Part 4.

Tracking progress on the State Oral Health Plan

The State Oral Health Plan sets a clear strategy for tracking progress on its priorities. By establishing objectives and reporting progress over time, partners across the state will know whether we are advancing the vision of optimal oral health for all Ohioans across the lifespan.

This section includes 8 SMART (Specific, Measurable, Achievable, Realistic and Time-bound) objectives that will be used to measure improvement on the priorities outlined in the State Plan. (For more information on SMART objectives, see pages 41-42.) Each objective includes a short-term (2024), intermediate (2027), and long-term (2030) target, as well as priority populations. To improve on the objectives in this section, action must be focused on supporting priority populations who experience significantly worse outcomes than the state overall. By setting universal long-term targets, the State Plan sets a bold goal that disparities will be eliminated across these SMART objectives by 2030. Oral Health Ohio plans to track and report progress on the short-term and intermediate targets.

Health behaviors: Improved nutrition, reduced juice consumption

Indicator (source)	Baseline (2019)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
1. **Juice consumption.** Percent of Ohio children, ages 2-5, who had 1 or more 100% fruit juice drinks yesterday (Ohio Medicaid Assessment Survey)	64.5%	61.1%	59%	57%
Priority populations				
Black Ohioans	77.6%	68.2%	62.6%	57%
Ohio children living in households earning 100-206% of the FPL	72.7%	65.6%	61.3%	57%
Medicaid enrollees	73.1%	65.8%	61.4%	57%
Rural, non-Appalachian Ohioans	75.2%	66.9%	62%	57%

Access to quality care: Increased workforce capacity and availability

Indicator (source)	Baseline (2020)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
2. **Dentist workforce**: Average number of dentists per 100,000 population, by county (Area Health Resource File/National Provider Identification File, as compiled by County Heath Rankings)	44	46.3	48	49.7
Priority populations				
Appalachian type counties	37.6	42.4	46.1	49.7
Southeast Ohio	35.7	41.3	45.5	49.7

Dental outcomes: Increased preventive care

Indicator (source)	Baseline (2019-2020)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
3. **Preventive dental care, child.** Percent of children, ages 1-17, who have seen a dentist or other oral health care provider for preventive dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments in the past year (National Survey of Children's Health)	74.1%	75.3%	76.3%	77.2%
Priority populations				
Hispanic Ohioans	66.5%	70.8%	74.0%	77.2%
Other, non-Hispanic Ohioans*	61.8%	68.0%	72.6%	77.2%
Ohioans earning 0-99% of the FPL	64.9%	69.8%	73.5%	77.2%
Ohioans earning 100-199% of the FPL	65.3%	70.1%	73.6%	77.2%
Ohioans who are 1-5 years old	52.3%	62.3%	69.7%	77.2%

* Non-Hispanic Ohioans who are not Black or white

Dental outcomes: Increased preventive care (cont.)

Indicator (source)	Baseline (2020)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
4. **Preventive dental care, new mothers.** Percent of Ohio women with a live birth during the past year who had their teeth cleaned during pregnancy (Ohio Pregnancy Assessment Survey)	40.7%	41.8%	42.6%	43.4%
Priority populations				
Hispanic Ohioans	27.5%	33.9%	38.6%	43.4%
Black, non-Hispanic Ohioans	31.6%	36.3%	39.9%	43.4%
Other, non-Hispanic Ohioans*	28.8%	34.6%	39%	43.4%
Ohioans earning $32,000 or less	27%	33.6%	38.5%	43.4%
Ohioans earning $32,001-$57,000	34%	37.8%	40.6%	43.4%

* Non-Hispanic Ohioans who are not Black or white

Dental outcomes: Reduced unmet need for dental care

Indicator (source)	Baseline (2019)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
5. **Unmet dental care need, adult.** Percent of Ohio adults, ages 19 and older, with unmet dental care needs (Ohio Medicaid Assessment Survey)	14.3%	12.8%	11.9%	11%
Priority populations				
Black Ohioans	19.1%	15.4%	13.2%	11%
Hispanic Ohioans	23.0%	17.5%	14.3%	11%
Ohioans earning 0-100% of the FPL	23.1%	17.6%	14.3%	11%
Ohioans earning 100-206% of the FPL	20.2%	16%	13.5%	11%
Adult Ohioans with any disability	23.4%	17.8%	14.4%	11%
Adult Ohioans with a cognitive or developmental disability	30.1%	21.4%	16.2%	11%
Ohioans enrolled in Medicaid	21.1%	16.5%	13.8%	11%
Uninsured Ohioans	37.9%	25.7%	18.3%	11%
Ohioans living in metropolitan areas	15.8%	13.6%	12.3%	11%
Ohioans who are 19-24 years old	18.4%	15%	13%	11%
Ohioans who are 25-44 years old	17.7%	14.7%	12.8%	11%

Oral health outcomes: Reduced tooth decay and reduced periodontal disease

Indicator (source)	Baseline (2019-2020)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
6. Oral health problem, child. Percent of children, ages 1-17 years old, who experienced oral health problems such as toothaches, bleeding gums, or decayed teeth or cavities within the past year (National Survey of Children's Health)	12.8%	11.9%	11.3%	10.6%
Priority populations				
Black, non-Hispanic Ohioans	18.1%	15.1%	12.9%	10.6%
Ohioans earning 0-99% of the FPL	19.3%	15.8%	13.2%	10.6%
Ohioans earning 100-199% of the FPL	14.8%	13.1%	11.9%	10.6%
Ohioans earning 200-399% of the FPL	14.2%	12.8%	11.7%	10.6%
Uninsured Ohioans	27.8%	20.9%	15.8%	10.6%
Ohioans who are 6-11 years old	19.5%	15.9%	13.3%	10.6%
Indicator (source)	**Baseline (2020)**	**Short-term target (2024)**	**Intermediate target (2027)**	**Long-term target (2030)**
7. Permanent teeth removed, adult. Percent of adults, ages 18 and older, who had 6 or more permanent teeth removed (Behavioral Risk Factor Surveillance Survey)	16.1%	14.7%	13.6%	12.5%
Priority populations				
Black, non-Hispanic Ohioans	18.4%	16%	14.3%	12.5%
Ohioans who earn <$15,000	33.0%	24.8%	18.7%	12.5%
Ohioans who earn $15,000 - $24,999	29.2%	22.5%	17.5%	12.5%
Ohioans who earn $25,000 - $34,999	19.8%	16.9%	14.7%	12.5%
Ohioans who are 45-64 years old	18.9%	16.3%	14.4%	12.5%
Ohioans who are 65+ years old	34.1%	25.5%	19%	12.5%

Oral health outcomes: Increased early detection of oral and pharyngeal cancers

Indicator (source)	Baseline (2015-2019)	Short-term target (2024)	Intermediate target (2027)	Long-term target (2030)
8. **Oral cavity and pharynx cancer stage diagnosis.** Percent of oral cavity and pharynx cancers with an early-stage diagnosis (Public Health Data Warehouse)	30.8%	32.5%	33.6%	34.6%
Priority populations				
Black, non-Hispanic Ohioans	26%	29.9%	32.3%	34.6%
Hispanic Ohioans	27%	30.5%	32.5%	34.6%

Tracking progress on community conditions

The State Oral Health Plan does not include SMART objectives related to community conditions priorities (healthy food access, poverty, and transportation). However, the Plan acknowledges that addressing these priorities is critical to achieving the long-term goal and vision of the State Plan. State Plan partners are encouraged to work alongside other Ohio organizations who are working to improve community conditions. Through a collective impact approach, public and private organizations across the state can work together to address challenges and measure progress on healthy food access, poverty, and transportation.

Refer to the state documents linked on page 14 for relevant plans and efforts on which to partner.

Oral health data limitations and recommendations

The SMART objectives above are based on data from a variety of publicly available sources. While care was taken to select metrics from credible sources, each of these sources has its own limitations. Several data gaps and limitations are outlined below.

Publicly available data: The State Oral Health Plan relied on the limited amount of oral health data that is publicly available and consistently updated to track progress over time. Publicly available data often comes from state or national surveys and relies on self-reported conditions and behaviors. Other administrative data, such as Medicaid claims data, is often unavailable at the state level and could not be used for this Plan. High-quality, granular, timely, and specific hospital and provider data is also not publicly available. Finally, data from the Ohio Medicaid Assessment Survey online dashboard reports race and income categories that are not mutually exclusive.

Data lag: Publicly available data sources, such as government surveys and vital statistics records, often lag by one to three years between the time of data collection and the time of release. This is important to acknowledge from a policy perspective, as data may predate important policy changes or other factors which could impact performance on a metric. For example, the impact of the COVID-19 pandemic may be better reflected in some measures than others.

Disaggregated data: Data is not consistently disaggregated by race and ethnicity, income level, educational attainment, county, disability status, and other important characteristics across national- and state-level data sources. As a result, few priority populations may be identified for some SMART objectives, while others have more.

There is also a lack of data to identify other groups that experience disparities and inequities, like recent immigrants or LGBTQ+ Ohioans. Small sample sizes for some groups may also lead to data suppression. Aggregation of data for groups with smaller populations, such as Asian Ohioans, can mask health disparities for subpopulations.

Recommendations

A strong, interoperable, and transparent data system is necessary for evidence-based policymaking and program evaluation. Lack of comprehensive and disaggregated state and local data on oral health hinders Ohio's ability to make targeted improvements and advance equity. Without oral health data, community leaders and State Plan partners cannot accurately identify and address inequities or measure progress.

Policymakers and other State Plan partners can improve oral health data collection, reporting, and transparency by:

1. Hiring a Dental Director at the Ohio Department of Health to oversee the establishment of a statewide coordinated process to work across systems to improve oral health data management and infrastructure. This includes establishing oral health coordinators at other organizations/state agencies.
2. Dedicating resources to data infrastructure, including software, hardware, and personnel needs.
3. Engaging epidemiologists to analyze data from the National Nutrition Examination Survey and report on oral hygiene and oral health clinical data for Ohio, disaggregated by race, ethnicity, age, and income, and to compare Ohio to national values.
4. Utilizing state-added Behavioral Risk Factor Surveillance Survey oral health questions related to Emergency Room visits, oral hygiene practices, cleanings, and dental pain to assess the state of oral health in Ohio, and publicly reporting the findings.
5. Incentivizing data sharing and collaboration among providers, local organizations, and across programs within state agencies.
6. Encouraging collection and public release of quality data from Medicaid claims, hospital systems, and other state-level data repositories, in a timely (quarterly, monthly, etc.) manner.
7. Requiring, via contract, that Medicaid managed care organizations publicly share program data.
8. Creating a state dashboard of indicators, validating them, and using them to annually assess the State Oral Health Plan.
9. Developing data standards on priority populations and consistently collecting information about race, ethnicity, language, disability status, zip code, sexual orientation, veteran or immigration status, and other characteristics in patient satisfaction surveys, program evaluation tools, and wherever else oral health data is collected.
10. Strategically over-sampling public surveys in minority communities so that reliable estimates can be reported, and the health of that population can be assessed.
11. Establishing community partnerships with local civic organizations, health departments, hospitals, behavioral health providers, and schools to host key informant interviews and focus groups and to help determine data-related needs, especially with organizations that represent priority populations.