Part 5. Background, purpose, and process

Part 5 includes relevant background information, additional details on the process for developing the State Oral Health Plan, and descriptions of State Plan components.

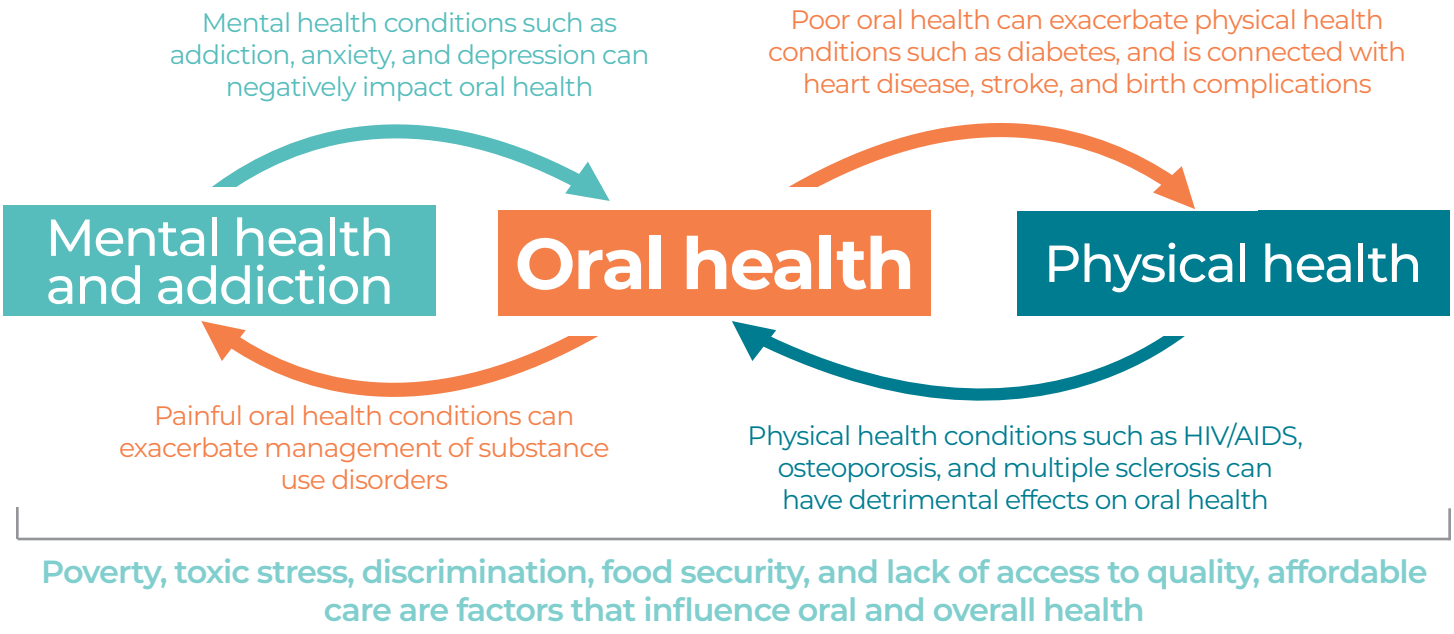
Connections between oral health and overall health

As displayed in figure 10, there are many factors that influence oral health. Community conditions like poverty, food security, toxic stress, and discrimination; health behaviors; and care access and affordability can impact oral health and overall health. Many Ohioans face obstacles to optimal oral health.

There are connections between oral health and mental health and addiction.[13] For example, anxiety is associated with teeth grinding and clenching. Anxiety and depression can also be associated with self-neglect and lack of preventive care, which may lead to poor oral health outcomes. On the other hand, drug use, such as tobacco or methamphetamine, can cause poor oral health conditions, and someone in recovery from substance use disorder may struggle with dental pain management and opioid prescriptions.[14]

Additionally, because the mouth is a prominent part of personal appearance, people with visible signs of poor oral health are often negatively judged and socially stigmatized. This affects mental health and can have other influences on well-being, such as employment outcomes and social relationships.

Figure 10. **Connections between oral health and overall health**



Oral health also has many connections to physical health. For instance, poor oral health and periodontal disease can exacerbate conditions like diabetes, and have been connected to heart disease, stroke, dementia, and birth complications.[15] Physical health conditions, including osteoporosis and HIV/AIDS, have also been connected to tooth loss and oral lesions.[16] Some medications cause dry mouth, which can also lead to oral health problems.[17]

History of medical/dental separation

Until the 1800s, dental treatment was performed, unregulated, in barber shops. The dental profession was officially established in 1840 when the first dental college in the world opened in Baltimore, Maryland. Prior to its opening, the two founders approached the University of Maryland College of Medicine about integrating dental instruction into medical school. However, the physicians rejected the proposal, as they believed dentistry was more akin to a craft, rather than a life-saving treatment.

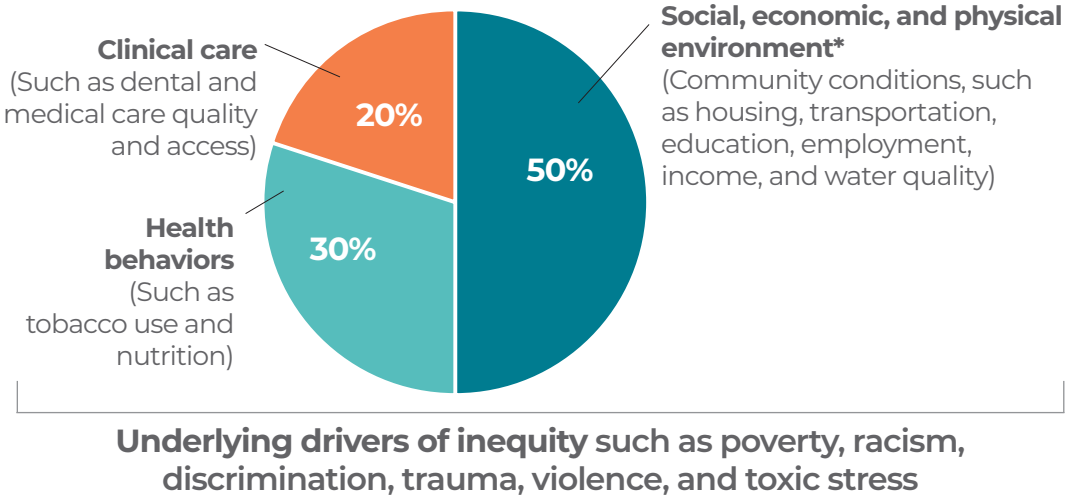
Since then, organized medicine and dentistry have fought to keep the medical and dental systems separate due to desires of professional autonomy and independence, and the belief that oral health does not affect overall health—a misconception that factored into the separation of medical and dental insurance.

The idea of medical insurance first originated in the U.S. in 1929[18], but dental insurance was not created until several decades later, in 1954.[19] Since their creation, the two have served different functions. While medical insurance was designed to protect against large, unpredictable expenses, dental insurance was intended to fund predictable and lower-cost preventive care. Dental insurance has often been perceived as a "benefit" rather than a "necessity."[20]

What shapes our oral health?

There are many modifiable factors that influence oral health and overall health, as shown in figure 11. These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health." The State Plan addresses many of these drivers, including poverty, transportation, healthy food access, health behaviors, and access to quality oral health care.

Figure 11. **Factors that influence oral and overall health**



* These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health."
Source: Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

How will we know if oral health is improving?

The long-term goal of the State Plan is that Ohio has an oral healthcare system that is available, accessible, and affordable for all Ohioans. This goal contributes to the vision of optimal oral health for all Ohioans across the lifespan. To achieve this goal and vision, Ohioans need regular access to preventive dental care and treatment when issues, such as tooth decay, arise. Ultimately, we will know if oral health is improving when there is reduced tooth decay and periodontal (gum) disease, increased early detection of oral and pharyngeal cancers, and when disparities in oral health outcomes are eliminated, as displayed in the conceptual framework (figure 2 on page 5).

How was the State Plan developed?

Facilitated by the Health Policy Institute of Ohio (HPIO), under contract with Oral Health Ohio, the State Plan was developed with an analysis of secondary data and input from approximately 200 Ohioans through:

- **Healthcare provider focus groups:** HPIO and Oral Health Ohio hosted five virtual focus groups with 52 participants from a variety of dental and medical specialties and locations across the state (refer to the **Assessment of Ohio's oral health strengths and challenges** for more information)
- **Consumer focus groups:** A total of 114 community members in five cities (Columbus, Athens, Cleveland, Toledo, and Cincinnati) attended focus groups to provide input on the state of oral health in their communities (refer to the **Assessment of Ohio's oral health strengths and challenges** for more information)
- **Advisory committee**: A multi-sector advisory committee with 27 members met four times to provide guidance and feedback throughout development of the Plan (see Appendix A for a list of committee members and the group's core values). The advisory committee was responsible for reviewing, discussing, and selecting the priorities for this State Plan, as well as the goals and action steps to address each priority:
  - **Priority selection**: After reviewing assessment findings, advisory committee members were asked to complete a prioritization survey to select the areas of focus for the State Plan.
  - **Goals and action steps selection**: The advisory committee selected the Plan's goals via an online survey. Action steps for achieving each goal were collected from public repositories of evidence-based strategies and selected with advisory committee input.

Components of the State Oral Health Plan

To provide partners with a roadmap to reach the vision of the State Oral Health Plan, the Plan includes the following components:

Equity

Priorities

Taking action

Tracking progress

The following sections describe each component in more detail.

 Equity

This Plan defines **health equity** as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, focusing on societal efforts to address avoidable inequalities, recognizing and rectifying historical injustices, addressing contemporary injustices, eliminating health and healthcare disparities, and assuring structural and personal conditions are in place to support optimal health. To eliminate disparities and inequities, policies, programs, and services must be tailored to Ohioans with the greatest need, such as Ohioans of color, Ohioans with disabilities, Ohioans with low incomes, and Ohioans living in rural or Appalachian regions. These groups, among others, face bias, discrimination, and structural barriers to oral and overall health that can be eliminated through deliberate action.

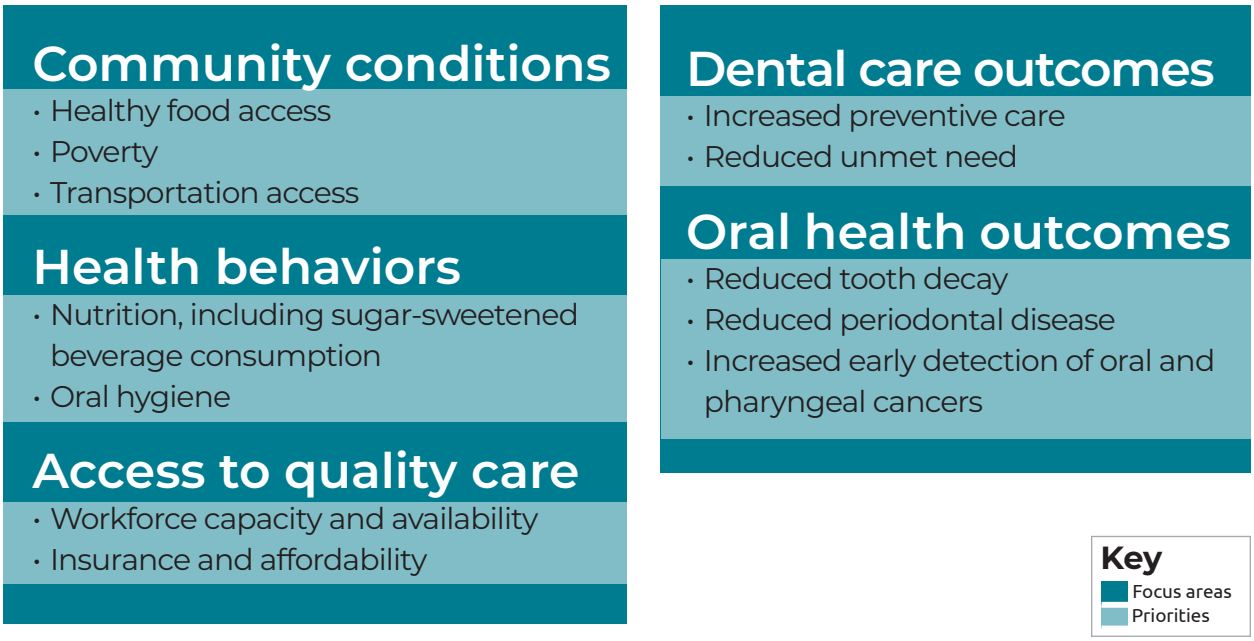
The State Plan helps partners advance equity by:

- **Identifying priority populations**. Based on available data, groups of Ohioans who experience outcomes at least 10% worse than the state overall were identified as priority populations. Priority populations were also identified based on the **Assessment of Ohio's oral health strengths and challenges**, including findings from the healthcare provider and consumer focus groups, as well as feedback from the advisory committee.
- **Prioritizing equity in action steps.** Each of the Taking Action sections in the State Plan highlights considerations for prioritizing equity when implementing policies, programs, and services. Additionally, action steps marked with the equity symbol () are likely to reduce disparities based on a review of research by **What Works for Health**. An action step without an equity symbol can still be effective in advancing equity if it is tailored and adapted to meet the needs of priority populations.
- **Setting universal targets to eliminate disparities.** All State Plan SMART objectives include universal long-term targets to reinforce the importance of eliminating disparities for Ohioans that experience the worst outcomes. This means that the long-term targets for all priority populations are the same as the long-term targets for the state overall. More information about SMART objectives can be found on page 41.

Priorities

The State Plan is organized into five focus areas. Within these focus areas, the State Plan identifies 12 priorities. Figure 12 lists the focus areas and priorities of the State Plan.

Figure 12. **Focus areas and priorities of the State Oral Health Plan**



These priorities were identified through a multi-step selection process informed by:

- The results of the **Assessment of Ohio's oral health strengths and challenges**, including secondary data analysis and findings from the healthcare provider and consumer focus groups
- Advisory committee feedback provided through a prioritization survey and small group discussions
- Input from other subject matter experts

Taking action

The purpose of the Taking Action sections is to provide state and local partners with next steps to advance the priorities and achieve the vision of the State Plan.

Each Taking Action section includes:

- **Goals**: Broad statements that express a desired outcome to address the priority.
- **Action steps:** Specific recommendations, including the implementation of policies, programs, and services to achieve the goal.

Figure 13 provides an example of a goal and action step.

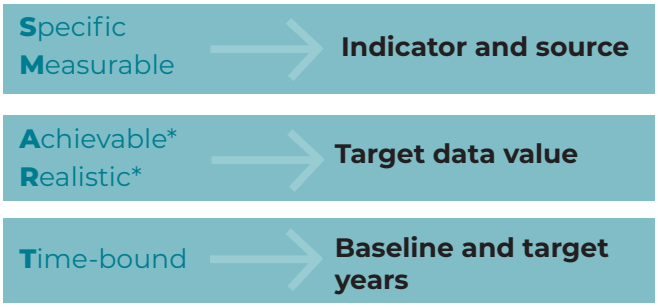
Figure 13. **Goal and action step example**

The goals in the State Plan were selected by the advisory committee through a prioritization survey, and then action steps were added to address each prioritized goal. The action steps in the State Plan are evidence-informed, meaning that there is either research evidence showing that the policy, program, or service has achieved positive outcomes relevant to State Plan priorities, or there is information provided by subject matter experts that the approach is promising.

Tracking progress

Progress will be tracked on the State Oral Health Plan priorities so that partners across the state will know whether we are advancing the vision of optimal oral health for all Ohioans across the lifespan.

State Plan progress will be tracked using SMART objectives, which are:



The State Plan includes 8 SMART objectives, based on the indicators included in the tables on p. 29-34. Oral Health Ohio will track and report progress on these objectives at the short-term and intermediate target dates (2024 and 2027). Oral Health Ohio will also report on progress on the goals and action steps in the State Plan.

The eight SMART objective indicators were selected with advisory committee assistance. Data for each indicator is:

1. Publicly available
2. Measured at the state level
3. Able to be broken out by factors such as race, ethnicity, income, insurance type, and/or disability status so that priority populations could be identified
4. Updated regularly (annually or biannually) so that targets could be set and progress could be monitored

Each SMART objective includes a short-term (2024), intermediate (2027), and long-term (2030) target, as well as priority populations. By setting universal long-term targets, the State Plan sets a bold goal that disparities will be eliminated across these SMART objectives by 2030. To achieve this goal, action must be focused on supporting priority populations who experience significantly worse outcomes than the state overall.

Community conditions

Although the State Plan does not include SMART objectives related to the community conditions priorities, this Plan encourages oral health stakeholders to engage in a collective impact approach with partners across the state who are working toward improvement in healthy food access, poverty, and transportation. Relevant state plans with priorities and/or targets in these areas are linked on page 14.

Target setting methodology

To select the long-term, universal targets for each SMART objective in the State Plan, HPIO identified a similar metric from Healthy People 2030 or another state's oral health plan to use as a rough benchmark. HPIO then calculated the percent change of each benchmark metric from baseline year (e.g., 2019) to target year (e.g., 2030) and applied that as a rate of change to the number of years between baseline and target for Ohio's State Oral Health Plan.

After this calculation was performed, some targets in the State Plan were adjusted based on:

- Whether the target was an appropriate balance of achievable and aspirational given Ohio's policy environment.
- The degree of disparities for priority populations. For SMART objectives with the largest disparities, the target for the state overall was reduced so that the priority population targets were more achievable.

The long-term target for dental workforce had no benchmark metric on which it could be based. HPIO set the long-term target for this metric based on information collected at the consumer and provider focus groups, as well as feedback from subject matter experts.

After the long-term targets were selected, HPIO calculated a consistent rate of annual change for both Ohio overall and priority populations from their baseline values to the long-term target value. This means that the rate of change is greater for priority populations so that universal targets can be achieved in 2030. The targets for 2024, 2027, and 2030 were pulled out as the short-term, intermediate, and long-term targets for the State Plan.

All targets were reviewed by members of the advisory committee, as well as several additional oral health data experts in Ohio, and their feedback was integrated into target setting decisions.