and fluoride program early and often (mobile/portable, and at schools); Children should be pain free
 - Make mandatory under Medicaid; attend prenatal classes; oral health component
 - Dental professionals train medical professionals to identify, refer or treat oral health needs (physicians, nurses, staff and administration)
 - Identify physicians who will take a leadership role and support the training
 - Work with state level associations
 - 80% fluoridation community water systems across Idaho; 3 targeted counties over the next thirty-six months (Bannock; Bonneville; and Farmingway (Sp?))
 - Involve the Centers for Disease Control and Prevention

- Conduct a cost/benefit analysis
 - Public information campaign to build support
 - Work with DEQ and public water system
 - Involve Delta Dental;
 - Involve the medical community and identify someone to take the lead (remove the resistance)
 - Determine the approach to effect outcomes by community
 - Mandate as a last resort
- Fully funded preventative program in all 7 health districts and coordinated by a full time dental hygienist
 - Lobby for a legislative initiative (policy and funding)
 - Assess grant options that do not create limitations on options and resources
 - Approach the Health and Welfare Committee and determine how the IOHA could better inform, help make policy and policy decisions
 - Find and develop supportive data to help make the case to place oral health higher on the list of legislative priorities
 - Integrate dental hygienists into the local dental society
- Parents assisted in being responsible for their own dental health, and the dental health of their children
 - Media/public awareness campaign (general and custom for any and all socio-economic or cultural group) Educational programs: how to be a good dental care consumer
 - Impact of oral health including prenatal care
 - Rewards/incentives for keeping appointments
 - Coordinate with Health Care for the Homeless
 - Involve school nurses
 - Preventive aspect
- Increase school-based sealant programs
 - Sealant, varnish and fluoride program early and often (mobile/portable, and at schools)
 - Children should be pain free
- Varnish program in every WIC program in Idaho (3 month recall); report at Head Start and Early head Start
- Increase Medicaid reimbursement for pregnant women who need to get their teeth cleaned; expand Medicaid benefits to include periodontal and restorative services for 1 year after delivery
- Integrate child prevention oral health services with the well-child exam; professionally trained in varnish applications, risk assessment, and screening
- Increase preventative dental claims
- Children will be able to concentrate on learning and be free of dental pain

- How do we move this forward?
 - Keep the process simple; collaborations can get cumbersome and unrealistic; keep the process manageable and pragmatic
 - Dentists and hygienists get together to address the expanded functions idea
 - Develop a plan so potential partners can determine how to be involved, and their appropriate role and contribution
 - Share today's outcomes and learning with oral health constituents, providers and other stakeholders (primary care providers, etc.)
 - Call our legislatures
- The following individuals are interested in continued involvement regarding prevention and education strategies
 - Lisa Penny
 - Lalani Ratnayake
 - Roxanne Joyner
 - Tina Fisher
 - Kathy Tuller

Idaho Foundations

A list of Idaho-specific funding opportunities is provided below.

The Idaho Community Foundation (ICF) was established in 1988 with assistance from The Whittenberger Foundation of Caldwell and the Council on Foundations to provide a larger pool of philanthropic capital to fund worthwhile philanthropic projects in Idaho. <http://www.idcomfdn.org/about.htm>

The M.J. Murdoch Charitable Trust. The Trust's mission is to enrich the quality of life in the Pacific Northwest by providing grants to organizations that seek to strengthen the region's educational and cultural base in creative and sustainable ways. Although major emphases are education and scientific research, grants are given to a wide variety of organizations, including those that serve the arts, public affairs, health and medicine, human services, and people with disabilities. To learn more, visit: <http://www.murdock-trust.org/>

Leppert, Elaine C., ed. *Directory of Idaho Foundations*. 9th ed. Caldwell, ID: Caldwell Public Library, 1999. Based on 990-PF returns filed with the IRS by foundations and corporations either headquartered in Idaho or with a history of giving in Idaho. Available from the Caldwell Public Library, 1010 Dearborn St., Caldwell, ID 83605-4195. Tel.: (208) 459-3242. http://fdncenter.org/learn/topical/sl_dir.html

To see a list of the Top 10 States by Foundation Grant Dollars Received, visit: http://fdncenter.org/fc_stats/listing02.html

Founded in 1976, the Center for Policy Alternatives (CPA) is the nation's leading nonpartisan progressive public policy and leadership development center serving state legislators, state policy organizations, and state grassroots leaders. <http://www.stateaction.org/issues/healthcare/dental/dentalfundsc.cfm>

Helpful Web Links (General)

The web pages are in alphabetical order based on broad interest area headings.

Best Health Practice Models

A report on Improving Health in The Community by the Institutes of Medicine that covers defining health (broader determinants), a health improvement process and disease specific examples can be found at: <http://www.nap.edu/readingroom/books/improving/>

For best practice networks of professionals collaborating to transform health, click here: <http://ww1.best4health.org/startbp.cfm>

The Bureau of Primary Health Care's (BPHC) Models That Work web site can be accessed by clicking here: <http://www.bphc.hrsa.dhhs.gov/mtw/database/mtwquery.cfm>

The University of Kansas Community Toolbox with sections covering assessment, strategic planning and grant writing can be accessed here: <http://ctb.ukans.edu/tools/CWS/cws.htm>

National Housing Institutes Community Building and Community Organizing issue brief on creating effective models can be found at: <http://www.nhi.org/online/issues/85/combuild.html>

The Agency for Health Care Policy Research offers tools, tips and case studies for consumers and patients, clinical information, data and surveys, and funding opportunities: <http://www.ahcpr.gov/>

This website was designed to assist health care professionals and administrators in finding pertinent resources, both on and off the Internet. A wealth of links and reference materials are available here for career enhancement, employment searches, and professional development. You will also find resources in this executive toolbox linking you to many other health topics, such as medical legal issues, industry news, corporations, medical research, healthcare legislative and policy concerns, professional associations, management strategies, human resources and more: <http://www.pohly.com/>

To view 20 Measures of Sustainability, please visit: <http://www.njfuture.org/HTMLSrc/20meas.html>

Tremendous link site for health issues related to violence and other issues, as well as links to general best practice, assessment, and legal sites can be accessed here: <http://www.growing.com/nonviolent/research/dvlinks.htm>

Foundations and Grants

The Council of Foundations: <http://www.cof.org/>

The Foundation Center: <http://fdncenter.org>

The Chronicle of Philanthropy provides an overview of the not-for-profit world from grants to fund-raising to policies affecting not-for-profits (as well as board governance and other infrastructure issues: <http://www.philanthropy.com>

Federal grant opportunities are listed at <http://www.fedworld.gov> and at <http://www.financenet.gov>

Two great resource pages for foundations <http://www.fdncenter.org> and <http://www.grantsearch.org>

Some free Internet grant assistance can be found at <http://granthelp.clarityconnect.com/>, <http://www.thegrantdoctors.com>, and here <http://www.grantwriters.com/>

Two of my favorites <http://www.house-of-hope.org/grants-central-station.htm> and <http://www.guidestar.org/index.html>

Some other links worth visiting:

<http://www.cyberworkshops.com/index.htm>

<http://www.fundsnet.com/>

<http://www.dhhs.gov/progorg/grantsnet/>

<http://www.bphc.hrsa.dhhs.gov/mtw/mtw3.htm>

<http://www.ngma-grants.com/>

Health Data and Statistics

United States Department of Health and Human Services poverty guidelines: <http://aspe.os.dhhs.gov/poverty/poverty.htm>

National Center for Health Statistics (Centers for Disease Control: CDC) can be accessed at: <http://www.cdc.gov/nchs/default.htm>

The United States Statistical Abstract on-line (Adobe Acrobat .pdf file format) can be accessed at: <http://www.census.gov/prod/www/statistical-abstract-us.html>

Fact finder for the U.S. Census Bureau for population, housing, economic and geographic data <http://factfinder.census.gov/>

United States Bureau of Labor and Statistics: <http://stats.bls.gov/>

To access government agency web pages click here:

<http://galaxy.einet.net/galaxy/Government/Government-Agencies.html>

Health insurance data for the population can be located at:
<http://www.census.gov/ftp/pub/hhes/www/hlthins.html>

Healthy People web site with leading health indicators, implementation ideas, publications and of course, data: <http://web.health.gov/healthypeople/>

Links to United States statistics (population, economic and social):
<http://www.trinity.edu/departments/library/statistics.html>

The world wide web library of statistics: <http://www.stat.ufl.edu/vlib/statistics.html>

Hospital data from the American Hospital Directory web page:
<http://www.ahd.com/>

Lexis-Nexis public databases (*a fee may apply*): <http://www.lexis-nexis.com/lnccl/>

Health Economics

Various studies that demonstrate the economic impact (value) of health care on the community can be viewed at:
<http://www.uwex.edu/ces/cced/publicat/981.html>,
<http://www.wvruralhealth.org/impact.htm>,
http://www.jhu.edu/news_info/reports/impact/

The professional's guide to health economics, medical and pharmacy resources on the Internet: <http://www.exit109.com/%7Ezaweb/pjp/>

Health Reform Online (HRO) is an information resource for healthcare managers, analysts and decision makers who want to learn more about the economics and financing of health care delivery in developing countries. The site is hosted by the World Bank. To learn more, click here: <http://www.worldbank.org/healthreform/>

Health Policy and Health Systems

The National Center for Policy Analysis (NCPA) is a nonprofit public policy research institute. This website offers a wealth of analysis, debate, and in-depth research from around the world. To view health topics, click here: <http://www.ncpa.org/pi/health/>

The National Health Policy Forum (NHPF) is a nonpartisan education and information exchange program primarily serving federal legislative and executive agency staff working in health care and related areas. Its goal is to foster more informed government decision making by promoting broader interaction among opinion leaders in the public and the private sectors, to learn more, click here: <http://www.nhpf.org/>

The National Conference of State Legislatures (NCSL) was founded in 1975 in the belief that legislative service is one of democracy's worthiest pursuits. Representing the citizens of a district and the people of a state is the very essence of free government. The National Conference of State Legislatures is a bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories. The Conference is a source for research, publications, consulting services, meetings and seminars. It is the national conduit for lawmakers to communicate with one another and share ideas. To access this site, click here: <http://www.ncsl.org/login.htm?returnpage=http://www.ncsl.org/>

The National Health Law Program is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or under insured low-income people. A great source for research, advocacy, child health, racial and cultural issues and links. Check it out at: <http://www.healthlaw.org/>

The Health Insurance Association of America (HIAA) is the nation's most prominent trade association representing the private health insurance system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. It is the nation's premier provider of self-study courses on health insurance and managed care. To read more about HIAA, click <http://www.hiaa.org>

The Electronic Policy Networks web page regarding recent health care policy: <http://www.epn.org/ideacentral/health/>

Mathematica Policy research has policy information in the following categories: health, welfare, nutrition) at <http://www.mathematica-mpr.com/>

The National Governors Association website has state policies and best practices: <http://www.nga.org/>

A recent hot topic tobacco settlement. A web site that sought to keep the public informed of developments in the effort by states attorney general offices: <http://stic.neu.edu/>

Policy Research

FedLaw was developed to see if legal resources on the Internet could be a useful and cost-effective research tool for Federal lawyers and other Federal employees. Fedlaw has assembled references of use to people doing Federal legal research and which can be accessed directly through "point and click" hypertext connections: <http://thomas.loc.gov/bss/d101query.html>

This was the referring site for the above link:
<http://lcweb.loc.gov/global/legislative/congress.html>

This site will cover the major legislative and executive branch publications of the U.S. Government. Many of these publications are now available, full text, via the World Wide Web: <http://library.uncg.edu/depts/docs/resource.html>

A neat website that focuses on the U.S. Legislative Branch and then some:
<http://lcweb.loc.gov/global/legislative/congress.html>

A division of the Library of Congress that prepares short, neutral reports on legislative initiatives and other topics at the request of Congress:
<http://www-libraries.colorado.edu/ps/gov/us/crs.htm>

GPO Gate is a service of the Libraries of the University of California as members of the Federal Depository Library Program. The gateway provides access to the full-text databases made available by the GPO Access service of the Government Printing Office in Washington, D.C.:
<http://www.gpo.ucop.edu/search/default.html>

Select federal government web sites:
http://www.lib.berkeley.edu/GSSI/su_govre.html

An excellent primer for federal searches. Information from the U. S. Government is appearing with increasing frequency on the Internet. In many cases the Internet is the only place to locate important government information. Virtually all agencies now maintain their own web pages, on which are linked statistical data, news releases and other full-text publications. As time passes, more data will be in online format rather than standard print sources. In the future, searching the Web will become the primary means of locating government data. This "hands-on" workshop is designed to demonstrate how to maximize retrieval of federal government information on the Web:
<http://gort.ucsd.edu/pcruse/universe/intro.html>

Rural Health Policy and Grants

The Rural Policy Research Institute (RUPRI) conducts policy-relevant research and facilitates public dialogue to assist policymakers in understanding the rural impacts of public policies and programs. Many policies which are not explicitly "rural policies" nevertheless have substantial implications for rural areas, and RUPRI is dedicated to understanding and articulating these implications. RUPRI utilizes an inter-disciplinary approach to facilitate understanding of the rural impacts of public policies and to provide decision support to policy makers: <http://www.rupri.org/index.html>

Home of the Rural Empowerment Zone and Enterprise Community Program: <http://www.ezec.gov/index.html>

The Rural Health WebRing is comprised of sites dedicated to rural health issues - it includes government, educational and health agency websites from around the world: <http://www.rural-health.org.au/>

A study showing that the **R**rural/Urban Differences in Health Care Are Not Uniform **A**cross **S**tates **@**
http://newfederalism.urban.org/html/series_b/b11/b11.html

The Rural Studies Program was created in November of 1994 by the Board of Directors of the Tennessee Valley Authority to research issues shaping the future of rural America. To learn more, please visit: <http://www.rural.org/>

The Project HOPE Walsh Center for Rural Health Analysis was established in September 1996 to conduct timely research on issues affecting health care in rural America. Current projects are funded by the Office of Rural Health Policy (ORHP), the Agency for Health Care Policy and Research (AHCPR), and the Robert Wood Johnson Foundation. Check it out at: <http://www.projhope.org/CHA/rural/index.htm>

California's Rural Health Policy Council has a web site that organizes funding opportunities by sources: <http://www.ruralhealth.cahwnet.gov/fundingfederal.htm>

The Michigan Center for Rural Health Grants organizes funding opportunities - public and private: <http://www.com.msu.edu/micrh/grants.htm>

The Federal Office of Rural Health Policy has a section on its web-site **F**unding Information: Grants to Rural Providers and State Programs **@**click here to learn more: <http://www.ruralhealth.hrsa.gov/>

The Safety Net

America's Health Care Safety Net: Intact but Endangered released in 2000 by the Institute of Medicine can be viewed at <http://books.nap.edu/catalog/9612.html>

The Role of TennCare in Health Policy for Low-Income People in Tennessee. In 1994, Tennessee embarked upon a major health care reform. The state attempted to expand coverage to all low-income people in the state and to rely on private managed care plans as the mechanism for delivering care to new eligibles and those traditionally covered by Medicaid. The intent was to save enough money through efficiencies wrought through managed care and by converting federal and state payments made directly to hospitals for indigent care to payments for insurance coverage. These funds, together with some new state tax revenues, were expected to finance the expansion of coverage. To learn more, click here: <http://newfederalism.urban.org/html/occa33.html>

The policy and market-driven changes in the health care sector taking place across the country are not confined to metropolitan areas. Rural communities are experiencing changes impelled by many of the same forces that are affecting urban areas. To read more about Supporting the Rural Health Care Safety Net, click here: <http://newfederalism.urban.org/html/op36/occa36.html>

An executive summary of the status of America's health care safety net can be viewed at: <http://luna.cas.usf.edu/%7Embuntonp/sophc/safenet.html>

State Child Health Insurance Programs (SCHIP)

The Health Care Financing Administration's (HCFA) informational website on the State Children's Health Insurance Program (SCHIP) that is intended to provide materials of interest to various audiences regarding the passage of SCHIP, also known as Title XXI, as part of the Balanced Budget Act of 1997 is located at: <http://www.hcfa.gov/init/children.htm>

The Start Healthy, Stay Healthy campaign is a national outreach effort conducted by the Center on Budget and Policy Priorities, a private, nonprofit research and policy organization based in Washington, D.C. Since 1994, the campaign has been enlisting a wide array of community-based organizations, health and human services providers, advocacy groups, program administrators and others to identify children from low-income working families who may be eligible for free or low-cost health insurance programs. The campaign also promotes coordination between newly enacted state child health insurance programs and Medicaid to ensure that children are not in danger of being left without coverage. To learn more, please visit: <http://www.cbpp.org/shsh/>

CHIP: A Look at Emerging State programs from the Urban Institute: http://newfederalism.urban.org/html/anf_a35.html

The Children's Defense Fund site that provides a SCHIP overview with some specific **Aspects** on populations, states and policies
<http://www.childrensdefense.org/>

A web site that looks at the entire family structure and impacts of policies:
<http://www.familiesusa.org/>

The American Academy of Pediatrics: <http://www.aap.org/>