

**Proceedings of the Illinois Oral Health Summit**

**and**

**The Illinois Oral Health Plan**

***Illinois' Response to the U.S. Surgeon General's Report:  
Oral Health in America***

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## Introduction

The U.S. surgeon general's report: *Oral Health in America*, published in May 2000, describes both the "marked improvement in the nation's oral health in the past 50 years" and the simultaneous "silent epidemic of oral disease affecting our most vulnerable citizens." In Illinois, huge strides have been made in improving the oral health of the state's residents. Community water fluoridation, dental sealants, advancements in dental technology and growing public awareness of positive oral health behaviors have made it possible for many in Illinois to maintain optimal oral health for a lifetime.

At the same time, Illinois mirrors the nation in that oral disease remains pervasive among families with lower incomes or less education, the frail elderly, those with disabilities, those who are under-insured and minority groups. Preventable oral diseases account for a great deal of tooth loss and can act as a focus of infection that impacts outcomes of serious general health problems such as coronary heart disease, diabetes, pre-term low birth weight and others.

The Illinois Oral Health Summit was convened by the Illinois Department of Public Health on September 11, 2001, at the University of Illinois at Chicago's School of Public Health. It was designed to provide a forum for Illinois policy makers and key stakeholders to learn about critical oral health issues from a variety of perspectives and, in light of that knowledge, to react to a draft of the state's oral health plan.

The major findings and suggested framework for action put forth by the U.S. Surgeon General form the basis for Illinois' plan. Augmenting this foundation is the collective wisdom of citizens, stakeholders and policy makers. The result is a comprehensive vision that can be embraced by all involved in the process. The plan articulates goals, priorities and strategies to improve the oral health of all Illinoisans. Its five policy goals reflect specific priorities and its recommended strategies and action steps suggest how to address each of them. The plan concludes with a call for the establishment of a select committee to monitor and provide guidance in the implementation of the plan.

It should be emphasized that the plan is a working document. Current and future readers are encouraged to look for opportunities to contribute to sustaining the oral health of all Illinoisans.

# **Proceedings of the Illinois Oral Health Summit**

## **Illinois' Response to the U.S. Surgeon General's Report *Oral Health in America***

The Illinois Oral Health Summit convened on September 11, 2001, in Chicago, Illinois. The summit was planned as one of Illinois' many strategic responses to the U.S. surgeon general's report, *Oral Health in America*, issued in May 2000. Welcoming comments and several key presentations on the summit agenda were completed before an unanticipated adjournment at 10:15 a.m. (CST). The tragic events of that morning prevented the summit from continuing as planned. Collectively, the minds and hearts of participants moved from Chicago to New York, Washington, D.C., and Pennsylvania. The purpose of this document is to describe the efforts that led up to the Illinois Oral Health Summit, to document the extensive collaborative preparation that helped the summit become a reality, and to describe post-summit events that have resulted in the development of the policy goals, priorities and recommendations of the state's oral health plan.

### **Background**

The Illinois Oral Health Summit was convened by the Illinois Department of Public Health on September 11, 2001, at the University of Illinois at Chicago's School of Public Health. It was designed to provide a forum for the state's policy makers and key stakeholders to learn about critical oral health issues from a variety of perspectives and, in light of that knowledge, to react to a draft of Illinois' oral health plan.

The U.S. surgeon general's report, *Oral Health in America*, published in May 2000 describes both the "marked improvement in the nation's oral health in the past 50 years" and the simultaneous "silent epidemic of oral disease affecting our most vulnerable citizens." Huge strides have been made in improving the oral health of Illinoisans. Community water fluoridation, dental sealants, advancements in dental technology and growing public awareness of positive oral health behaviors have made it possible for many in Illinois to maintain optimal oral health for a lifetime.

At the same time, Illinois mirrors the nation in that oral disease remains pervasive among families with lower incomes or less education, the frail elderly, those with disabilities, those who are under-insured and minority groups. Low income is a major risk factor for dental decay and periodontal disease. These preventable oral diseases account for a great deal of tooth loss and can act as a focus of infection that influence the outcomes of serious health problems such as cardiovascular disease, diabetes, pre-term low birth weight and others.

The Illinois Oral Health Summit was one component of a continuous and state-specific response to the “call for action” articulated in *Oral Health In America*. The call for action contained five key elements:

- Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.
- Build an effective oral health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.
- Remove known barriers between people and oral health services.
- Accelerate the building of the science and evidence base and apply science effectively to improve oral health.
- Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

Illinois has been responding for more than a decade to these key elements. For example, Project Smile, a statewide oral health survey conducted between 1993 and 1994, gathered the most reliable estimates of dental disease in children ever collected in Illinois. The survey results demonstrated that a very large number of Illinois schoolchildren still suffered from preventable oral health problems, and lacked basic preventive care (as determined by sealant prevalence), and that significant oral health disparities existed. As a result of the information gathered through this survey, the Illinois Department of Public Health intensified efforts to expand its school-based sealant program.

Illinois does not have in place a statewide oral health surveillance system that produces uniform agreed-upon data, collected routinely, that can be utilized to assess oral health status and oral health service delivery trends. Communities throughout Illinois have, in part, filled this void and established a trend of systematic oral health status assessment. Since 1996, more than 50 grantees, representing 61 local health departments, have participated in the Oral Health Needs Assessment and Planning Program developed by IDPH. The program helps communities develop local partnerships for collecting data, identify oral health needs and build oral health improvement plans. These community assessment results represent a growing database of information that suggest both access challenges and disparities in oral health throughout Illinois, particularly for low-income persons of all ages.

In 1998, the IFLOSS Coalition: *Communities to Improve Oral Health in Illinois*, a public-private partnership, was developed to help expand safety net clinics and outreach programs for uninsured and under insured individuals. Partners in this coalition include local health departments, dentists and dental hygienists, community health centers, maternal and child health workers, schools and other community members. In its short history, the coalition has established not only a statewide presence, but it also has developed materials and information to assist communities with the start-up and maintenance of dental clinics for the underserved.

Between 1999 and 2001, the federal Bureau of Health Professions (within the Health Resources and Services Administration) funded the UIC School of Public Health to convene individuals and organizations critical to the infrastructure of dental health service delivery in Illinois. The deans of both the UIC College of Dentistry and the SIU

dental program, and the dean of the UIC School of Public Health, and representatives from dental hygiene education programs, as well as others, came together to develop a roadmap that would assure a solid dental public health infrastructure for Illinois. The resulting infrastructure plan includes physical plants, technology, personnel, state-of-the-art educational programs and research tools. This strong foundation served as the basis for several action steps in Illinois' oral health plan.

On behalf of their constituents, the Illinois Rural Health Association, the Chicago Partnership for Health, the Campaign for Better Health Care and many other groups have formed partnerships to identify oral health needs and barriers to accessing oral health services and to develop recommendations to address these needs. Barriers identified include lack of transportation, lack of child care and language. Living in a nursing home also has been identified as a major barrier to oral health care and, to address this need, the Illinois State Dental Society and the Illinois Dental Hygienists' Association have been funded by IDPH to address basic oral health needs for those living in long-term care facilities. The Illinois Center for Health Workforce Studies released its research findings on barriers to children's oral health in *Access to Dental Services for Low-Income Children* in 2000. Another study on uncompensated care provided by health care providers and dentists in Illinois contained recommendations to expand access and services to low-income and vulnerable populations.

These efforts and countless others by individuals, organizations and communities across Illinois created the need for a forum that could provide information to state leaders about the extent and success of these efforts, and to propose a plan for bringing them together. The Illinois Oral Health Summit was designed to serve as that forum for policy makers and resource holders in Illinois. The plan would provide a strategy for moving forward.

## Process

### *Steering Committee*

In August 2000, the National Governor's Association (NGA) announced that it would convene a policy academy on oral health. Interested states were asked to submit an application that included a description of a state team – with representatives from the governor's office, the state health agency, the state Medicaid agency, the state dental association, the legislature, the primary care association, the business community and the not-for-profit sector – that would participate in the academy. Although Illinois was not funded, the application process established a core group of individuals who together could tackle some very important oral health issues.

The Illinois Department of Public Health, Division of Oral Health, asked this group to serve as the steering committee for the Illinois Oral Health Summit. The committee was to develop a draft oral health plan for Illinois and to prepare for and convene an oral health summit in September 2001. Committee members included representatives from the following organizations, associations and state agencies:

- IFLOSS Coalition: *Communities to Improve Oral Health in Illinois*
- Illinois departments of Human Services, Public Aid and Public Health
- Illinois General Assembly

- Illinois Maternal and Child Health Coalition
- Illinois Primary Health Care Association
- Illinois State Dental Society
- Ounce of Prevention Fund
- University of Illinois at Chicago School of Public Health

The committee, which convened monthly via conference call between April and September 2001 and conducted other business via E-mail, formalized the purpose of the summit: to showcase existing efforts in Illinois' response to the U.S. surgeon general's call to action, to provide information to policy makers and resource holders on these existing efforts, and to share the draft of a state oral health plan as yet another element of Illinois' response to the national call to action. To meet this charge, the steering committee developed the summit agenda, recommended speakers and coordinated the invitation process for the summit.

Additionally, the steering committee reviewed the strategy suggestions and findings from efforts and research on oral health conducted in Illinois. Based on this information, the committee approved a proposed list of oral health priorities for the state developed by IDPH's Division of Oral Health.

#### *Community Input Sessions*

The IFLOSS Coalition recommended to the steering committee in April 2001 that a series of community input sessions be held around Illinois. The sessions had several purposes:

- To listen to community perspectives on local oral health issues and priorities.
- To react to the proposed set of oral health priorities identified by the summit steering committee.
- To ask for community input and advice as to how to address oral health priorities in Illinois.

Seven meetings were held between May 25 and July 17, 2001, in Alton, Aurora, Bloomington, Champaign, Chicago, Mount Vernon and Rock Island. These meetings captured input from approximately 300 community members from across Illinois. Participants felt that the common priorities shared at these meetings reflected their local needs and issues. The themes and advice offered throughout this process were incorporated into the proposed Illinois oral health plan. A summary of findings from the community meetings was included in the materials distributed at the Illinois Oral Health Summit and is available from IDPH's Division of Oral Health. The state summary and notes from each community meeting were sent to the local conveners in August 2001 for review and subsequent distribution.

#### *Summit White Papers*

The summit steering committee determined that a "call for papers" would be another opportunity for organizations or individuals to share information or perspectives on oral health with summit participants. Submissions were received from the Illinois State Dental Society, the Illinois Dental Hygienists' Association, IDPH's Division of Oral Health, the Illinois Chapter of the American Academy of Pediatrics, the Ounce of Prevention Fund and the Cook County Department of Public Health. Each paper was reviewed by

the Division of Oral Health for the steering committee and distributed at the summit. The “white papers” are available from IDPH’s Division of Oral Health.

### ***Summit Day***

The summit began with a welcome from both Dr. John R. Lumpkin, director of the Illinois Department of Public Health, and Dr. Caswell Evans, director of the National Oral Health Initiative, Office of the U.S. Surgeon General. Dr. Evans congratulated Illinois on its impressive efforts and suggested that the state’s oral health plan could serve as a model for the nation. Amy Abel, meeting facilitator, reviewed the summit agenda and expectations for the meeting.

Lewis Lampiris, D.D.S., M.P.H., chief of the Division of Oral Health, began the educational portion of the agenda by providing a historical background on the efforts and events that contributed to the need for the summit. He also described the role and importance of a state oral health plan for Illinois’ current and future efforts. Dr. Lampiris concluded by calling on those convened to formulate a formal charge that would ensure that the group’s efforts continued.

The summit’s first panel presentation focused on those issues highlighted in the surgeon general’s report that are especially critical in Illinois. The first panelist, Dr. Robert Boone, a family physician from Champaign, Illinois, presented his perspective on the relationship between oral health and systemic health. (NOTE: Dr. Boone’s presentation has been transcribed and his comments are available from the Division of Oral Health, along with the presentation materials from other panelists.) Ray Cooke, president of the IFLOSS Coalition and director of the Springfield Department of Public Health, described the role of local health departments in the prevention of oral disease in the entire population. Dr. Bruce Graham, dean of the UIC College of Dentistry, then made a presentation on behalf of the dental and dental hygiene education programs in Illinois. This presentation covered the issues and challenges faced by the educational institutions, particularly how to serve first and foremost as educators, but also as safety net providers of dental services.

Following Dr. Graham’s presentation, Dr. Susan Scrimshaw, dean of the UIC School of Public Health, asked that the summit conclude in light of the circumstances unfolding in New York, Washington, D.C., and Pennsylvania. At this time, key senators, representatives and agency directors in Illinois were also being called to emergency duties and could no longer devote their attention to the oral health summit.

### ***Post Summit***

In light of the events that occurred on September 11, an alternative strategy was developed to assure that the Illinois oral health plan would be completed. Summit participants were asked to review the materials that were to have been presented at the summit and to submit written feedback to IDPH’s Division of Oral Health. Over the course of the next three months, written comments from 25 individuals and organizations were compiled and organized by the Department’s oral health staff and reviewed by the steering committee. The plan was modified, approved by the steering committee and remains on file at IDPH. The summit steering committee will continue to facilitate and assist with the implementation and monitoring of the state’s oral health plan.

The major findings and suggested framework for action put forth by the U.S. surgeon general form the basis for Illinois' plan. Augmenting this foundation is the collective wisdom of citizens, stakeholders and policy makers. The result is a comprehensive vision that can be embraced by all involved in the process.

The plan articulates goals, priorities and strategies to improve the oral health of all Illinoisans. Its five policy goals reflect specific priorities and recommended strategies and action steps suggest how to address each of them. Furthermore, potential collaborators and resources needed to support each of the priority areas are identified. The plan concludes with a call for the establishment of a select committee to monitor and provide guidance in the implementation of the plan.

It should be emphasized that the plan is a working document. Current and future readers are encouraged to look for opportunities to contribute to sustaining the oral health of all Illinoisans.

#### ***Illinois Oral Health Plan Components***

- Five policy goals that reflect the framework for action suggested by the U.S. surgeon general's report, *Oral Health in America*.
- Illinois-specific priorities for each goal area, identified through multiple processes and input across the state of Illinois.
- Recommendations and suggested strategies to meet the priorities identified. These ideas were drawn from existing efforts in Illinois to assess and improve oral health.
- An appendix to the plan includes a list of those participating in the steering committee, summit, infrastructure development, town hall meeting, and community oral health needs assessments.

#### ***Abbreviations in the Illinois Oral Health Plan***

CDC – Centers for Disease Control and Prevention

ECC – Early Childhood Caries

HRSA – Health Resources and Services Administration

HPRC – Health Policy and Research Center

IDHA – Illinois Dental Hygienists Association

IDHS – Illinois Department of Human Services

IDPA – Illinois Department of Public Aid

IDPH – Illinois Department of Public Health

IPHCA – Illinois Primary Health Care Association

ISBE – Illinois State Board of Higher Education

ISDS – Illinois State Dental Society

PHFI – Public Health Futures Illinois

SIU – Southern Illinois University

SIUE – Southern Illinois University at Edwardsville

SPH – School of Public Health

UIC – University of Illinois at Chicago

WIC – Women, Infants and Children's Program

USDA – United States Department of Agriculture

**Special note: For purposes of this plan, references to the “Medicaid insured” population also includes children insured by the Illinois KidCare program.**

# THE ILLINOIS ORAL HEALTH PLAN

## POLICY GOAL I

**Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.**

### ILLINOIS PRIORITIES

- Educate the public, health professionals and decision makers about the relationship between oral health and systemic health with an emphasis on –
  - Prevention of early childhood caries
  - Prenatal oral health care for women
  - Behaviors that assure good oral health, for example, daily oral hygiene, routine dental checkups, the proper uses of fluoride, proper nutrition, injury prevention and being tobacco free
  - Removal of fear and misunderstandings about going to the dentist
  - Early detection and prevention of oral and pharyngeal cancer
- Maximize use of the entire health care and dental health workforce – particularly public program staff (e.g., WIC, family case management, maternal and child health, mental health and long-term care) – to educate the public on the value and importance of oral health.

### RECOMMENDATIONS AND STRATEGIES

**Recommendation 1. Develop a comprehensive statewide oral health education and awareness program that should include, at a minimum, the following elements:**

- A statewide media campaign with messages about the value and importance of oral health and the impact of poor oral health on systemic health
- Specific messages for populations identified as most at risk for poor oral health (e.g., low-income populations, populations with developmental disabilities and the elderly).
- Culturally and linguistically appropriate materials
- The incorporation of oral cancer prevention and awareness messages into existing state and local cancer prevention efforts

#### *Strategy*

**Coordinate current statewide efforts and resources, including, but not limited to the IFLOSS Coalition marketing plan, CDC funded IDPH oral health educator, IDPA materials developed to educate Medicaid insured persons on the value of oral health, IPHCA educational effort regarding Medicaid benefits, ISDS/IDHA Long Term Care Facilities Oral Health Education Project, UIC School of Public Health HPRC State Models for Oral Cancer Prevention project, and SIU Oral Cancer Awareness Campaign.**

**Recommendation 2. Develop an early childhood caries (ECC) prevention program with the following components:**

- Data on early childhood caries prevalence

- Messages on ECC prevention in appropriate settings (e.g., day care centers) and programs funded through IDPH and IDHS
- Pilot programs to demonstrate effective ECC prevention strategies

***Strategies***

IDPH is currently collecting statewide ECC prevalence data. IDPH in collaboration with IDHS should assess program staff knowledge, attitudes, and beliefs concerning ECC prevention and develop a training program based on these findings.

WIC, family case management and other IDHS programs, should serve as the foundation for pilot efforts. Local health departments, early intervention staff and birth-to-3 networks should be involved in planning pilot programs to demonstrate ECC effectiveness. It is estimated that annually \$200,000 would be required to develop, pilot and implement ECC programs in 20 communities throughout Illinois.

Under the auspices of the WIC regional directors and staff examine the list of food items covered under the WIC program and consider alternative to high-sugar drinks. Utilize recommended WIC food prescription changes developed by the National WIC Association for the United States Department of Agriculture.

**Recommendation 3. Promote regular dental exams for children. At a minimum –**

- Encourage dental exams for young children beginning at age 1.
- Investigate the possibility of requiring a dental exam prior to school entrance and before entering grades K, 5 and 9; propose policy changes as necessary.

***Strategies***

Assess continuing education needs of general dentists in the management and treatment of infants and children and develop continuing education courses to address identified needs.

Provide community-based experiences for students of dentistry, dental hygiene, nursing, and family medicine and pediatric medicine in the management and appropriate dental treatment of children under the age of 5.

Assess the need for expanding the number of pediatric dentists.

Expand the number of dental clinics providing oral health services to children before the age of 3.

Establish a public-private partnership between IDHS, the Maternal and Child Health Coalition, the Ounce of Prevention Fund, the IFLOSS coalition, hospitals, IPHCA and others to address this recommendation.

Establish partnerships between children’s oral health advocates and local school boards to encourage mandatory dental examinations at the local level.

Consider the development of a statewide legislative strategy for requiring mandatory dental examinations.

**Recommendation 4. Provide prenatal education to all pregnant women with an emphasis on the relationship between maternal oral health and pre-term low birth weight, and between maternal oral health and infant oral health, and the benefit of establishing positive oral health behaviors in infancy.**

***Strategies:***

**Establish a public-private partnership between the Maternal and Child Health Coalition, IDHS, the Ounce of Prevention Fund, the IFLOSS coalition, hospitals, IPHCA and others to develop and implement programs to educate the primary care community and low-income women themselves on the relationships between oral health and adverse pregnancy outcomes and to develop other strategies to address this recommendation.**

**Investigate the Mile Square Health Center pilot program targeting pregnant women and their infants for possible expansion or replication.**

**Recommendation 5. Implement comprehensive school health curricula with an oral health education and prevention component in all Illinois schools to assure that children are healthy and, therefore, better able to learn.**

***Strategies:***

**The ISBE and IDPH should actively pursue funding from the CDC to establish a comprehensive school health program in all Illinois schools.**

**Coordinate efforts among IFLOSS, IDPH, ISBE, school nurses, IDHS school health staff, school health educators, school health clinic staff and others to assure oral health is addressed within the framework of comprehensive school health.**

**Encourage policies limiting access to candy and soda machines in schools as part of this effort, in order to reinforce a healthy oral health message within schools.**

**Recommendation 6. Encourage or require protective mouthguard use in school or other sports programs for those sports at high risk for oral or facial injury.**

***Strategy***

**Coordinate efforts among IFLOSS, school coaches, coaching associations, park districts, YMCA, IDPH and ISBE in implementation of the Project Mouthguard program throughout Illinois.**

**Recommendation 7. Maximize the capacity of local health departments to dedicate existing resources for oral health education.**

***Strategies***

**Incorporate information regarding behaviors that assure good oral health into existing local health department programs wherever possible. (NOTE: Programs target different age groups, and separate strategies may be needed.)**

**Utilize health department-based child care nurse consultants who work in homes and child care centers to provide oral health education and prevention information.**

**Recommendation 8. Provide pediatricians, nurses, emergency room physicians and other medical professionals, and the institutions where they are educated and trained, with information on oral disease prevention and treatment.**

***Strategies***

**Develop programs to educate medical providers (including medical students and medical residents in pediatrics, internal medicine and family practice) about the prevention of oral disease, ECC, existing oral health services in communities and where to refer patients for oral health services.**

**Include oral health disease control as a component of overall health promotion in the curricula and training experiences of all Illinois schools of medicine, public health, nursing and other allied health professions.**

**Build and strengthen critical partnerships between dental and medical communities with an emphasis on pediatricians and primary care providers.**

**Assure that non-dental health care providers are included on a state oral health advisory committee.**

**Recommendation 9. Implement and maintain a public/private statewide partnership that focuses on the prevention and control of oral and pharyngeal cancer.**

***Strategies***

**Supplement funding for the National Institute of Craniofacial and Dental Research (NICDR) project to expand statewide, community-based efforts that empower local communities to prevent oral and pharyngeal cancer.**

**Coordinate activities of the Statewide Partnership for Oral Cancer Prevention and Control with the steering committee and other groups involved with development of the Illinois Oral Health Plan.**

## **POLICY GOAL II**

**Build an effective infrastructure that meets the oral health needs of all Illinoisans and integrates oral health effectively into overall health.**

### **ILLINOIS PRIORITIES**

- Increase the representation of African Americans and Hispanics in Illinois dental and dental hygiene schools.
- Increase the number and types of community-based experiences that benefit both communities and students of dentistry and dental hygiene.
- Improve outreach to involve dentists and dental hygienists in private practice in community-based efforts to improve oral health and access to care.
- Establish a uniform system for assessing oral health workforce capacity as a component of an Illinois oral health surveillance system.
- Assure capacity of schools of dentistry and dental hygiene to recruit and retain faculty and to provide state of the art teaching and research opportunities.

### **RECOMMENDATIONS AND STRATEGIES**

**Recommendation 1. Increase the representation of students from under-represented minorities at the UIC College of Dentistry, the SIUE School of Dentistry and dental hygiene schools and programs.**

#### ***Strategies***

**Fund the Dental Student Scholarship Program, which provides full tuition grants and monthly living stipends to under-represented minority students who attend Illinois dental schools. Inform and educate these students about the scholarship once established.**

**Illinois schools of dentistry and dental hygiene schools, in collaboration with other health professions schools, could seek funding for the development of programs to attract under-represented minority students into the health professions.**

**Develop alternatives to monetary payback for scholarship recipients such as community service and/or mentoring responsibilities for minority populations.**

**Investigate the ISBE teacher shortage scholarships as a model for dental health professional scholarship programs.**

**Recommendation 2. Increase the number and types of community-based experiences available to students of dentistry and dental hygiene.**

#### ***Strategies***

**Support the IPHCA and AHEC effort to provide community-based experiences for health professions students through the SEARCH (Student Resident Experience and Rotations in Community Health) program. Illinois-specific support is required to expand the SEARCH program, which is currently at capacity. Additionally, consider letters of support and participation in the SEARCH advisory committee at the request of and as needed by IPHCA.**

Create linkages between schools of dentistry and dental hygiene so that community-based programs (school-based and school-linked clinics, dental sealant programs and state facilities that serve the developmentally disabled) can serve as service and rotation sites for students of dentistry and dental hygiene.

**Recommendation 3.** Integrate information and training experiences into the dental and dental hygiene education curricula that will allow these dental health professionals to treat a diverse public.

***Strategies***

Incorporate principles of culturally competent health care into the curricula of all Illinois programs for the health professions, including dental schools and dental hygiene schools.

Provide specific experiences for students in the treatment of populations that require special care, particularly the developmentally disabled, the elderly and children under age 5.

**Recommendation 4.** Expand the continuing education opportunities for currently practicing dentists and dental hygienists in the area of dental public health.

***Strategies***

Under the leadership of the IDPH Division of Oral Health, develop a partnership among training programs for dentistry and dental hygiene education, dental professional associations, and public health education and training programs to recommend and develop qualified continuing education opportunities in dental public health and oral disease prevention for existing practitioners of dentistry and dental hygiene.

Develop service learning opportunities for dentists and dental hygienists in collaboration with facilities that serve special needs populations, such as the developmentally disabled, nursing home residents and those living with HIV disease.

Coordinate local public health department continuing education programs with local dental and dental hygiene association efforts to do the same.

**Recommendation 5.** Establish a process for the systematic collection of oral health workforce capacity in Illinois. Once established, assess the distribution of and potential need for dental specialists, particularly pediatric dentists.

***Strategies***

A feasibility study for this approach should be implemented first in collaboration with the Illinois Center for Workforce Studies and the Illinois State Board of Dentistry.

The State Board of Dentistry could consider dental workforce data element collection as part of the licensure renewal process and make appropriate recommendations to the Illinois Department of Professional Regulation regarding the oral health workforce in Illinois.

**Recommendation 6. Assess capacity of current dental schools in Illinois to recruit and retain qualified faculty and to maintain state of the art of facilities.**

***Strategy***

**ISBE could commission a study to assess the current needs of dental schools in Illinois and to develop recommendations to address identified needs.**

## **POLICY GOAL III**

**Remove known barriers between people and oral health services.**

### **ILLINOIS PRIORITIES**

*Any plan to address barriers to oral health in Illinois must incorporate a strategy for funding the reimbursement of Medicaid services at a floor of 75 percent of the 50<sup>th</sup> percentile (average) of fees charged by a private dental practice.*

- **Expand the scope of Medicaid-covered oral health services to include preventive services for adults.**
- **Increase the start-up and maintenance funding resources available for public dental clinics to address the unmet oral health needs of the Medicaid population, the uninsured and the underinsured.**
- **Expand funding for IDPH's school-based dental sealant program to allow penetration of the program throughout Illinois.**
- **Identify funding streams for a statewide community-based education and awareness program, pilot projects in care coordination to improve access to services, and early childhood caries prevention programs.**
- **Develop an Illinois loan repayment program for dentists and hygienists who agree to practice in dental underserved areas and to treat underserved populations.**
- **Expand the dental workforce in rural areas.**

### **RECOMMENDATIONS AND STRATEGIES**

**Recommendation 1. Increase Medicaid funding to raise reimbursement rates to a minimum floor of 75 percent of the 50<sup>th</sup> percentile of fees charged by private dental practices.**

**Recommendation 2. Expand the scope of services provided to Medicaid beneficiaries to include, at minimum –**

- **Preventive services particularly for adults (cleaning [prophylaxis], periodic exams)**
- **Periodontal (gum) procedures, particularly for pregnant women**
- **Endodontics (root canal) procedures for posterior (back) teeth**
- **Partial dentures**
- **Operating room costs/anesthesia for persons with developmental disabilities who require sedation**

#### ***Strategies to address Recommendations 1 and 2***

**Educate policy makers, legislators and state agencies on the economics of operating a dental practice (including overhead costs); how reimbursement rates compare with rates currently being charged by private dentists; and how Medicaid dental rates compare to Medicaid reimbursement paid to other healthcare providers.**

**Educate and motivate other advocacy groups in Illinois to include these issues in their agenda to improve health and access for their constituents and populations.**

**Encourage and support IDPA in its continuing efforts to improve the dental Medicaid program.**

**Recommendation 3. Increase the proportion of low-income children and pregnant women – both insured and uninsured – and the proportion of persons who live in geographically underserved areas who receive dental examinations, preventive oral health services and restorative care.**

***Strategies***

**In collaboration with colleges of dentistry and schools of dental hygiene, assure that all current enrollees are competent in managing the oral health needs of pregnant women and children.**

**Assess continuing education needs of general dentists in the management and treatment of pregnant women, infants and children and develop continuing education courses to address identified needs.**

**Assess the need for expanding the number of pediatric dentists.**

**Establish a public-private partnership between IDHS, the Maternal and Child Health Coalition, the Ounce of Prevention Fund, the IFLOSS coalition, hospitals, IPHCA and others to develop and implement programs to educate the primary care community and low-income women themselves on the relationships between oral health and adverse pregnancy outcomes and to develop other strategies to address this recommendation.**

**Recommendation 4. Increase access to dental services for persons with developmental disabilities.**

***Strategies***

**With input and support from both the private and public sectors, develop centers of excellence throughout Illinois for the dental management of persons with disabilities.**

**Increase reimbursement for services to persons with developmental disabilities who require densitization and relaxation procedures.**

**Require individual care plans (community- or institution-based) to address oral health goals and to educate IDPA auditors on the standards to assure that such goals are met.**

**Provide information through local health departments as well as through public program staff to the guardians of persons with developmental disabilities on the importance of good oral health.**

**Recommendation 5. Increase funding for public health clinic start-up and maintenance grants and other safety net programs including community/migrant health centers and not-for-profit volunteer programs.**

***Strategies***

**Increase funding to \$100,000 for clinic start-up grants (currently administered through IDPA) and establish funding for 10 such programs on an annual basis; transfer the responsibility of the program to IDPH.**

**Create and fund a safety net clinic maintenance grant program to be administered by IDPH.**

**Continue funding IDPH-administered community and migrant health center dental expansion and new start-up grants through the tobacco master settlement agreement.**

**Continue supplemental funding for safety net programs that utilize dental volunteers through the tobacco master settlement agreement.**

**Recommendation 6. Replicate and expand the current IDPH school-based dental sealant program into new communities.**

***Strategies***

**Increase funding to support infrastructure needs and reimbursements so as to increase the number of schoolchildren served by the dental sealant program. The minimum amount needed to increase the number of children served by this program over current levels is \$1 million for services.**

**Develop material for educating the private practice community about the role and objectives of this program.**

**Recommendation 7. Implement a pilot case management system addressing the oral health care needs of low-income and uninsured individuals, specifically missed dental appointments, and lack of longitudinal information on the oral health care of Medicaid insured and uninsured persons.**

***Strategy***

**Fund a pilot case coordination project to specifically reduce the missed appointment rate for low-income patients. Develop the program in collaboration with family case management, WIC, Medicaid, local health department programs, school nurses, the private sector and educational institutions. Examine existing case management approaches to determine the role of such programs in meeting this objective.**

**Recommendation 8. Replicate model programs that help insurance beneficiaries (both public and private) to understand their dental benefits and the value of those benefits.**

***Strategies***

**IPHCA has implemented a program that trains community college students to educate publicly insured persons on the value of their health insurance benefits. This program**

could be replicated and focused on oral health with outreach to community college programs in dental hygiene.

Coordinate with the Illinois Department of Human Services to develop a strategy to communicate the role and value of both adult and child dental benefits to TANF clients.

**Recommendation 9.** Pursue Illinois-specific funding for loan repayments for Illinois dental school graduates and graduates of dental hygiene training programs who agree to practice in a dental underserved shortage area or a rural area, or to serve an underserved population (e.g., persons with developmental disabilities) upon graduation. Focus resources on applications from rural areas, in an effort to improve retention in rural communities.

***Strategy***

Identify state funding to match federal loan repayment program dollars for dentists and dental hygienists.

**Recommendation 10.** Decrease the number of people in Illinois who are uninsured for dental services.

***Strategy***

In collaboration with Public Health Futures Illinois, develop programs for the business community on the importance of oral health in relation to employee health in an effort to assure dental coverage as part of employer sponsored health insurance plans.

## **POLICY GOAL IV**

**Accelerate the building of the science and evidence base and apply science effectively to improve oral health.**

### **ILLINOIS PRIORITIES**

- **Develop an oral health surveillance system or a common set of data that can be used to define the scope of oral health needs and access to oral health services, to monitor community water fluoridation status, and to measure the utilization of dental services by the entire population in Illinois. Assure that the system has the capacity to capture data on special populations (low-income, Medicaid insured, elderly, developmentally disabled, children with special health care needs) as well as the insurance status of all population groups.**
- **Maximize the contribution and use of existing public health data (e.g., IPLAN, local oral health needs assessments) to inform the science base necessary to improve oral health in Illinois.**

### **RECOMMENDATIONS AND STRATEGIES**

**Recommendation 1. Develop the infrastructure necessary for an oral health surveillance system with the capability to define oral health status, the scope of oral health needs, access to oral health services, community water fluoridation status and utilization of dental services by the population.**

#### ***Strategies***

**Under the auspices of IDPH, utilize funding and technical assistance from the U.S. Centers for Disease Control and Prevention (CDC) to assist state efforts in the development of a statewide oral health surveillance system, and establish a working partnership with representatives from IDPH, IDPA, IDHS and others to organize a systematic review of current data sources. Maximize the involvement of Illinois' educational institutions in this partnership, particularly faculty with training in dental epidemiology.**

**Examine existing data sets containing public health and oral health data for potential relevance and contribution to a state oral health surveillance system. At a minimum, the following data sets should be assessed for elements to be included in the state oral health surveillance system:**

- **Behavioral Risk Factor Surveillance System/Youth Behavioral Risk Surveillance**
- **Illinois State Cancer Registry**
- **National Oral Health Surveillance System data submitted by Illinois**
- **IPLAN community planning data**
- **Illinois Medicaid data**
- **Data on the health insurance benefit packages for both public and private insurance plans, data from the SIU Insurance Study and the Behavioral Risk Factor Surveillance System data for adults on insurance status**
- **Illinois Cornerstone system**
- **PRAMS**
- **Hospital discharge data**

**Implement a uniform system and method for collecting caries experience/prevalence, untreated caries and sealant prevalence in Illinois (estimated minimum cost is \$250,000).**

**Recommendation 2. Enhance and increase the resources available for local health departments to gather accurate and useful data on oral health for use in local planning.**

***Strategies***

**Expand the IDPH oral health needs assessment and planning grants to include resources for all local health departments, and include an evaluation component.**

**Integrate oral health assessments with the IPLAN community planning process.**

## **POLICY GOAL V**

**Use public-private partnerships to improve the oral health of those who suffer disproportionately from oral diseases.**

### **ILLINOIS PRIORITIES**

- **Monitor the implementation and continued development of this Illinois Oral Health Plan.**
- **Establish a formal mechanism for leaders in dental education (dentistry, dental hygiene, dental residency training programs) to convene on a routine basis and discuss strategies, synergies and opportunity.**
- **Support the IFLOSS Coalition as a working public/private partnership focused on oral health improvement for all residents of Illinois.**
- **Assure the active participation of the oral health community in statewide health improvement organizations such as the Illinois Maternal and Child Health Association, Prevention First, the Campaign for Better Health Care and Public Health Futures Illinois.**
- **Include representatives from key stakeholder groups and from populations disproportionately affected by oral health problems (e.g., the elderly, persons with developmental disabilities) in the planning and implementation of ideas in the oral health plan, as well as on state and other committees that monitor and provide for the oral health of Illinois residents.**

### **RECOMMENDATIONS AND STRATEGIES**

**Recommendation 1. Monitor the implementation and continued development of the Illinois Oral Health Plan.**

#### ***Strategy***

**Establish a public/private partnership including leaders in dental education, professional and membership organizations and state leaders to monitor the implementation and continued development of the Illinois Oral Health Plan.**

**Recommendation 2. Develop a formal mechanism for leaders in dental education (dentistry, dental hygiene, dental residency training programs) to convene on a routine basis and discuss strategies, synergies and opportunities.**

**Recommendation 3. Identify funding streams to assure the long-term development and institutionalization of the IFLOSS Coalition.**

## Appendix A

**AGENDA**  
**Illinois Oral Health Summit**  
**University of Illinois at Chicago School of Public Health**  
**September 11, 2001**

### Purpose

- Serve as a resource to policy makers by providing information, and a forum to answer questions and clarify efforts, roles and accomplishments of the many groups working to improve oral health in Illinois.
- Present to policy makers and legislators an Illinois response to the “Call to Action” proposed in the Surgeon General’s Report: *Oral Health in America*. One element of that response is the development of a state oral health plan.
- Secure the commitment of Summit attendees to a series of next steps that continue Illinois’ response to the Surgeon General’s Call to Action, including revision and implementation of a state oral health plan.

### Introductions and Welcome

Dr. John R. Lumpkin, M.D., M.P.H.

*Director, Illinois Department of Public Health*

Caswell Evans, D.D.S., M.P.H.

*Director, National Oral Health Initiative, Office of the U.S. Surgeon General*

### Illinois’ Response to the Surgeon General’s Report: Accomplishments to Date

Amy Abel

*Facilitator, Felix Burdine and Associates*

Lewis Lampiris, D.D.S., M.P.H.

*Chief, Division of Oral Health, Illinois Department of Public Health*

### Panel Presentation: Perspectives on Priority Oral Health Issues

A physician’s perspective on oral health as it relates to systemic health

*Robert Boone, M.D., Family Physician, Champaign, Illinois*

Role of Local Health Departments in Preventing Oral Disease

*Ray Cooke, M.P.H., President, Illinois IFLOSS Coalition*

Issues and Challenges in Dental and Dental Hygiene Education

*Bruce Graham, D.D.S., Dean, UIC College of Dentistry*

Public Support and Funding to Address Disparities in Oral Health

*Julie Janssen, R.D.H., M.A., Public Service Administrator, Illinois Department of Public Health*

Safety net infrastructure: Community and Migrant Health Centers

*Steven Geiermann, D.D.S., Regional Dental Consultant, HRSA Midwest Field Office*

Dental Practice and Dentistry in Illinois

*Bill Tonne D.D.S., President-elect the Illinois State Dental Society*

Oral Health Surveillance and Research Need

*Susan Scrimshaw Ph.D., Dean, University of Illinois at Chicago School of Public Health*

### Break

### Presentation of A Draft Illinois Oral Health Plan

Lewis Lampiris, D.D.S., M.P.H.

**Reactor Panel (invited)**

**The Honorable Bradley J. Burzynski, Illinois State Senator**  
**The Honorable Steven J. Rauschenberger, Illinois State Senator**  
**The Honorable Kathleen Parker, Illinois State Senator**  
**The Honorable Donne E. Trotter, Illinois State Senator**  
**The Honorable René Kosel, Illinois State Representative**  
**The Honorable David E. Miller, Illinois State Representative**  
**John Lumpkin, M.D., Director, Illinois Department of Public Health**  
**Matt Powers, Deputy Administrator, Illinois Department of Public Aid**

**Facilitated Discussion**

- **Reaction and questions from audience to draft Illinois Oral Health Plan**
- **Suggestions for moving forward**

**Next Steps and Roles**

- **Summary and general agreement on next steps**
- **Roles of individuals and organizations**
- **Follow up activities and timelines**

## **Appendix B**

### **Participants in Developing the State Oral Health Plan**

#### **Oral Health Summit Steering Committee**

Ray Cooke, BBA, MPH, President, IFLOSS Coalition  
Robyn Gabel, MSPH, MJ, Executive Director, Illinois Maternal and Child Health Coalition  
Julie Janssen, RDH, MA, Public Service Administrator, Division of Oral Health, Illinois Department of Public Health  
Mike Jones, Health Policy Analyst, Office of Epidemiology and Health Systems Development, Illinois Department of Public Health  
Bruce Johnson, President and Chief Executive Officer, Illinois Primary Health Care Association  
Greg Johnson, Director of Professional Services, Illinois State Dental Society  
Ann Kirwan, Manager, Birth to Three Project, Ounce of Prevention Fund  
Representative Reneé Kosel, Illinois General Assembly, 38<sup>th</sup> District  
Lewis N. Lampiris, DDS, MPH, Chief, Division of Oral Health, Illinois Department of Public Health  
Representative David E. Miller, Illinois General Assembly, 29<sup>th</sup> District  
Nelly Ryan, Associate Administrator, Division of Medical Programs, Illinois Department of Public Aid  
Stephen Saunders, MD, MPH, Associate Director, Family Health, Illinois Department of Human Services  
Susan Scrimshaw, PhD, Dean, School of Public Health, University of Illinois at Chicago  
Amy Abel, Felix Burdine and Associates

#### **Community Oral Health Infrastructure Development Participants**

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Trucia Drummond, DDS, President, Illinois State Dental Society  
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External Advisor: Linda Kaste, DDS, MS, PhD, Division of Dental Public Health and Oral Epidemiology, Department of Stomatology, College of Medicine, Medical University of South Carolina  
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Project Staff: Karen Peters, DrPH, Project Director, Health Research and Policy Centers, School of Public Health, Health Research and Policy Centers  
Project Staff: Amy Abel, Felix Burdine and Associates

#### **Town Hall Conveners**

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#### **Town Hall Participants**

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Marianne Jones, Private Citizen  
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Mary Moore, Proctor and Gamble  
Marty Payeur, Coordinated Youth & Human Services  
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**Beatrice Williams, Unit #4 Family Information Center**

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Toney Hickman, RICCA (Rock Island County Council on Addictions)  
Charles Johnson, DDS  
Colleen Kannenberg, Assistant Local Office Administrator, Department of Human Services  
Jerry Lack, Congressman Lane Evans Office  
Diane Lopez, Project Now  
Monica Lopez, Division of Specialized Care for Children  
Leo Lundberg, DDS  
Marianne Moore, Project Now  
William L. Parker, DDS  
Bruce Peterson, Administrator, Mercer County Health Department  
Tammy Quillen, Project Now Head Start  
Julie Redington, Pediatric Nurse Practitioner, Visiting Nurse and Homemaker Association  
Barb Robinson, Community Health Care Inc.  
Stella Schneckloth, Project Now  
Lynne Schweppe, RN, Mercer County Health Department  
Sandra Sommer, Director, Clinical Services, Henry County Health Department  
Martin Tinberg, BA, MSPH, Administrator, Rock Island County Health Department  
Mary Beth Wood, Clinical Manager, Care Group Illinois

**Oral Health Needs Assessment and Planning Grantees  
Advisory Members**

*Year 1 (July 1, 1996 – June 30, 1997)*

Calhoun: Myra Burge; Dr. Jeff Colligan; Debbie Grasse; Marge Hillen; Dr. Richard Kirchhoff;  
Dr. Norman Martinez; Robert H. Parish, DDS; Judy Pohlman; Mike Seimer; Terry Strauch; Kim Vogel;  
Judy Zahrli

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McHenry: J. Maichle Bacon; Dr. Hagenbruch; Robert Holas; Theresa Heaton; Suzanne Hoban; Esther Perez; Sally Fyfe Stachniak; Barbara Yurgaitis, MPH

Monroe-Randolph: Chris Blechle; Don Campbell; Bob Chunn; Don Dietz; LaVonne Evans; Judy Hamil; Dean Harbison; Dr. J. Harrison; Dr. Ivanuck; Karen Kaiser; Imogene Lehman; Dr. Matlock; Norman Mehrtens; Suzanne Neff; Debbie Opel; Loren Prest; Dr. Raney; Tom Smith; Dr. Trost; Dr. Waltemate; Dr. Welscheff; Dr. Wolz

Montgomery: Vera Allen; Renee Epplin; Shelley Hallmen; Lorna Jones; Kristy Joyce; Rhonda Joyce; Amy Stewart; Dolores Wheelhouse, RN

Rock Island: Carolyn Billedo; Nita Carver; Sarah Detweiler; Kathy Fobert; Theresa Foes; Beth Haverback; Charles Johnson, DDS; Lois Johnson; Linda Keller; Dr. Casey Kenny; Dr. Peter Metcalf; Sally O'Donnell; Brad Potter; James Steer, DMD

St. Clair: Enone Collier; Kathy Darnell; Jed Deets; Sara Duguay; Leigh Emigh; Mildred Fort; Robert Kuebel, DDS; Jerry Obst; Mark Peters; Tom Stedman; Scott Steiner; Anne Thomure; Tom Vernier; Janet Webb

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*Year 2 (July 1, 1997 – June 30, 1998)*

Boone: Kevin Alperstein, DDS; Jane Anne Anderson; Michael Brechon, DDS; Fred Brereton; James Chapko, DDS; Jan Christopherson, PhD; Ronald Conder, DDS; Curt Degner, DDS; Dale Drake, DDS; Elaine Drake, DDS; Joseph Frost, DMV; Andrew Geddes, MD; Kent Hess, MD; Fayne Kniep, RN; Alan Kossman, DDS; Deborah S. Loos; Gordon Lucas, MD; Sue Magyar, RN; Nancy Joyce Turnipseed, BSN

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Kane: Jennifer Banas; Dr. Leon Darmon; Ginny Hoel; Dr. Greg Karr; Dr. Neeraj Khanna; Mary Maltby; Eileen Petesch; Cope Schmidt; Gloria Torres; Marilyn Westerhoff; Sue Windland

**Lake:** Jeanne Bernardin; Maria Fe Corpuz-Bato; Brian Gniadek, DDS; Carl R. Hagstrom, DDS; Paul Kattner, DDS; Loe Miserendino, DDS; David Zeffery, DDS

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**Tazewell:** Patricia Adkins, RDH, BS; Margo Argadine; Bonnie Jones; Jenny Lee; Gordon Poquette; Kim Ritchart, RDH; Judy Sauder; Ellen Smith; Glen Thompson, DDS; Amy Tippey; Jeanette Ulrich; Tom Wojitas

**Whiteside:** Dr. Orval Deweerth; Beth Fiorini; Joan Hermes; Gordan Nunemaker; Dr. Donald Rastede; Dr. Harold Readel; Dr. Jessica Weaver; Dr. William Yemm; Michael Zurn

**Will:** Ruth Forni; Jackie Goggins; Doug Ihne; Carol Koch; Dawn Parker, MPH; Jean Roach; Thomas J. Steitz, DDS

*Year 3 (July 1, 1998 – June 30, 1999)*

**Coles:** Bob Allison; Betty Dodson; Barb Druin, RN; Julie Dryden; Steve Forsyth, DDS; Nancy Frederick; Karen Gonzalez; Jerry Hastings, DDS; Vickie Hermann, DDS; Mary Jorstad, RDH; Cathy Reynolds, RN; Linda Sauer; Jill Temple; Donis Vail-Griffy; Judy Veach; Brenda Warren

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**Ford-Iroquois Bi-County Health Department:** Jeanne Brown; Dr. Kevin Brucker; Julie Clark; Tondra Harris; Nancy Henrichs; Kathy Hethhke, RN; Lisa Oakley; Natalie Price, RDH; Bronwen Teague; Robert Walters

**Logan:** Suzie Aper; Debby Cook; Rachelle Cooke; Nancy Cooley; Deane E. Doolen, DDS; Lloyd Evans, BS; Leonard Janet; Beth Turley

**Winnebago:** J. Maichle Bacon, MPH, RS; Girish Banaji, DDS; Sandra Berumen-Jimenez; Sandra Covert, RDH; Beverly Darsie; Andrea Doughty, PhD; Patricia Gomez; William J. Grzelak, DDS; John Halversen, DDS; Karen Hoffman; Jason Lamont; Pam Maher; Tom McGinnis; Diane Mitchell; Jody Moncado, RN; Erin Mullins; Peggy Neal; Christina Newkirk; Allen Pang, DDS; Diana Saavedra; Rosemary Sciortino, RDH; Gary L. Sooter; Sarah Tarara, RDH; Vickie Weidenbacher-Hoper; Lynne Williams

*Year 4 (July 1, 1999 – September 30, 2000)*

**DeWitt-Piatt Bi-County Health Department:** Chuck Baccus; Gaila Barcus; Ann Barnett; Linda Bartlett; Susanne Darby; Terry England, DDS; Sandra Finnerty; Barb Holmes, RDH; Connie Keelin; Jim McNamara; Susanne Mortimer; Joni Newberg; Cindy Reynolds; Gary Riegel, DDS; Ann Roppel, RDH, BA; Trisha Scerba, MD; Maxine Schwartz; Kathy Shepherd; John Sochor, DDS; Michelle Strode, RN; Bonnie Trenkle; Gail Winterroth; Bruce Wintersteen, DDS

**DuPage:** Bonnie Jane Adelman; Cindy Barger, RDH; Karen Bollin; Pat Cieben; Beth Enke, RDH; Liz Johnson; Karen Levine; Kirk McMurray; Nianci Pan; Beverly Parota, RDH; Arlene Sharp; Dr. Stachniak; Dorothy Thompson

**Effingham:** Lisa Ballinger; Shawn Bourland, RN; Joyce Guse, MS; Linda Hampton, MSW; Marge Lancaster, RN; Sue Ann Minor; Julie Poland; Janet Workman, LPN; Rick Workman, DDS

**Fulton:** Alaan Coleman; Crista Flynn; Judy Hille; Dr. Albert Klinski; Jan McCullin; Dr. Shantha Murphy; Jean Sprecher; Elaine Wilcoxon; Gary E. Zaborac

**JoDavies:** Marti Atwater; Dr. Bob Chorak; Mairi Douglas, RN, BSN; Joe Garrity, MD; Karen Heinen, RN, BSN; Dr. Tim Hinde; Dr. Peter Janecke; Dr. Tom Janecke; Mary Koester; Diane Kussmaul; John Lang; Representative I. Ron Lawfer; Ken Mulholland; Dr. J.R. Neumeister; Dr. Greg Painter; Dr. Steven Petras; Dr. Brian Schoenrock; Senator Todd Sieben; Dr. Dan Visel; Dr. Dennis Walters

**Mercer:** Patsy Bewley; Sanya Boucher, RN; Gina Cone, RN; Gary Cortright; Tommy Dahl; Senator Richard Durbin; US Representative Lane Evans; Senator Peter Fitzgerald; Sally Frye; Becky Hyett, RN; Charles E. Johnson, DDS; Al Kulczewski; Rachel O'Brian; Gary S. Olson, DDS; Susan Pearson; Bruce Peterson; Mary Reed, RN, MS; Pastor Chuck Reynolds; Florence Roth, RN; Lynne Schweppe, RN; Diane Styles, RN; Carol Taylor; Bob Vickrey; Donna Wade; Joann Watson, RN

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*Year 5 (October 1, 2000 – September 30, 2001)*

**Jackson:** Jeanie Akamanti; Sandy Beebe; Dr. Doug Baker; Cindy Canning; Kim Farrington; Dr. Joe Hudgins; Elaine Jurkowski; Carla J. Lauter; Miriam Link-Mullison; Virginia Maerker; Sandy Maurizio, RDH, MSEd; Nancy Muzzarelli; Dr. Peter Pirmann; Cathy Reed; Phil Schaefer; Woody Thorne

