
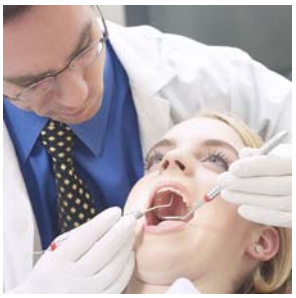


Evaluation of the State Oral Health Collaborative Systems Grant Program

Final Report

Submitted to:
U.S. Department of Health and Human Services
Health Resources and Services Administration
5600 Fishers Lane, Parklawn Building
Rockville, MD 20857

Submitted by:
Health Systems Research, Inc.
1200 18th Street, N.W., Suite 700
Washington, DC 20036

Contract No. 250-01-0011
Task Order No. HHSH24055018

September 2006

Health Systems Research, Inc.
An Altarum Company

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Maternal and Child Health Bureau

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Final Report

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Table of Contents

Appendices

Executive Summary

Overview

In 2003, the Maternal and Child Health Bureau (MCHB) began funding the State Oral Health Collaborative Systems (SOHCS) grant program with the purpose of enhancing the ability of States and Territories to improve their oral health infrastructure on behalf of better health outcomes for mothers, pregnant women, infants, children, and children with special health care needs (CSHCN). Over the course of the initiative, more than $5 million has been invested in a variety of State-level systems building activities targeting the core components of a public health infrastructure namely, assessment, policy development, and assurance. The diverse activities conducted under this initiative were in response to the unmet needs and oral health disparities experienced by many families from low socioeconomic groups that were documented in the U.S. Surgeon General's (2000) report ***Oral Health in America.***

In 2005, Health Systems Research, Inc. (HSR), a health policy, training, and technical assistance firm in Washington, DC, was awarded a 1-year contract to evaluate the activities conducted by the SOHCS grantees. The purpose of the evaluation was to gather qualitative information on the strategies States/Territories used to increase the ability of communities to prevent oral disease and improve access to timely and appropriate oral health services for underserved children and families, especially those enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP). Evaluators were asked to investigate the activities conducted by the grantees and their strategies for implementation, outcome measurement, and sustainability and to identify promising approaches and models that could be replicated in States/Territories and communities facing similar challenges. In addition, the evaluation was to review specific strategies States/Territories used to overcome barriers, develop partnerships and facilitate planning processes. Since grantees planned and implemented collaborative activities in partnership with families, dental and medical health providers, Head Start and Early Head Start programs, nutritionists, policymakers, and community stakeholders to meet State-specific needs for improved infrastructure, HSR was tasked with gathering information from a variety of sources and individuals to document outcomes.

Methodology

The evaluation consisted of a series of key-informant telephone interviews approximately 90 minutes in duration with the SOHCS Program Director and other stakeholders, including the State Dental Director, dental providers, and other significant participants or recipients of grant activities. In addition, HSR conducted nine 2-day site visits with States or Territories that demonstrated successful outcomes over the course of the initiative based on information HSR gained from analysis of their progress reports and with the input of the Maternal and Child Health (MCH) Chief Dental Officer and SOHCS Program Director. For the purposes of this evaluation, only States/Territories that engaged in continuous, progressive activities from the initial 1-year grant through all additional years of the SOHCS grant program were included in the evaluation sample. In the course of 4 months, phone interviews were conducted with 38 States and Territories and site visits were convened with the grantees in the District of Columbia, Florida, Georgia, Indiana, New Hampshire, South Dakota, Texas, Virginia, and Wisconsin.

The following interviewees were considered critical to the evaluation process:

1. SOHCS Project Director and any staff members directly working on SOHCS activities
2. The State Dental Director
3. Other governmental State-level partners, (e.g., the MCH Director, Head Start Collaboration Office, Department of Education, Medicaid)
4. Local partners, including providers, private and nonprofit organizations, and other relevant stakeholders.

The SOHCS evaluation was conducted in three phases:

Phase 1 included preparatory work such as evaluation design, data abstraction, identification of key topics, and the conduct of logic model conference calls with grantees to determine the degree to which they used logic model tools to develop program activities. Phase 2 included all data collection activities, such as the development of interview guides and the conduct of the phone interviews and site visits. Information gathered during the interviews was then transcribed into a database designed specifically to synthesize this information. Finally, Phase 3 included comprehensive data analysis and report writing activities.

Considerations for the Evaluation

An overview of the grant applications and annual reports from the grantees indicated that the flexibility of the SOHCS grants fostered a wide variety of infrastructure-building activities, including:

- Coalition building activities
- Program planning and support
- Public awareness/media campaigns
- The development of strategies to increase oral health services workforce and access
- Surveillance and evaluation
- The establishment or expansion of clinical interventions
- The identification of new or expanded funding for oral health services.

Since State and Territories were able to design their activities in order to meet their unique needs, there was great variability among grantees' goals and outcomes. Often a single grantee would be implementing several of the above activities simultaneously. In other instances, SOHCS grants were used in multiple ways, such as augmenting the funding for existing activities, leveraging new funding, or supporting the planning efforts of a Statewide Coalition or workgroup. The interconnectedness of collaborative systems activities presented a challenge for evaluators, because it was difficult in most cases to isolate the uses of the grant dollars completely. In addition, the ambitious nature of the grants themselves meant that although their core activities were consistent and progressive over time, often new opportunities, obstacles, or partners required a slight reprioritization or reorganization of grantee activities. With this variability in mind, throughout the evaluation, HSR did not exclude any SOHCS-funded programs from the evaluation knowingly and included information which grantees may have

provided on their primary, secondary, or tertiary activities. This provided HSR with additional data from which to identify patterns and promising approaches that could inform current and future MCH oral health initiatives.

Evaluation Results

Due to the number and variety of activities and the differing capacities of States/Territories to implement their SOHCS program, comparisons between grantees is problematic. Therefore, this evaluation focuses on qualitative process measures and attempts to identify particular strategies that met with success in different settings. The key findings of this evaluation mirror the topic areas covered during the phone interviews and site visits – the SOHCS grant application and planning process, implementation of activities, successes and challenges, and program sustainability – and are summarized below.

Grantee planning activities

Few States/Territories recounted difficulties in completing the initial grant application and the subsequent renewals via the Health Resources and Services Administration's Electronic Handbook. In most instances, the SOHCS grant presented a timely opportunity to implement programs that had been delayed or postponed due to lack of funding. The flexibility of the funding to meet individual State needs and support a wide range of infrastructure-building activities also simplified the planning process. Other key findings regarding SOHCS grant planning follow:

- SOHCS grant activities were intended to be closely related to other oral health activities underway in the State.
- The grant application process was considered straightforward and did not pose significant problems for many of the grantees.
- Goal setting was often data driven using a variety of established needs assessment measures and evidence-based practices.

Implementation

Depending on the activities being undertaken by the State under the SOHCS program, the complexity of issues encountered during the implementation phase of the grant varied considerably. In general, States/Territories that were augmenting an existing program encountered fewer challenges, whereas States/Territories that used the funding to create new programs needed to engage partners, design an approach, develop planning and oversight mechanisms, and design a methodology to track results. These startup activities were critical to program implementation but required significant time and may account for the varying speeds with which programs got off the ground. Other findings regarding implementation follow:

- Grantees were able to use SOHCS funds to address a broad range of infrastructure needs and to tailor their programs to meet the unique circumstances in their State.

- In all States/Territories, partners played a critical role in planning and implementing SOHCS-funded activities.

- When surveillance activities were conducted, they usually enhanced reporting on MCHB performance measures or involved oral health screenings of early childhood populations.

- The use of SOHCS funds to support the salary of a staff position dedicated to the conduct of oral health program activities or the development of a State oral health plan raised the stature of oral health and the visibility of oral health issues.

- SOHCS grants were often used to support the delivery oral health clinical services, sometimes in innovative ways.

- Many States/Territories used their grant to support oral health awareness, promotion, or advocacy campaigns implementing oral health education and social marketing strategies, often in conjunction with other infrastructure-building activities.

- Training programs were also an important focus of SOHCS grant activities, and many grantees sought to expand oral health infrastructure by reaching out to pediatricians, primary care doctors, nurses, or child care providers.

Successes and Challenges

Grantees felt that they had been successful with their SOHCS grant activities, although it was difficult for those who were not supporting direct services to demonstrate this concretely. In general, measures of infrastructure-building success were either subjective or simply a record of process measures. Despite this challenge, most grantees and their key stakeholders noted success in many areas, including increased awareness of the importance of oral health among a variety of target audiences including families, health and oral health providers, community leaders, insurers, and policymakers. Through the application of dental sealants, fluoride varnish, and other preventive measures, the oral health of certain MCH populations was improved. State oral health plans, the cornerstone of systems change, made great progress under SOHCS.

The evaluation found a number of common challenges among grantees, including the following:

- The ability to find and hire qualified staff was one of the major barriers encountered in grant program implementation.

- State practice acts often made it difficult to increase the oral health workforce.

- Funding will remain a challenge, especially for those families covered by Medicaid and SCHIP programs and for State oral health programs with limited staffing and budgets.

Sustainability

Despite these challenges, most grantees were very optimistic about their ability to sustain some of the activities supported by the SOHCS grant. Those most closely linked to their MCH programs are confident that block grant funds will be allocated to continue their successful efforts. In a number of States/Territories, specific plans are in place to apply for or pursue other State or foundation funding to continue their programs. In still others, partners such as dental schools, public health departments, or school systems have been approached to contribute to future efforts. The outward success and increased visibility of successful SOHCS programs have improved the likelihood of continued funding despite many restricted State budgets. With an increased ability to demonstrate the cost-effectiveness of early intervention, the ability of States/Territories to sustain future programs would be enhanced. As grantees approach their final year of funding, their collaborative efforts to secure future funding to continue SOHCS activities will become more energized and strategic.

With regard to sustainability, States/Territories requested that MCHB continue to make oral health a priority in all MCH programs – believing that this will enhance sustainability of this and all other oral health efforts, now and in the future.

Cross-cutting findings

The very flexible nature of these infrastructure grants was considered especially valuable by grantees. Although this flexibility makes for more diverse and varied outcomes that are difficult to compare, the nonprescriptive feature of this initiative was a quality that States/Territories found especially effective:

- Programs were able to use the money to further their State-specific oral health goals and fund, or leverage funding to, the filling of holes in their infrastructure.
- The flexibility of the funding made it possible for some grantees to address several issues in their oral health infrastructure at the same time.
- For grantees with less well-developed oral health programs or from smaller States/Territories, the structure of the grant program and SOHCS grantee annual meetings were invaluable for building contacts and learning more about possible programs.

Areas to Explore for Program Enhancement

The SOHCS grant program generally appears to be functioning smoothly and permits grantees to address a variety of oral health infrastructure issues. However, remarks from the grantees, observations by evaluators, and the analysis of qualitative data indicate some possibilities for program enhancement.

1. Considering the number of bureaucratic and logistical challenges documented regarding the hiring of staff members or recruitment of volunteers, future grant applications could

include additional questions or guidance on these issues to ensure that grantees anticipate and plan for these challenges during their program implementation.

2. In addition, many States/Territories have requested additional support or training with regard to the conduct of cost-benefit analysis of prevention activities. Technical assistance to help States/Territories identify and implement appropriate data collection methods as well as analyze, summarize, and present findings is critical to generating support by funders and policymakers for increased access to care and a strong oral health infrastructure. Anecdotes, no matter how compelling, do not provide the impetus needed to secure adequate future investment.

3. Finally, many oral health grantees operate limited oral health programs with few staff members and minimal support. Unlike other public health endeavors, oral health often has to "fight its way to the table." Although the Surgeon General's reports ***Oral Health in America*** and ***National Call to Action*** have increased awareness of the extreme oral health disparities and need for successful interventions, most State Dental Directors or Oral Health Program Directors operate in relative isolation. While the SOHCS grants enabled them to build collaborative partnerships within their States/Territories and communities, many grantees, especially from States/Territories with smaller programs, would benefit from more structured opportunities to meet, either physically or virtually, with their peers. Peer-to-peer learning, such as that provided and funded by the annual SOHCS Grantee meeting, was considered especially valuable. Additional opportunities of this nature should be explored as States/Territories move on to other infrastructure-building activities.

Ultimately, the research demonstrated that the SOHCS grants achieved their goal to improve the oral health infrastructure in States/Territories with limited access to flexible funding to address specific needs. MCHB should continue to include oral health as a priority in all the grants and contracts that it funds. In addition, despite plans in place for sustainability, future MCHB oral health funding opportunities with the appropriate balance of guidance and flexibility would continue to be used to improve outcomes for those populations experiencing the greatest oral health disparities. A continued focus by MCHB on preventive measures such as dental sealants, fluoride varnish, and timely assessment and treatment of disease will prove cost effective and ultimately will improve the long-term oral health of mothers, infants, children, and CSHCN.

Chapter I. Introduction and Overview

In September 2005, Health Systems Research, Inc. (HSR) was awarded a contract to evaluate the Maternal and Child Health Bureau's (MCHB) State Oral Health Collaborative Systems (SOHCS) grant initiative. This effort built upon the U.S. Surgeon General's report ***Oral Health in America***, which was released in 2000, and its 2003 companion document ***The National Call to Action to Promote Oral Health***, which called for the development of a national oral health plan consisting of five core components: (1) changing perceptions so that oral health becomes an accepted component of general health, (2) building the science and evidence base to improve oral health research, (3) integrating oral health into the overall health infrastructure, (4) removing known barriers to oral health care, and (5) using public-private partnerships to reduce oral health disparities. Answering this call, Congress appropriated funding for grants specifically for this purpose. Beginning in 2003, MCHB made competitive awards to States and Territories to support the conduct of activities to improve their oral health infrastructure, especially as it impacts health outcomes for the maternal and child health (MCH) populations of pregnant women and mothers, infants, young children, and children with special health care needs (CSHCN). This report provides the results of a systematic evaluation of the SOHCS initiative conducted by HSR over the past year. It includes an overview of the Federal, State, and local environments in which the grantees conducted their activities, their program outcomes, challenges, and plans for sustainability. This chapter provides context for the different phases of the evaluation as proscribed by MCHB, defines some common terms used throughout the document, and outlines the remaining chapters of this evaluation report.

MCHB and Oral Health

Established in 1912 and institutionalized with the passage of Title V of the Social Security Act in 1935, MCHB has been charged with implementing numerous programs to improve the health and well-being of all women, mothers, children, and CSHCN. Initially, Title V funds were allocated to States/Territories to support the efforts of a variety of health practitioners, including physicians, dentists, public health nurses, social workers, and nutritionists. By taking this comprehensive and holistic view of health, MCHB has drawn attention to the relationship between good oral health and the overall health and wellbeing of MCH populations and provided guidance to States/Territories and regions in the conduct of activities to promote the visibility of oral health needs and improve the oral health infrastructure.

In 1981, Title V was converted to a block grant to States/Territories, and oral health services were no longer mandated. Over time, the oral health component of MCH, as well as other State-funded dental public health programs, languished or disappeared entirely. Fortunately, more recent MCH Block Grant Guidance and implementation language has increased the emphasis on and visibility of the oral health needs experienced by many children and families. It is currently estimated that 80 percent of all State dental programs receive some funding through MCH Block Grants. MCHB also supports additional State oral health activities through its discretionary grant program and various demonstration grants to encourage fluoridation of community water systems, new and expanded school-based sealant programs, and the integration of health delivery systems.

In an effort to monitor and expand oral health activities, MCHB added access to dental sealants as a Block Grant performance measure and required that States/Territories conduct a needs assessment every 5 years and develop health plans that include an oral health component. The changes have reversed the decline of many State oral health programs. In fact, the Title V Information System (TVIS) for the period 2005–2010 indicates that 39 States and Territories consider oral health services a priority need, and 35 States and Territories have instituted additional specific oral health performance measures for MCH populations.

In order to satisfy performance measures and meet the increasing need for access to oral health prevention and treatment services, State MCH programs will strive to expand or integrate oral health more fully into other Title V program activities.

At the Federal level, MCHB supports other State oral health programs and activities, including:

- The renewal and reenergizing of an Intra-Agency Agreement between the Head Start Bureau and MCHB, which includes funding for Regional Forums, Professional Forums, expert consultation, and other training activities to integrate oral health better into programs serving Head Start children, families, and communities
- The establishment of a National Oral Health Policy Center and a National Oral Health Resource Center
- A cooperative agreement with the Association of State and Territorial Dental Directors (ASTDD)
- The development of an oral health component to the American Academy of Pediatric's Bright Futures materials.

OMB Performance Measures for the MCHB Oral Health Programs

- The percentage of children under the age of 21 enrolled in Medicaid for at least 6 months continuously who receive any preventive or treatment dental service
- The number of States/Territories that include in their oral health plans at least 5 of the 10 essential elements of the guidelines included in ASTDD's "Building Infrastructure and Capacity in State and Territorial Oral Health Programs"

Title V Oral Health Performance Measure

- The percentage of third-grade children who have received protective sealants on at least one permanent molar tooth

Other Federal agencies and private foundations are also providing funding to States/Territories to strengthen infrastructure and improve oral health outcomes. For example, the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF) have initiated competitive oral health programs for States and Territories. In 2001, the CDC began entering into cooperative agreements with 12 States and the Territory of Palau; since then, the Center has distributed $3.8 million a year. Between 2002 and 2005, RWJF allocated $900,000 each to Arizona, Oregon, Pennsylvania, Rhode Island, South Carolina, and Vermont through its State Oral Health Access grant program. Collectively, these and other funding opportunities are beginning to address the disproportionate burden of dental caries on low-income minority families. Additionally, they are helping States/Territories move closer to

the Healthy People 2010 oral health goal to "prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services."

SOHCS Grants

Congress has continued its efforts to increase funding for addressing oral health disparities and improving oral health infrastructure at the State level. During Fiscal Years 2003–2005, Congress appropriated $5 million to fund the dental needs of women and children through the Bureau's Special Programs of Regional and National Significance. The Congressional Report that specified this funding required that the programs meet the following goals:

- Reduce the incidence of early childhood caries and baby bottle tooth decay.
- Support community water fluoridation and dental sealant programs in schools.
- Implement State-identified objectives for improving oral health.

With this funding, MCHB launched the SOHCS grant program along with other oral health training and technical assistance activities. The SOHCS initiative represents an important evolution in MCHB's longstanding efforts to promote comprehensive MCH systems of care. In its first funding cycle, 2003–2004, MCHB awarded 1-year planning grants to 47 States/Territories. The following year, $3.8 million was awarded in 3-year grants to 49 States and Territories to fund activities through 2007.

In the Program Guidance, MCHB states the goals of the SOHCS Grant Program:

- Help stabilize State oral health program activity.
- Integrate oral health better into State MCH programs.
- Address MCHB performance measures.
- Implement the Surgeon General's ***Call to Action*** as it affects women and children.

The SOHCS grants also support States/Territories' efforts to develop, implement, or strengthen otherwise State oral health collaborative strategies. These grants aim to increase access to oral health services for Medicaid and State Children's Health Insurance Program-eligible children and other underserved children and their families. Since 2004, funds ranging from $50,000 to 65,000 per year have been awarded to States/Territories to conduct a wide range of activities that address State specific oral health infrastructure needs. As with many health and human services issues, States/Territories' oral health needs are diverse. Accordingly, SOHCS funds have been used for a variety of assessment, policy development, and assurance activities, including:

- Coalition building activities
- Program planning and support
- Public awareness/media campaigns
- The development of strategies to increase oral health services workforce and access
- Surveillance and evaluation
- The establishment or expansion of clinical interventions
- The identification of new or expanded funding for oral health services.

The SOHCS Evaluation

In 2005, HSR was awarded a contract to assess both the activities funded by the SOHCS grant and the grantees' ability to strengthen and increase the oral health infrastructure for MCH populations against the goals, objectives, and processes which they identified for their individual programs. This included studying and reporting on the individual and collective successes that States/Territories experienced while integrating oral health into existing systems of care.

Over the course of 12 months, HSR's evaluation team used a systematic combination of data collection strategies, including data abstraction, document analyses, identification of key topics, logic model conference calls, key-informant telephone interviews, and a series of site visits. At the request of MCHB, HSR focused predominantly on qualitative data in order to highlight the grantees' achievements, as well as the barriers they faced and the strategies they used to overcome them. Some of the research questions this evaluation explores are:

- How did the SOHCS grants contribute to the development of an oral health system of care?
- What reasons were given for any changes to goals and objectives?
- Have the grantees been successful in achieving the goals initially proposed?
- Why was it necessary to carry over funds from one year to the next?
- What are the common characteristics identified by grantees for building successful partnerships?

The evaluation was conducted in three phases:

Phase 1: Preparatory Work. In the first phase, HSR met with the Project Officer to refine goals and objectives. During this phase, HSR also identified current oral health system challenges, performed data abstraction, identified States/Territories for phone interviews and site visits, and conducted logic model conference calls to gain insight into the ways grantees used this process to identify grant activities. In addition, the Evaluation Director determined both the staff and the evaluation methodology.

Phase 2: Data Collection. HSR designed protocols and questionnaires for the key-informant phone interviews and site visits, scheduled and conducted phone interviews and site visits, and recorded data from all sources.

Phase 3: Data Analysis and Report Writing. In the third and final phase, HSR developed a database, a codebook, and a data analysis process. HSR also analyzed all data, drafted and finalized status reports on all grantees, and provided detailed sets of recommendations for improved integration/collaboration on oral health activities by MCHB grantees.

Throughout all phases HSR provided cross-checks and supervision to ensure consistency of data collection methods and overall quality control to the project.

Common Definitions

From the outset of the evaluation it was important to assure that MCHB, the HSR staff, and the SOHCS grantees were in agreement about the purpose of the evaluation and shared a common understanding of some key terms used throughout the process. To aid in the understanding of this report, the terms most frequently used are listed alphabetically and defined below:

Basic Screening Survey (BSS). Developed by ASTDD, the BSS is a standardized set of surveys designed to collect information on dental care access and on the observed oral health status of participants by identifying gross dental or oral lesions. It was developed to be used by screeners with or without a dental background, in which the screener records the presence of untreated cavities and urgency of need for treatment. Most grantees administered the BSS to children in the second and third grades and also examined these children for the presence of dental sealants on permanent molars.

Core Health Functions Framework. Recommendations by the Institute of Medicine on those functions they deemed necessary to help the public health community strengthen the Nation's public health infrastructure. These recommendations organized the mission of public health around three core health functions: assessment, policy development, and assurance. ASTDD (2000) later structured their document ***Guidelines for State and Territorial Oral Health Programs*** around this core health function framework.

Implementation. Implementation is the process of putting program functions and activities into place.

Infrastructure. An infrastructure consists of systems, people, relationships, and the resources that would enable State oral health programs to perform public health functions. Capacity enables the development of expertise and competence and the implementation of strategies. Building infrastructure and capacity is a high priority for State oral health programs, since this will allow the States/Territories to achieve the new national objectives and improve the oral health of Americans.

Oral Health. Oral health is defined by the Surgeon General as having "more than healthy teeth." The mouth reflects general health and well-being, and oral diseases and disorders can affect health throughout the lifespan. In young children, the most prevalent chronic disease is dental caries.

Outcome Evaluation. An evaluation used by management to identify the results of a program's efforts. It provides management with a statement about the net effects of a program after a specified period of operation. This type of evaluation provides management with knowledge about (1) the extent to which the problems and needs that gave rise to the program still exist, (2) ways to ameliorate adverse impacts and enhance desirable impacts, and (3) program design adjustments that may be indicated for the future.

Process Evaluation. Process evaluation focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it

carries out. Like monitoring evaluation, process evaluation addresses whether the program was implemented and is providing services as intended. However, by additionally documenting the program's development and operation, it allows an assessment of the reasons for successful or unsuccessful performance and provides information for potential replication.

Providers. Dental providers include dentists, dental hygienists, and others who have received specific training in oral health diagnosis and treatment. Non-dental providers include health professionals, such as pediatricians, nurses, and general medical practitioners for whom the diagnosis of dental health requires additional training in oral health prevention and treatment.

Resources. For the purposes of this evaluation, the term resources is defined very broadly to encompass all those elements, fiscal and otherwise, that contribute to the success of an oral health program, including staff members; volunteers; finances/funding; training; technical assistance or support; and sources of information such as MCHB, ASTDD, and the CDC.

Social Marketing. Social marketing is a disciplined, consumer-focused, research-based process to plan, develop, implement, and evaluate interventions, programs, and multiple channels of communications that are designed to influence the voluntary behavior of a large number of the target audience

States and Territories. SOHCS grantees included both States and Territories. Therefore, throughout the remainder of the report, the use of the word "States" is inclusive of U.S. Territories and the District of Columbia. States are identified by their two-letter postal abbreviation.

Report Overview

Chapter II provides an overview of the three phases of the SOHCS evaluation. These phases include Phase 1: Preparatory Work, Phase 2: Data Collection, and Phase 3: Data Analysis and Report Writing.

Chapter III includes an overview of the processes States undertook in order to develop a SOHCS grant application, including the partners involved, the challenges faced, and feedback on the application guidance. This Chapter also describes the relationship of the SOHCS grant within the State's broader MCH activities and the relationship between SOHCS and other oral health programs.

Chapter IV of the report reviews some cross-cutting issues that all SOHCS grantees considered prior to and during the implementation of their program activities. In this chapter, HSR provides a broad overview of staffing, partners, target audiences, and outcome measurement concerns that every grantee addressed when developing its SOHCS grant. This is followed by a thorough discussion of grantee activities in Chapter V. For organizational purposes, these activities are organized according to the established elements of strong infrastructure – assessment, policy development, and assurance. In this chapter, HSR analyzes various aspects of program implementation, including the activities undertaken, the resources required, and the development of sustained partnerships.

Chapter VI documents the successes and challenges that grantees encountered in implementing their programs, as well as the unique strategies that grantees used to overcome these barriers. Text boxes in this chapter highlight promising models and approaches to inform current and future grantees.

Sustainability is discussed in Chapter VII, specifically the plans that States have put in place to sustain the improvements gained by the SOHCS initiatives. Chapter VIII reflects the feedback that grantees provided to evaluators regarding ways to enhance future MCHB oral health programs, and it documents their training and technical assistance needs.

Chapter IX concludes with a synthesis of key research findings based on the information gained throughout all phases of this evaluation. As requested by MCHB, this evaluation report concludes with suggestions for consideration regarding future oral health funding strategies and summarizes the overarching lessons learned from this examination of the SOHCS grantees.

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Chapter II. Overview of SOHCS Evaluation Process

This chapter will review the preparatory work conducted prior to the commencement of data collection activities. These activities provided Health Systems Research, Inc.'s (HSR) evaluation team with a broad understanding of the State Oral Health Collaborative Systems (SOHCS) activities and some of the challenges States encountered in strengthening their oral health infrastructure. The preparatory work helped to identify key differences between grantees for further exploration during the data collection activities under Phase 2. The preparatory work included:

- Identification of key topics
- Data abstraction
- Phone interviews and site selection
- Logic model calls.

Each of these activities will be described in turn.

Phase 1: Preparatory Work

Identification of Key Topics

Significant research is being conducted and published on the topics of early childhood caries (ECC), the relationship between periodontal disease and birth outcomes, and emerging science and new technologies to diagnoses and treat dental disease. However, the Maternal and Child Health Bureau (MCHB) felt that the information that would result from a conventional literature review would not provide the nuanced background necessary to inform this evaluation. On October 31, 2005, MCHB convened a meeting to discuss the specific oral health issues of relevance to the evaluation of the SOHCS program. Mark Nehring, Project Officer and Chief Dental Officer for MCHB, was joined by the following partners: Ann Drum, Director, Division of Research, Training and Education; Pam Vodicka, Public Health Analyst, Oral Health Program; John Rossetti, current Regional Head Start Oral Health Consultant and former MCHB Chief Dental Officer; and Ray Lala, Division of Medicine and Dentistry Bureau of Health Professions and former State Dental Director of South Carolina. These MCHB oral health stakeholders met with the HSR SOHCS Evaluation Project Director and Manager to identify the key topics that frame the SOHCS Program and its context, including:

- Overview of oral health care system
- Policy and program barriers impacting access to care
- Emerging science and the shifting focus of oral health care
- Possible research strategies and questions.

The ensuing conversation provided the evaluators with the context for understanding the oral health care system today, as well as global challenges the SOHCS grantees might encounter. The discussion of the current environment of oral health policy and practice was aimed at informing the HSR instrument development and data collection processes and ensure insightful analyses of both the quantitative and qualitative data. A summary document detailing this daylong

discussion fulfilled the deliverable of the literature review, as per discussion with the Project Officer and as documented in the monthly report. The key points from this discussion are outlined in the sections that follow.

The Oral Health Care System

Meeting participants unanimously agreed that there is no single oral health care system in this country. Unlike the public health care system, which encompasses a variety of primary and specialized care providers as well as multiple safety net programs, oral health in the United States is delivered through an underfunded and fragmented system of private dentists and public clinics. Consequently, infrastructure-building activities are even more relevant. The perceived separation between oral health and physical health is profound even at the source of dental education, which is provided apart from traditional medical schools with minimal cross-training between the medical and dental professions. Moreover, the general public is unaware of the importance of preventing or treating oral disease, especially the preventable disease of dental caries. In response to these facts, MCHB expressed a special interest in various awareness building and advocacy strategies that have successfully mitigated disparities in oral health across racial and socioeconomic groups.

The disconnect between the public health infrastructure and the private dentists who provide the majority of dental services across the country also provides a challenge to improving access to oral health prevention and treatment for the many mothers, children, and families that the SOHCS grant was designed to address. Most private dental providers manage their own practices, which are often disconnected from the public health system. These private dentists have a finite capacity to treat clients and are often able to fill their practices with insured or fee for service patients. Due to an uneven distribution of providers, rural families often must travel hundreds of miles in order to access care, which adds to the challenges that low-income families face in seeking out dental care. The lack of an oral health system is also evident in the lack of evening, weekend, or emergency oral health clinic hours.

The SOHCS grants provide States the flexibility to address these challenges by increasing collaboration with other State programs and agencies, community-based organizations, and the existing public health infrastructure to incrementally improve the oral health system of care for low income children, pregnant women, and children with special health care needs (CSHCN).

Policy and Program Barriers to Access to Care

Also discussed during this meeting with MCHB leadership was the topic of oral health disparities and the policy and program barriers that States face in improving outcomes for underserved populations. There was reference to several prominent studies and researchers which provided additional context to the needs the SOHCS grants were developed to address. According to the Surgeon General, non-Hispanic Blacks, Hispanics, American Indians, and Alaskan Natives have the poorest oral health of any of the racial and ethnic groups in the United States. The disease burden of dental caries disproportionately affects poor children from racial and ethnic minorities, with 20 percent of all children exhibiting 80 percent of the disease (Mouradian et al., 2000). Children from low-income families have poorer oral health outcomes across the lifespan, which impacts their overall health, employability, and quality of life.

In addition to a lack of available providers, there are a number of policies that impact access to care for the populations with the greatest oral health disparities. The lack of (1) Early Periodic Screening, Detection, and Treatment oral health periodicity schedules of similar import as the schedule of well-baby checkups and (2) recent legal challenges to community water fluoridation are two public health challenges that have a disproportionately negative effect on low-income families, who often lack other means to access oral health care. In addition, the use of multidisciplinary providers such as pediatricians, hygienists, or school nurses encounters resistance from many members of the dental community and often violates or challenges current State Practice Acts. Use of these alternative providers could also help overcome some of the access barriers. The funding of oral health prevention and treatment is also problematic. For example, Medicaid reimbursement for the application of fluoride varnish, a high-impact early intervention, is not universal. Additional funding barriers include a dearth of private-employer-provided dental insurance and the low (often below cost) reimbursement rates provided by Medicaid or the State Children's Health Insurance Program. The MCHB staff indicated that policy changes often lag behind scientific advances and exacerbate the challenges faced by many underserved and ethnic minority groups.

Emerging Science and the Shifting Focus of Oral Health Care

The SOHCS grantees are also affected by the state of the science surrounding oral health. Due to scientific advances, oral health care in this country is a rapidly changing field. In recent years, there has been a shift in focus from a surgical model of dental treatment to a prevention-oriented disease management approach. The emergence of a prevention focus is evident across grantees' activities and in many instances encompasses both the dental and medical professions. Although the MCHB staff meeting with HSR in October recognized that the evaluation team need not be experts in the science behind oral health treatment and prevention, they mentioned several aspects of the science behind new prevention strategies that are especially relevant to understanding some of the collaborative approaches the grantees are undertaking to improve oral health infrastructure in their communities. These issues include the importance of early intervention to prevent ECC; the relationship between a pregnant woman's oral health and that of her infant; preventive treatments, including fluoride varnishes and dental sealants; and the importance of cross-disciplinary training.

- **ECC.** ECC is a major public health concern. ECC is an infectious disease that is passed from mother/caretaker to child. It is caused by the bacteria *Streptococcus mutans* (*S. mutans*), which, under frequent exposure to fermentable carbohydrates, produces acids that can demineralize the outer surfaces of the teeth. When exposure is prolonged over a significant period of time, severe tooth destruction and disability occurs. It is estimated that 5 to 10 percent of young children age 5 years or younger have ECC. This proportion increases to nearly 20 percent among children from families with low incomes and to more than 40 percent in some racial/ethnic minority populations (Seif, 1999). Therefore, taking a proactive approach to ECC is an important cost-effective strategy to improve oral health outcomes.

- **Oral Health and Pregnant Women.** Although the science is inconclusive, some studies have shown a relationship between periodontal disease and preterm, low birth weight babies. Some studies suggest that pregnant women with periodontal disease may be seven

times more likely to have a baby born too early and too small. One explanation is a labor-inducing chemical found in oral bacteria called prostaglandin. Very high levels of prostaglandin are found in women with severe cases of periodontal disease. In addition to birth outcomes, maternal and child health (MCH) programs should promote the idea that oral health is related to overall health, advising pregnant women to have dental checkups during the second trimester of pregnancy. Additionally, new mothers should be informed about the transmissibility of the bacteria that causes oral disease, ways to avoid baby bottle disease, the importance of good nutrition, and the need for their child to see a dentist prior to the age of 1 year.

- **Prevention Strategies.** In addition to regular brushing, families with access to oral health information and treatment encounter a variety of prevention methods. One successful public health intervention has been the fluoridation of community water systems, although this method now is being challenged in some communities. Fluoride supplements and the application of fluoride varnishes are alternative preventive practices which are becoming more prevalent. The MCH performance measure of dental sealants on primary teeth and dental sealant programs in schools and communities are making a difference in the oral health of many children. Fluoride varnish programs, whether applied by a dentist, a hygienist, a nurse, or a pediatrician, have been shown to be very effective in reducing the presence of *S. mutans* in preschool-age children and improving long-term oral health of the child. Studies of xylitol in Europe and more recently on American Indian reservations seem to indicate that xylitol may be another method for preventing oral disease.

- **Cross-disciplinary training.** There is an increasing need to bridge the systems gaps between oral and medical health. The use of cross-disciplinary training through continuing medical education (CMEs), conference workshops, or online curricula can help to educate providers on the importance of including oral health assessments and care in determining the overall health of a child or pregnant woman. Xylitol and fluoride varnish interventions can be provided easily by non-dental personnel, including school nurses, pediatricians, and dental hygienists. Many SOHCS activities are based on a cross-disciplinary approach to oral health.

MCHB felt that an overview of these issues would provide a context within which the researchers could design an evaluation that would highlight how SOHCS activities addressed these issues in their efforts to improve oral health infrastructure. The MCHB leadership noted that the most significant data to be collected for this study would be qualitative in nature, varying from State to State and across the broad array of SOHCS activities proposed. In providing this overview of oral health infrastructure, science, and political and social context, MCHB directed the evaluation team to identify successes and challenges faced by the SOHCS grantees and promising practices that could be applied more broadly in future interventions. Through this identification of cross-cutting themes and strategies, the evaluation could document grant outcomes and perhaps could provide a foundation for future MCHB-funded oral health infrastructure-building activities.

Data Abstraction: Grant Applications

To support the conduct of the evaluation, MCHB provided HSR with access to the following data sources:

- Grantee applications for all years
- Health Resources and Services Administration (HRSA) Electronic Handbook (EHB)
- Copies of letters regarding no cost extensions
- Title V Information System (TVIS)

The next step in the evaluation process involved a review of the grant applications from all years of the SOHCS initiative. This preliminary overview provided the HSR staff with an understanding of the activities, partners, and challenges faced by each grantee. Collectively, the applications indicated shifts in activities, barriers overcome, staffing, and funding allocations. Research analysts reviewed the applications and completed a data template for later analysis that included the following fields: State name, year of application, amount requested, and name and contact information for the Project Director. Since the SOHCS grants were released in 2003 for a 1-year period and from 2004 onward for multiyear opportunities, abstractors also pulled the following information from each application:

- Level of focus (e.g., State, county, school)
- Goals
- Goals changes over time
- Objectives
- Participate in mutual committees and task forces
- Objective changes over time
- Core activities
- Challenges of implementation
- Target audiences
- Intended outputs and associated outcomes
- Indicators to measure performance
- Partnerships/partners/coalition members.

EHB

Between the inauguration of the SOHCS grants and the most recent application, HRSA implemented the EHB for grant applications, renewals, and reports. Since some of the grantees had transitioned to use of the EHB over the course of their projects, the MCHB Project Officer arranged for HSR to get “read-only” privileges to the handbook to complete the data collection and abstraction process. Review of the 3 years of data for each State was then conducted, and the analysts indicated any changes in goals over the duration of the grant, identified barriers if possible, and summarized particular information on sustainability and supports. Some of the files also included letters requesting carryover and extensions enabling the evaluators to document the amounts and years of any carryover requests in the summary document that was created for each State. If evident from the reviews, the research analysts also indicated whether the State had an oral health plan and a full- or part-time State Dental Director and whether the SOHCS grantees collaborated with the MCHB Early Childhood Collaborative Systems grantees or Head Start programs.

TVIS

In addition to abstractions from hardcopy and electronic applications, at the request of the Project Officer, HSR also accessed the TVIS for information regarding whether each State’s

2005–2010 Title V Needs Assessment listed oral health as a priority need and whether specific oral health performance measures were being tracked. These data were pulled from the TVIS and entered into a Microsoft Excel spreadsheet for each State receiving a SOHCS grant. Some States had neither an oral health priority need nor a performance measure, but most had both. However, in some cases, the target population for the SOHCS grants did not coincide with the need or measure.

Phone Interview and Site Visit Selection

The next activity under Phase 1 of the evaluation was the identification of States that would participate in the phone interviews and site visits. The information obtained during the data abstraction process provided an overview of the SOHCS grantees' activities and enabled HSR to identify States to be included in the evaluation sample for phone interviews or site visits. As noted previously, the SOHCS grants were awarded in 2003 as 1-year planning grants to 47 States and, starting in 2004, as multiyear infrastructure-building grants to 49 States. HSR evaluators determined that some of the initial 47 grantees did not apply for followup funding after their initial phase, and several of the 49 States pursuing infrastructure-building goals did not submit renewal applications. In order to measure grantees with equivalent time implementing programs and developing outcomes and in consultation with the Project Officer and the MCHB Chief Dental Officer, only States with continuous or progressive grant goals from the initial funding opportunity in 2003 through the 2004–2007 grant cycles were included in the research sample. This requirement eliminated States that participated in only the first opportunity or did not reapply continuously for the SOHCS grant after the 2004 cycle. States that received SOHCS funding for less than 3 years of the SOHCS initiative were not included in the evaluation (Connecticut, Idaho, South Carolina, American Samoa, and the Federation of Micronesia). This reduced the total number of States to be evaluated to 47.

Since MCHB determined that nine SOHCS grantees would participate in site visits but not phone interviews, by default, 38 States were eligible for participation in the phone interview data collection phase of the evaluation. Since the purpose of the 2-day site visits was to explore in greater detail the impact that the SOHCS grants had on oral health infrastructure-building activities, it was critical that the States selected for site visits indicate successful implementation of their SOHCS activities. With input from the Project Officer, the following criteria were used to identify the States for participation in the site visit component of the evaluation:

- Continuous or progressive activities on the same goals since 2003
- Sites representing a variety of SOHCS grant activities
- A record of successful outcomes
- Geographic diversity including different regions and urban versus rural programs.

Based on these criteria, MCHB approved the following nine States for site visits: Washington, D.C., Florida, Indiana, Georgia, New Hampshire, South Dakota, Texas, Virginia, and Wisconsin. Once selected, MCHB sent an e-mail to the SOHCS Program Director requesting their participation in the site visit phase of the evaluation.

Staff Assignment

Next, five HSR interviewers were assigned to conduct the interviews. Two of the interviewers were very familiar with oral health issues, and three required additional preparation. The literature review was distributed to all the evaluators along with some additional information on ECC, dental workforce, and clinical interventions. An HSR staff person directing another MCH oral health project was available to the evaluators to answer any questions. To enhance the consistency of the data collection and maximize the expertise of each evaluator, the Project Manager assigned each evaluator States conducting similar core activities as identified during the data abstraction process. For purposes of the phone interviews only, the broad categories of grantee activities were defined as surveillance, infrastructure/planning, clinical interventions (e.g., sealants, fluoride varnish), and public awareness. States were informed via the SOHCS listserv to expect a call to schedule time for a phone interview. HSR used administrative support to contact each State individually and establish a master schedule of calls. The SOHCS grantee in each State was asked to coordinate any local partners to participate in the phone interviews.

Collectively this preparatory work provided the foundation for the data collection processes that followed.

Phase 2: Data Collection

The data collection process consisted of the conduct of logic model calls, the development of the discussion guide for use during the phone interviews, its modification for use during the site visits, and the procedures HSR used to conduct both these activities.

Logic Model Calls

The first component of the data collection process during Phase 2 of the evaluation was the conduct of logic model conference calls to collect information that could be used to inform the development of the discussion guides used during the telephone interviews and site visits. At the SOHCS Grantee meeting conducted on December 5–7, 2005, HSR senior staff members provided grantees with an overview of the evaluation process and asked for volunteers to participate in the logic model calls in early 2006. MCHB tasked HSR with conducting several conference calls with States to gain an understanding of the extent to which the logic model information that was provided to States during the SOHCS application process was used to identify and implement grantee activities. A copy of this logic model is presented in Appendix A. Eight States volunteered for the logic model conference calls, including New York, Maine, Wisconsin, North Carolina, Washington, D.C., Ohio, Kansas, and Virginia. These States reflected varying levels of experience in the use of logic models for program planning and implementation.

Prior to the calls in January, the SOHCS grantee volunteers were informed of the threefold purpose of the logic model calls. First, evaluators wanted to gain insight into how the logic model was used during the SOHCS program design, application process, or grant implementation. Secondly, HSR wanted to examine similarities and differences between the elements MCHB included in the sample logic model and the elements the sites were using. Finally, HSR hoped to learn about the differences in State perceptions of the usefulness of the

logic model based on the particular focus of their SOHCS grant activities. As a reminder, States were also given a copy of the sample logic model that was included in the SOHCS application.

The logic model calls were conducted by the Director of the SOHCS evaluation, who has significant experience with the use of logic models for program design. The conference calls were designed to answer the following questions regarding SOHCS grant application and implementation:

1. Do you have a logic model for your program? If yes, when did you develop it? Why did you develop it? How have you used it? If no, how might you use the generic logic model?

2. How does the fact that this grant program is to support the development of infrastructure change the usefulness of a program logic model?

3. How are the activities that you are developing or have implemented similar to and different from those in the sample MCHB logic model?

4. What outputs are associated with your activities? How are these the same/different than those in the MCHB logic model?

Brief summaries were drafted of each of the logic model calls, and the information obtained from these calls informed the development of the interview discussion guides. The chief finding from the small sample of States participating in the conference calls was that their ability to make use of a logic model in the planning of their oral health activities was directly related to the amount of outside training and knowledge they had concerning their development and use. If the State had participated in Centers for Disease Control and Prevention training on logic models or received significant technical assistance from a local foundation, the United Way, or another funding source, they were much more likely to integrate the use of a logic model into the development of their SOHCS grant or to base their SOHCS grant application on a previous oral health activity that was supported by logic model analysis. Conversely, if States were inexperienced with the use of logic models, they were more likely to have overlooked the logic model in the Appendix of the application. In fact, about half of the States on the conference calls had no recollection that an MCHB logic model was included in the initial application. There also was some discussion of the value of a logic model in evaluating outputs and outcomes of certain infrastructure building activities. It was clear to those on the calls that some of the oral health outcomes being sought were long term and that their activities lent themselves more easily to process milestones, output measures, or intermediate outcomes.

Taken collectively, the data abstraction, the phone interview and site visit selection process, and the logic model calls provided the HSR staff with the preparation it needed to move on to the next phase of the evaluation process.

Discussion Guide Development

From the information gathered during the data abstraction process and logic model calls, the HSR staff was able to identify the most appropriate oral health partners to participate in the interview process. While some States had a single SOHCS Project Director over the course of

the grant (often the State Dental Director or Oral Health Program Manager), other States experienced changes in personnel. Consequently, in order to collect the most accurate information, HSR included the Project Director and key contributors to the project in the telephone discussion. With this in mind, HSR developed a single discussion guide that could be used with interviews with just the Project Director or, if necessary, during a conference call with the Project Director and one or two key stakeholders. As per the direction of MCHB, HSR conducted one call with each State.

The topics to be explored during the phone interview included:

- The planning process and the development of goals and activities
- Implementation of activities
- Successes and challenges
- Strategies for overcoming barriers
- Other resources used or needed to achieve goals
- Impacts and outcomes of SOHCS grant activities
- Institutionalization and sustainability
- Considerations for future MCH-funded oral health grants.

Once completed, a draft protocol was submitted to MCHB for review and comment. Edits were made and an evaluation team meeting was held to review the guide and ensure that the individuals who would be conducting the interviews had the same interpretation of the discussion points to be covered. After two different evaluators conducted four phone interviews, the team reconvened to share their suggestions on ways to modify the guide to solicit information from the SOHCS grantees most effectively and efficiently. In addition, there was discussion on how to manage conference calls when multiple SOHCS stakeholders were participating. Once again, the protocol was modified. A copy of the final discussion guide for use during the phone interviews can be found in Appendix B.

On average, the phone interviews took between 90 minutes and 2 hours to conduct, depending on the complexity of the grant activity, the number of participants on the call, and the availability or willingness of the grantee to provide the interviewer with details. The conference calls were not tape recorded; instead, the evaluator entered the information gained during the conference call into a discussion guide template. On average, it took the evaluators an hour to transcribe their notes from the interview for later transfer to the SOHCS database. In general, the conduct of the phone interviews went smoothly, and time zones and common availability proved to be the most prominent challenges. Overall, the grantees were eager to share their experience with the SOHCS evaluators.

Site Visits

As the phone interviews were underway, consideration was given to how to integrate the findings from the nine site visits into the information being gathered during the conference call discussions. To ensure consistency of data collection, HSR decided to use a similar discussion guide for the site visits, with modifications depending on who was being interviewed. HSR also decided that the evaluator conducting the visit would work with the Project Director to determine

who would be the most appropriate participants in the site visit discussions. The following interviewees were considered critical to the evaluation process:

- The SOHCS Project Director and any staff members directly working on SOHCS activities
- The State Dental Director
- Other governmental State-level partners (e.g., the MCH Director, the Head Start Collaboration Office, the Department of Education, Medicaid)
- Local partners, including providers and private and nonprofit organizations
- Others that you feel would be informative to the evaluation.

Despite the scheduling constraints of a 2-day site visit, HSR sought to speak with each stakeholder independently and in the sequence provided above. It was considered appropriate for a small group of local partners or a State coalition or workgroup to be interviewed together. For statewide partners, it was not necessary for individuals to travel to a central location if a conference call could be arranged. The Project Director was informed that if their State was conducting a variety of activities with the SOHCS grant, HSR would be interested in all of them – particularly those that had been successful.

Below is a chart outlining the rationale behind the selection of the particular States identified for the site visits.

Site Visit	State	Description of Program	Domain / Foci	Region	Rationale
May 8–9, 2006	IN	Implement the SEAL INDIANA program.	Systems Building	Midwest	The mobile dental unit is a novel and successful approach to providing oral health services to children with no access to dental care.
May 9–10, 2006	DC	Develop an oral health surveillance system as well as standards and regulations.	Coalitions/ Partnerships	Mid-Atlantic	This is a good example of an urban school-based dental sealant program, with many system barriers to overcome.
May 18–19, 2006	FL	Coordinate and facilitate Florida's Oral Health Improvement Plan for Disadvantaged Persons.	State Oral Health Improvement Plan	South	HSR developed and refined plan using input from many partners – a State focusing on oral health plan improvement.
May 22–23, 2006	VA	Integrate oral health education and preventive services into existing MCH programs.	Integration of Oral Health Activities into MCH Priorities	Mid-Atlantic	This is a strong Head Start partnership with the potential for long-term impact through the training of Head Start and Early Head Start staff members. HSR created a dental home model for all Medicaid children; it could be related to SOHCS efforts.

Site Visit	State	Description of Program	Domain / Foci	Region	Rationale
May 22–23, 2006	NH	Increase services provided by primary care providers for children under age 3.	Partnering with Non-Oral Health Professionals	Northeast	A shortage of oral health providers necessitated the creative expansion of the delivery of oral health services.
May 30–31, 2006	TX	Collect baseline oral health data; provide oral health services at Head Start and Women, Infants, and Children sites.	Coalitions/ Partnerships	West	Although the goals from 2003 were different, HSR laid the foundation for the work in subsequent years. They have strong Head Start and other academic organization partnerships.
June 1–2, 2006	SD	Provide oral health surveillance, oral health education, and access to services for the MCH and Medicaid populations.	Partnering with Non-Oral Health Professionals and the Public	West	The number of American Indians on reservations in the State poses a unique set of challenges. This is a very strong coalition, partnering with Medicaid and dental associations.
June 5–6, 2006	WI	Train the trainer and consultants used to provide training on MCH needs and oral health.	Partnering with Non-Oral Health Professionals and the Public	Midwest	This makes creative use of small-State staff members to create and manage a system for reaching MCH targets.
June 29–30, 2006	GA	Undertake system development projects in selected communities.	Systems Building	South	HSR developed a logic model as well as actual products (a CD) and collaborated with Head Start on screening, with a local focus and local partners to implement activities.

The site visits occurred over the course of a day and a half and were conducted by a single evaluator, as specified by MCHB. No transcripts were made of the discussions, and the evaluator took handwritten notes, which were later entered into the interview template for coding. Each site visit included a varying number of interviews, partners, and program site visits (e.g., the sealant program in the D.C. city schools). See Appendix C for a summary of information collected during the interviews conducted in each State.

Once all the data from the phone interviews and site visits were transcribed, the HSR team was ready to move onto the last phase of the evaluation process: data analysis.

Phase 3: Data Analysis and Report Writing

Phase 3 focused on data synthesis. The activities in particular were those associated with organizing the data, analyzing the data to answer evaluation questions, and using the findings to develop the evaluation report. Some of the critical processes in this phase are discussed below.

Database Development

Microsoft Access databases were developed to support data analysis for this important evaluation project. The first set of tables was structured to match the telephone interview protocols. Text from the interviews was placed in these tables. The database also included descriptive information about the sites, which was developed from a review and abstraction of the grantee applications and reports. The structure of the database is such that interview data can be extracted by question or by site.

The second database or set of tables is associated with the first, and it includes the codes associated with the major themes identified in the responses to the various questions. For each of the identified codes, the database contains an indication of whether this code is associated with a grantee's response. This dataset was used to produce frequencies of response and to conduct quantitative analyses. All of the tables were used together to generate the data used in this evaluation report.

Codebook Development

As part of the analysis process, HSR explored the interview data for major themes. These major themes were included in a codebook. The codebook was used to code all interview data, allowing HSR to assess the experiences of all of the SOHCS grantees systematically.

The codebook was developed using an iterative, inclusive process. A sample of 10 interviews was selected and a preliminary codebook was developed based on these interviews. This initial version was reviewed by all project staff members, and suggestions were made to modify the coding structure as well as to expand some of the codes. The codebook was modified based on these recommendations. Another 10 interviews were then used to expand the codebook, and an additional review resulted in a modification of the codebook. The codebook included examples of what was to be included under each of the codes. The codebook is included as Appendix D.

Data Analysis Process

HSR analyzed the data collected for this study by section, taking pains to ensure the inclusion of all data collected. Responses were frequently analyzed by associating responses with the critical elements of the grantee's program. Data analysis was descriptive. Counts and frequencies were generated using Access query and reporting functions. Some data were exported into SAS for ease of analysis. The qualitative data were analyzed in conjunction with the quantified data. Frequencies of major themes were generated and specific quotes were explored in order to understand the nuances of the various responses and to maximize the use of the interview data. The frequencies, counts, associations, and qualitative data are included in the findings sections that follow.

Chapter III. Grantee Planning Activities

This chapter analyzes State responses to questions regarding the State Oral Health Collaborative Systems (SOHCS) application process. It begins with a discussion of the relationship between State Maternal and Child Health (MCH) Programs and other State-level oral health programs and offers a general overview of the environment of dental public health within the States. The chapter reviews the specific leadership that emerged in response to the SOHCS Request for Proposal, as well as the existence of previous Oral Health Coalitions or planning committees. This chapter provides an overview of how States applied for this opportunity and how they identified interventions and activities to pursue.

Relationship with Title V Agency

Nearly all of the grantees (87 percent) indicated a relationship with their State MCH program, although the frequency and content of their interactions varied widely. The range of relationships included the following:

- The grantee receives significant funding and/or is within the MCH program.
- The grantee receives moderate funding.
- The oral health program contributes to Title V Needs Assessment.
- The grantee receives no funding from the Maternal and Child Health Bureau (MCHB) but receives administrative or other support.
- The grantee serves as an information resource or participates in the same committees or task forces.
- Oral health and MCH are parallel yet collaborative divisions/programs.

The most recent Title V Needs Assessment identified oral health as an MCH priority need, and many States felt that this indicated a collaborative relationship between the oral health and MCH programs. However, nearly a fifth of the grantees interviewed did not know what prominence, if any, oral health had in the assessment conducted for 2005–2010.

Relationship Between SOHCS and Other Oral Health Activities

When asked the degree to which SOHCS grant activities were integrated with the other oral health activities in the State, 40 States indicated that the activities were closely related. In many cases, SOHCS funds enabled States to expand or maintain existing oral health programs or to strengthen planning and other implementation activities in the following ways:

Arizona	The SOHCS grant is playing a significant role in helping the State reach the goals of the oral health plan to improve access and has generated increased public awareness.
Colorado	Efforts are made to ensure that nothing happens in isolation when planning new programs. Consideration is always given to how these will be integrated into existing programs or activities.
Maine	SOHCS has helped develop collaborative planning, as opposed to what some discrete group is doing; there is greater effort to work together.
Montana	SOHCS and Montana's oral health program are "one and the same."
Nebraska	SOHCS is so interrelated with other oral health activities that it is "part and parcel of everything that is happening."

In States with oral health programs with limited budgets and staffing, SOHCS was instrumental in increasing visibility for oral health issues and supporting new or renewed oral health planning activities.

The Role of Coalitions

Thirty of 47 States had some type of statewide collaborative oral health planning group in place prior to their application to the SOHCS grant program in 2003. Many of these groups were specifically identified as Oral Health Coalitions, whereas others were identified as oral health advisory groups or task forces. The existence of these Coalitions varied in duration from groups convened specifically to participate in the SOHCS application process (Kansas, Maryland, and Wyoming) to others which were more longstanding (Maine, 1997; Montana, 1999; California, exact year not given). Other States indicated their reliance on county or local Oral Health Coalitions, rather than a single statewide group. The springboard for these Coalitions differed greatly; some States were energized by the Surgeon General's *A Call to Action*, some were motivated by their participation in an ASTDD-funded Head Start Oral Health Summit, and some were mandated legislatively. Oklahoma indicated that its SOHCS grant enabled it to merge two separate statewide Oral Health Coalitions. Some States noted that their Oral Health Coalitions had engaged partners successfully in addressing a variety of oral health needs (California, North Carolina, Rhode Island), including community water fluoridation, enhanced Medicaid/State Children's Health Insurance Program funding, and oral cancer screenings.

The majority (58 percent) of grantees indicated that a State entity, such as the State Offices of Oral Health or Medicaid, took the initiative to convene the group. However, a number of other entities assumed leadership of Oral Health Coalitions in other States. Some examples include the following:

State	Coalition Convened by
CA	California Dental Health Foundation and California Primary Care Association
CT	State Dental Association
KS	United Methodist Health Ministry Fund
ME	Maine Children's Alliance
NC	Partnership for Children/Smart Start Initiative
OH	Anthem Foundation of Ohio

In Massachusetts, Governor Michael Dukakis appointed a legislative commission to study oral health, and in Rhode Island, State Senator Elizabeth Roberts chairs the Coalition that emerged from the State's Senate Oral Health Commission in 1999.

Regardless of who convened the Coalitions, securing funding for oral health activities remains a challenge for most of the grantees. While some Coalitions rely on volunteer labor, in-kind contributions, and donated administrative support, other Coalitions rely on local foundations, health departments, or oral health programs to assume the administrative costs.

Applying for the SOHCS Grant

In the majority of cases, the SOHCS grant was written by and housed in the State Office/Program of Dental/Oral Health (74 percent). Montana, Nevada, North Dakota, Oregon, and Washington house their grants within their MCH programs. In some States, entities outside the State Dental or MCH Programs applied for and received the SOHCS grant. These entities included the California Dental Health Foundation, the Louisiana State University Health Sciences Center, and the North Carolina Academy of Family Physicians (for 2003–2004). Wyoming houses their SOHCS grant at both the University of Wyoming Institute for Disabilities and the State Dental Hygienists Office.

Due to staff turnover and transitions, some interviewees were not involved with the initial application process and did not have information on how the SOHCS grant was obtained or what issues arose during the process.

Grantees developed SOHCS grant goals in a variety of ways, and many grantees used this process as an opportunity to expand existing activities (36 percent) or to implement previously established goals or ideas (53 percent). Most States relied on group input to develop their SOHCS grant goals (84 percent), regardless of whether the group was run by internal State offices or external coalitions/organizations. Many grantees (47 percent) did not experience significant challenges in the development of their goals or the writing of their initial and subsequent grant applications. When issues were identified, they included the following:

Insufficient time	10%
State Bureaucracy / policy	12%
Weak infrastructure / lack of "right" people	14%
Other	27%

States sometimes offered more specific examples of challenges and issues they encountered during the SOHCS grant process. These examples are included in the table below:

State	Issues Encountered During Planning
Arkansas	Getting the contractual mechanisms to work efficiently (Office of Oral Health, Children's Hospital, UALR Children International, part-time dentist) was hard.
Delaware	It was hard for partners to understand their role in the planning process, since they were unfamiliar with the grant process and lacked sufficient internal administrative resources.
Kansas	Grantees experienced resistance from schools that did not want students taken out of classes for dental services.
Louisiana	Few dentists were willing to participate in sealant program.
Minnesota	State bureaucracy and paperwork are tied to all contracts, and the failure of internal agencies to meet their deadlines caused delays in SOHCS implementation.
Oklahoma	Policymakers had not identified oral health as a priority.

Most of the grantees indicated that the timing of the SOHCS grant was ideal and that since the groundwork had been laid, it was relatively easy to plan grant activities.

Grant Goals and Guidance

The grant goals included in the application were as follows:

Purpose of the SOHCS Grants (MCHB)

- Support States in developing, implementing, or enhancing efforts to integrate oral health into State MCH programs.
- Address MCHB performance measures in oral health.
- Stimulate action toward implementation of the Surgeon General's (2003) "National Call to Act to Promote Oral Health" as it affects women and children.

All but three States indicated that these goals were reasonable, though ambitious. Three States opposed this view. One felt that the amount of the award was insufficient to address such broad goals; another suggested that the national measure for sealants was too limiting and not "broad enough to deal with all States in all situations." While a third State expressed frustration that the oral health program did not receive any Title V funding: "If the MCHB doesn't require their funded programs to support/build strong collaborations with the oral health program, how can I?"

States only vaguely recalled the MCHB guidance provided in the application. Many of the respondents were not involved in writing the original grant applications or did not recall what guidance was provided. Several States indicated that they felt comfortable contacting the Project Officer and asking for clarification when the guidance was unclear. Many grantees indicated that the broad flexibility was an asset, but some found the lack of specificity troublesome. Several States recommended that MCHB clarify the guidance by conducting conference calls to address questions that arise.

Overall, States indicated that the application process presented no significant problems and welcomed the opportunity to apply for funding to strengthen their oral health infrastructure.

Grant Goals and Activities

In developing their SOHCS grant goals, 53 percent of States used this opportunity to implement recommendations of previous planning activities. Although some States conducted oral health planning as part of other MCH planning activities (Arkansas, Connecticut, Louisiana, Maine), other States used their SOHCS funding to augment planning conducted in conjunction with other funding agencies, including the following

Centers for Disease Control (CDC)
National Governors Association (NGA)
Policy Academies
Association of State and Territorial Dental
Directors (ASTDD)
United Way
Robert Wood Johnson Turning Point
Perkins Foundation
Robert Wood Johnson State Oral Health
Access Grants

Some of the previous planning activities that provided direction to the SOHCS application included State oral health plans, Healthy People 2010, Title V Needs Assessment, legislative commission recommendations, NGA Oral Health Policy Academies, ASTDD technical assistance, Head Start Oral Health Summits, and input from focus groups conducted by private firms.

Other grantees determined their activities using guidance and recommendations that were put forth by leading professional organizations such as the American Academy of Pediatrics, the American Dental Association, and ASTDD. Additionally, 23 of the grantees modeled their activities on evidence-based or best-practice models endorsed by these organizations and implemented by other oral health programs throughout the country. For example, grantees implementing sealant programs mentioned the *Seal America* manual, they also mentioned insights gathered from other State sealant programs and information gained from a review of ASTDD's promising practices as helpful resources in the design of their program.

Almost half of the grantees (23) used data to determine activities by identifying the greatest needs among a population or the areas of greatest need in the State.

Other States used their first SOHCS application to conduct needs assessments (Rhode Island, Iowa, Kansas, Maryland, Missouri, and Utah). This process could involve a review of existing data collected through a Title V Needs Assessment, Medicaid/EPSDT data, oral health survey, or surveillance data. In most cases, the information gathered during this year provided the direction for the subsequent SOHCS proposal. Although

one of the requirements for inclusion in this evaluation was a continuous or progressive use of SOHCS funding, the evaluation also included States that did not change direction but refined their goals for greater impact. Several States narrowed their 2003 goals with the 2004 application noting that the first set of goals was too ambitious or unrealistic.

While some States strategically sharpened the focus of their goals over the course of the SOHCS initiative, most States augmented or increased goals from year to year. For example, Texas and Virginia expanded the number of Head Start programs participating in their fluoride varnish program, and the District of Columbia increased the number of schools supporting the sealant program. Other States brought in new coalition members or partners, such as Women, Infants, and Children Program, or local dental hygiene programs due to the increased visibility the SOHCS activities provided. The flexible nature of the funding enabled the States to maximize the use of their SOHCS grants by conducting a variety of simultaneous infrastructure-building activities. Grantees used SOHCS dollars to augment current funding; leverage other funding for new oral health activities; and, in some instances, develop discrete projects. The specific grant activities, challenges, and implementation solutions are described in more detail in the following chapter.

Chapter IV. Implementation Considerations

As State Oral Health Collaborative Systems (SOHCS) programs were initiated in each State, grantees were faced with a number of similar issues to consider regarding the specifics of staffing, partners, the target audience, and the need to consider cultural competency and appropriateness of program activities. In addition, as activities began, it was important for grantees to identify appropriate elements and methods to track program outcomes. These cross-cutting issues transcend all SOHCS grant activities and were discussed during both the phone interviews and site visits. Specific strategies grantees used to address these core program components provided some unique examples of how grantees addressed these particular issues. While Chapter V describes grantee activities more specifically and will discuss these implementation considerations in a context that is specific to the type of activity, such as school-based sealant programs, this chapter is intended to present these decisions in a broader context across all grantees.

Staffing

Grantees were asked to describe the roles of individuals responsible for carrying out the SOHCS grant activities and the extent to which the staff considered the cultural appropriateness of activities. For those oral health programs that were staffed by only one full-time individual, this person typically assumed many responsibilities, including the task of coordinating activities as well as delivering the core activities under the SOHCS grant.

In over half of SOHCS grant programs (51 percent), the State/Territorial Dental Director or Oral Health Program Director was responsible for coordinating grant activities. Some programs had the benefit of additional oral health program staff; more than half of the grantees (55 percent) indicated that there is an individual other than a Dental Director that oversees coordination of activities. For example, several grantees reported having an individual in the position of sealant coordinator who is responsible for organizing sealant activities in the State/Territory, overseeing individual programs, and sometimes providing technical assistance as needed.

Grantees generally reported that because oral health programs often lacked sufficient staff members, the implementation of activities relied on those outside of the oral health program, such as consultants, partners, and volunteers. About one-fourth of grantees used oral health consultants to assist with implementation of activities, typically when technical expertise was needed to implement surveillance activities, such as development of a sampling methodology. A number of grantees relied on the volunteer work of dentists and dental hygienists and inkind contributions from related programs, such as maternal and child health (MCH) staff members.

Partners

Almost all of the grantees reported implementing activities with the assistance of partners, including public agencies and private organizations. These agencies and organizations supported the implementation of SOHCS activities in various capacities. Those mentioned most often as partners were as follows:

- State MCH agency and MCH programs (e.g., Women, Infants, and Children [WIC] Supplemental Food Program)
- Other State agencies (e.g., Medicaid, the Board of Education)
- Head Start (HS) (the State Collaborative Office and local programs)
- Schools (e.g., elementary schools, school staff members)
- Dental community
- Medical community.

State agencies, particularly the Title V agency, were identified as critical to the implementation of SOHCS-funded activities. As a result of these partnerships, grantees report that the SOHCS grant has allowed the oral health programs to develop much stronger relationships with State agencies that currently serve children, which has resulted in more linkages across agencies and expanded the reach of oral health messages.

Examples of Partnerships with HS

- The Division of Public Health in **Delaware** partnered with the HS Collaboration Office and HS programs throughout the State to organize a HS Oral Health Forum, which included 100 participants. The successful forum resulted in the development of action plans addressing the areas of access, provider education, and prevention.
- A number of activities were pursued in **Illinois** involving the HS staff. The grantee developed educational tools on oral health and then trained train HS to use them with the goal of institutionalizing the use of these tools. The grantee also developed a basic screening tool to conduct surveillance activities with HS programs.
- The **Rhode Island** Oral Health Program worked closely with a local HS program to implement a training program for parents. This program was based on a University of California, Los Angeles model and was designed to improve a parents' knowledge of oral disease prevention and empower them to handle oral health issues.
- The **Texas** Dental Director capitalized on her strong relationship with the HS program to implement a fluoride varnish program. The program was used statewide after a pilot program in Dallas proved to be successful.
- **Vermont** adapted its successful *Tooth Tutor* model to be used with the EHS population. The program links children to a dental home and conducts parental education using family nights and home visits.

The State MCH agency and Early Head Start (EHS)/HS programs were most often mentioned as partners during implementation of the SOHCS grant. Most grantees (62 percent) named their State MCH agency and personnel as a key resource in implementation, especially those that implemented interventions with WIC programs. Moreover, a large proportion of grantees worked with WIC and EHS/HS programs to

conduct a wide array of interventions, including education, outreach, screenings, and other clinical interventions.

Some grantees noted that the support of State Dental Associations was often critical to the success of a program, and two-thirds of grantees (66 percent) identified Dental Associations and private dentists (68 percent) as partners in SOHCS grant activities. The State Dental Associations and Dental Hygiene Associations have been involved in the planning of activities as well as the provision of direct services for the SOHCS grant. In fact, these professional Dental Associations were often helpful in facilitating the engagement of the private dental community. This involvement has been vital, as many SOHCS programs have relied on the participation of private dental providers, especially those participating on a volunteer basis. Typically, they volunteer in a limited capacity, such as by conducting screenings in schools during Basic Screening Survey surveillance activities or school-based sealant programs.

Culturally Appropriate Staff and Partners

In discussing the roles of staff members and partners in the implementation of grant activities, grantees also discussed how these individuals ensured that activities were culturally appropriate. A number of grantees reported that staff members working on SOHCS activities had prior training on cultural competency or were bilingual and able to work with non-English speaking populations. For example, some programs have hired bilingual staff able to do medical translation for dentists conducting screenings that do not speak Spanish.

Some programs relied on the use of translators to implement activities. The Connecticut SOHCS program supports two community grantees that have access to an extensive network of community translators and also have access to an International Institute that has been helpful. The grantee felt that these programs are well-informed about the emerging populations in their communities and are accustomed to working with diverse populations. The Pennsylvania grantee explained that their outreach coordinator used an interpreter when necessary to translate her educational presentations, which were specifically tailored to the audience.

Other grantees mentioned implementing interventions with program staff members in WIC and HS programs that are already considered to be culturally competent. Oregon reported working with home-visiting nurses and WIC staff members, which the respondent feels already are providing culturally appropriate care because they are trained to do so.

Target Audiences

Grantees were asked to discuss how target audiences and specific population groups were identified as recipients of grant activities. One-fourth (26 percent) of grantees used a needs assessment process to identify their populations of highest need. This could involve administering surveys and reviewing data. Some grantees considered the number of dental providers in a particular area, such as those designated by the Health Resources

and Services Administration as a Health Professional Shortage Area. Other grantees were well aware of populations considered to be in high need, such as HS children, and implemented interventions that were age appropriate. For example, prior to its SOHCS award, one grantee wanted to target children aged 0–3 using a fluoride varnish intervention and used this funding opportunity to implement such an intervention.

In the discussion of target audiences, grantees were asked about the cultural appropriateness of their grant activities. A handful of grantees (13 percent) reported that due to limited ethnic and racial diversity within their State, this issue merited limited consideration. Other grantees indicated that they were unsure about how to ensure that target audiences received services that were culturally appropriate.

Most respondents felt their activities were culturally appropriate for their target audiences and described different strategies for ensuring this.

Mentioned most often was the translation of materials in multiple languages and, at a minimum, in English and Spanish. This was especially important for grantees implementing interventions that required parental consent, such as sealant programs. For example, Massachusetts translated its information and consent forms into several languages, including Spanish, Portuguese, Vietnamese, and French-Creole, in order to serve the highly diverse school populations. In designing informational brochures and consent forms for a county with a large Latino population, Nevada translated materials into Spanish at a third- or fourth-grade literacy level. Some grantees used existing materials that were developed by other organizations and considered to be culturally appropriate for their target population. North Carolina reported that its State government has assisted the SOHCS program with translation services and will develop new materials specifically for Migrant and seasonal HS programs.

Development of Culturally Appropriate Messages in Utah

Utah used its SOHCS grant to develop a radio and television campaign that aired in Salt Lake City and other communities throughout the State. They worked with the Multicultural Center at the State Department of Health to ensure that campaign materials and messages were culturally appropriate, particularly for the Hispanic population, which is the largest racial/ethnic minority group in the State. Campaign images and message content was carefully reviewed with the consideration that was culturally appropriate and accurately translated. Hispanic media outlets also were selected for the campaign.

Other grantees, such as Colorado, invested a greater level of effort to tailor their activities. To assist them in developing materials for HS families, Colorado conducted listening sessions with Spanish-speaking HS parents. Although these sessions were not funded by the SOHCS grant, the information gathered in these sessions did inform SOHCS activities by helping the grantee to clarify the oral health needs of this population and tailor their health messages better.

Some grantees reported the use of a structured review process that included cultural competency. Connecticut included cultural competency as a requirement of the Request for Proposal process in selecting program sites for its school-based program and selected sites based in Hartford and Bridgeport that demonstrated the ability to serve diverse populations with immigrants from Latin American, Eastern Europe, Africa, and the Middle East. Some grantees use an internal review process, such as the Ohio *Help Me Smile* program, that has an Advisory Committee that comments on the cultural appropriateness of materials. Other grantees have access to resources, such as an Office of Minority Health or outside professional organizations that can review materials. Wyoming designed its materials with the help of a professional advertising agency and purposely selected images that were considered neutral and not culturally biased.

Monitoring Progress

SOHCS grantees were required to submit annual progress reports to the Maternal and Child Health Bureau (MCHB) when reapplying for funding. These reports described accomplishments toward goals and objectives, current staffing, technical assistance needs, and a description of linkages established with other programs. They were also required to report on the MCHB Oral Health Performance Measures and the Title V Oral Health Performance Measure. Included with the information grantees were asked to monitor, the MCHB requested that the grantees document their progress towards meeting ASTDD's (2000) ***Guidelines for State Oral Health Programs***. These specific measures were useful in that they provided benchmarks for measuring the success of infrastructure projects, which are often difficult to monitor objectively.

Grantees identified a variety of measures to document their progress towards grant goals and objectives. They most typically assessed their programs using process measures although some grantees were able to report objective measures such as the number of children screened, the number of fluoride varnish applications completed, and the number of referrals made.

Table IV.1 shows that three-fourths (74 percent) of grantees reported monitoring a task or activity and more than half (55 percent) captured the number of clients reached. Additional measures included the development of a training manual, the number of trainings conducted, and the approval of an Institutional Review Board. Grantees identified these measures based on their workplan, logic model, or task list.

Measuring Cost Benefit a Texas Priority

The **Texas** State Dental Director calculated an average fee for the services being provided through the SOHCS grant. A total of 3,093 children in Early Head Start and Head Start ranging in age from six months to five years received oral examinations and 3,075 of these children also received preventive dental services, which included topical fluoride varnish applications. As of July 1, 2006, the amount of $65,000 provided services with an estimated return on investment valued at $233,403 or otherwise stated, an estimated 359% return on the dollars invested from the grant.

Table IV.1: Examples of How Progress Was Monitored

Progress Measure	Percentage That Used This Measure
Monitoring of Tasks or Activities	74%
Number of clients reached	55%
Anecdotal evidence	21%
Other	6%
Number of Respondents: 47	

Note: One or more responses were given by each respondent.

Some grantees reported more sophisticated monitoring and evaluation techniques that assessed satisfaction of training, increase in knowledge, and reach of message. Others pointed to the fact that because of SOHCS, counties, or partners that observed the successful pilot programs plan to implement similar programs in their own communities. The textbox below highlights a few creative strategies for monitoring the progress of SOHCS initiatives.

Strategies to Monitor Progress

In **Alabama**, the sealant program is monitored using Medicaid Early and Periodic Screening, Diagnosis, and Treatment data. They also intend to use HS data in the future and successfully have laid groundwork to make this happen.

In addition to **Pennsylvania's** collection of service data (number of events, number of participants, level of disease, number that come for followup care), the outreach workers also administer questionnaires (pre and post surveys) to see if knowledge levels have improved with educational programs.

For their media campaign, the **Kansas** Action for Children established a target percentage of viewers who they expected would see the TV ads. They tracked the frequency of commercials shown in each market area, but they did not survey members of the viewing public directly. They will record anecdotal feedback from policymakers who received the oral health postcards mailed to them. For sealant activities, the Kansas SOHCS staff followed ASTDD State and local sealant program indicators. These data were collected at both the baseline and followup screenings.

Utah will be partnering with the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Department of Health's Multicultural Center to design and mail a culturally appropriate paper-based survey to parents/caregivers not included in the PRAMS sample. This data collection period will last 6 months and evaluate whether the SOHCS social marketing campaign influenced parents'/caregivers' decisions to access dental care and to assess their child's need for dental care. They will include a small incentive (a magnetic dry-erase board) and mail a followup survey to nonresponders in order to increase the response rate.

In **Texas**, one of the regional dentists developed a consolidated form and instruction book in both English and Spanish for dental provider use which conforms to HS and MCH reporting requirements. The consolidated form is a modification of the Nevada fluoride program consent and data collection forms and includes the level of need, decayed/missing/filled teeth, the need for referral, the treatment plan, and the required HS forms. Dentists receive assistance from other staff members (hygienists or the HS staff) to help with the record keeping.

A number of grantees expressed the desire to monitor and report additional measures, such as the number of school days missed due to dental problems. Such a measurement would be helpful both to build an argument to school officials about the importance of oral health and to show the impact of school-based oral health services. However, developing this reporting mechanism would require overcoming obstacles such as working around school privacy issues and identifying the staff and resources to collect and analyze this data.

The elements of staffing, partnerships, target audiences, cultural competency, and program measurement required varying amounts of effort and planning on behalf of grantees. Without consideration of these aspects of implementation, the likelihood of success resulting from grantee activities would be diminished. The next chapter discusses in more details the specifics of grantee activities and addresses unique implementation concerns as appropriate.

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Chapter V. Grantee Activities

This chapter will present the grantee activities within the structure of the three core public health functions: assessment, policy development, and assurance – a structure which has been used in oral health promotion efforts to help identify activities and components that comprise strong oral health infrastructure within State/Territorial health systems (Institute of Medicine, 1988; Centers for Disease Control and Prevention, 1994; Dillenberg, 1995; Association of State and Territorial Dental Directors, 2000). The grantees used SOHCS funds to support a wide range of activities across all three core health functions, presented below in Table V.1.

Although the goal of the State Oral Health Collaborative Systems (SOHCS) grant was to expand the oral health infrastructure, grantees were not limited in the type of activities they were able to fund. Because of this flexibility, grantees invested in a broad range of activities across all three core functions. In addition to funding a range of activities, all but one grantee supported multiple activities with their SOHCS grant. Seventeen grantees pursued two to four activities, while 29 pursued four or more activities. The most commonly reported activities included screenings/oral exams (70 percent), oral health education (62 percent), advocacy and policy development (53 percent), and surveillance (47 percent).

Table V.1: Grantee Activities

Core Function	Activity Funded by SOHCS Grant	Percentage That Conducted This Activity
Assessment	Surveillance	47%
	Needs Assessments/Special Studies	17%
Policy Development	Salary of the State/Territorial Dental Director	15%
	State/Territorial Oral Health Plan	26%
	Policy and Advocacy	53%
Assurance	Clinical Services:	
	Screenings/Oral Exams	70%
	Dental Sealants	43%
	Fluoride Interventions:	47%
	Fluoride Varnish	28%
	Other Topical Fluoride (e.g., fluoride mouth rinse, foam, toothpaste)	19%
	Cleanings/Restorative Treatment	13%
	Referrals for Ongoing or Urgent Care	38%
	Communications and Training:	
	Oral Health Education	62%
	Training/Technical Assistance	53%
	Social Marketing	15%

Core Function	Activity Funded by SOHCS Grant	Percentage That Conducted This Activity
	Formal Collaborations: State/Territorial Oral Health Coalition Other State/Territorial-Level Coalition or Workgroup Regional-level Coalition or Workgroup	 13% 19% 11%
Number of Respondents: 47		

Note: One or more responses were given by each respondent.

Assessment

Table V.2: Assessment Activities

Core Function	Activity Funded by SOHCS Grant	Percentage That Conducted This Activity
Assessment	**A.** Surveillance	47%
	B. Needs Assessments/Special Studies	17%
Number of Respondents: 47		

Note: One or more responses were given by each respondent.

In the context of oral health, the assessment function refers to the systematic collection, analysis, and dissemination of data on the oral health status of a community. Assessment is critical in monitoring trends in illness, injury, and death and in identifying community health problems. In addition, data that are collected are invaluable in isolating available health resources, unmet needs, and community perceptions about health issues. For example, the establishment of an oral health surveillance system can be used to monitor trends in oral health outcomes such as untreated tooth decay or urgent dental treatment needs. Assessment activities are grouped into the categories of surveillance activities and needs assessments/special studies. Table V.2 shows that almost half of the grantees (47 percent) funded surveillance while only 17 percent funded activities defined as needs assessments and special studies.

Table V.3: Percentage of Grantees That Directed Assessment Activities by Target Audience

Target Audience	Surveillance	Needs Assessments and Special Studies
Population Group:		
Children Ages 0–3 (i.e., Pre-K)	4%	4%
Elementary School-age Children (i.e., Grades K–5)	36%	2%
Middle and High School-age Children (i.e., Grades 6–12)	2%	2%
Pregnant Women	0%	0%
Parents/Caregivers	2%	0%
Adult Consumers	0%	0%
Families	0%	0%

Target Audience	Surveillance	Needs Assessments and Special Studies
General Population	0%	2%
Dental Providers	0%	6%
Medical Providers	0%	4%
Other Health and Social Service Providers	0%	9%
Organization:		
Community-based Organizations	0%	0%
EHS/HS Programs	13%	0%
WIC Programs	0%	0%
Unknown Target Population or Organization	2%	0%
Number of Respondents: 47		

Note: One or more responses were given by each respondent.

Surveillance

Table V.3 indicates that 17 grantees (36 percent) focused their surveillance efforts on elementary school-age children while only four grantees conducted surveillance activities outside of the school environment.

Most of the grantees that pursued school-based surveillance activities used the Basic Screening Survey (BSS). Most grantees administered the BSS to school age children in the second and third grades and also examined these children for the presence of dental sealants on permanent molars. Grantees reported selecting this age group based on the oral health Maternal and Child Health Bureau (MCHB) performance measure "percentage of third-grade children who have received protective sealants on at least one permanent molar tooth."[1]

Although the BSS was designed to be used by screeners with or without a dental background, most programs report having teams of dentists and dental hygienists conducting the dental screenings. In fact, a number of respondents noted that their State Dental Practice Acts mandate that dental screenings be performed by a dentist or in some cases, by a dental hygienist under supervision. Grantees readily admitted that this restriction posed barriers for carrying out surveillance activities. Some grantees were able to recruit dentists in private practice to conduct screenings, typically conducted on a volunteer basis. The grantees who used this process, such as South Dakota, also reported that their State Dental Association and State Dental Hygiene Association were instrumental in recruitment efforts. Other grantees turned to dental schools for volunteers. In Alabama, surveillance activities were carried out by the State Dental Director, faculty, and pediatric dental residents at the Dental School. In Rhode Island, where only dentists are permitted to conduct screenings, the respondent identified their "manpower" shortage as a major barrier. The program found it difficult to complete the BSS in a timely manner because it was a considerable cost to pay for dentists' time and without a dental school in the State, the respondent had few resources.

[1] MCHB: Maternal and Child Health Bureau Strategic Plan: FY 2003–2007; updated December 2003.

Six grantees, including Alaska and Montana, also conducted surveillance with Head Start (HS) and Early Head Start (EHS) populations in addition to the BSS conducted with third-graders. Illinois and Virginia specifically developed a basic screening tool to obtain oral health surveillance data in HS or EHS, respectively.

Beyond the process of collecting the surveillance data, some grantees encountered challenges in the process of analyzing the data. For example, New Mexico had difficulty finding a contractor that could carry out the needed analysis. The Vermont SOHCS program had identified data analysis as a goal of their SOHCS grant but had difficulty meeting this goal because the program was unable to hire anyone to analyze the data and the surveillance division in the Department of Health was unavailable to do the analysis.

Needs Assessments and Special Studies

Additionally, 17 percent of grantees reported conducting needs assessments and special studies. Table V.3 indicates that most of these activities focused on children's oral health issues. Two grantees, California and Texas, have conducted statewide oral health needs assessments. California's needs assessment has been used as a vehicle to create major policy changes to increase children's oral health outcomes specifically. In Texas, researchers assessed oral health needs across all populations around the State to identify the most critical oral health concerns and most appropriate interventions to address them.

Several grantees, including Minnesota, Rhode Island, and Washington, also developed reports which pulled data from multiple sources to paint a comprehensive picture of oral health needs and capacity issues. Minnesota plans to hold focus groups around the State with various stakeholders such as WIC, the Department of Health, and other community-based organizations to discuss the findings and implications of data presented in their oral health report. Rhode Island is using its oral health report in conjunction with a statewide oral health surveillance plan as the basis to initiate a new statewide oral health surveillance system. Washington is using its report to raise awareness among policymakers on the declining oral health status of its residents.

Other assessment studies targeted specific oral health capacity and health systems issues. For example, Kentucky conducted an oral health workforce study to help estimate future dental provider supply and demand for oral health services over the next decade. As part of a pilot project, Missouri developed a tool to monitor local-level emergency room data using a Web-based data system. This tool is designed to reduce the number of emergency room visits for tooth and jaw pain among children ages 19 and under in pilot communities by 50 percent over the project period.

Policy Development

The policy development function promotes the use of scientific knowledge in decisionmaking in order to develop comprehensive public health policies. Decisionmaking may include legislative actions, regulations or ordinances, guidelines, and standards that create an environment conducive to preventing oral disease and promoting oral health. Policies may address the implementation of leadership and

advocacy activities, in addition to oral health plans, which deal with a wide variety of services, including preventative care such dental sealants and treatments for vulnerable populations.

Table V.4: Policy Development Activities

Core Function	Activity Funded by SOHCS Grant		Percentage That Conducted This Activity
Policy Development	**A.**	Salary of the State/Territorial Dental Director	15%
	B.	State/Territorial Oral Health Plan	26%
	C.	Policy and Advocacy	53%
Number of Respondents: 47			

Note: One or more responses were given by each respondent.

Policy development activities are integral to many of the SOHCS grant activities. In fact, 53 percent of grantees used SOHCS funds to support policy and advocacy activities, as represented in Table V.4. Whether conceived prior to application for funding or upon program implementation, policy and the advocacy that accompanies it are necessary to create systems change on behalf of improved oral health for all. This section also discusses the key role a Dental Director plays in guiding policy development, as well as the way in which SOHCS grantees supported the collaborative development of their State oral health plans. The third aspect of mobilizing partnerships is included in significant detail in the discussion of assurance-based activities in the section that follows.

State/Territorial Dental Director

Policy development requires leadership to increase the awareness for oral health funding needs, goal setting, and establishment of policies at the State level. One way to provide this needed leadership is through the position of a State Oral Health Director or Oral Health Program Coordinator, ideally filled by someone with both a dental and a public health background who can act in a supervisory role in regards to an oral health unit staffed with professionals with both dental and public health training. Table V.4 indicates that a few grantees (15 percent) used their SOHCS grant to support some portion of the salary of a State-level Oral Health Director or Oral Health Program Coordinator or Manager (who may or may not be considered the State Dental Director).

Interviewees reported that the ability to fund an Oral Health Program Director/Coordinator from the SOHCS grant had a large impact on the oral health program in their State. One grantee had used contractors to conduct oral health activities in the past, but was unable to achieve consistent support for oral health activities. The SOHCS grant has allowed this State to support a full-time employee dedicated to this area; as a result, the capacity of the oral health program has been expanded to include partnerships with other programs (diabetes, tobacco control, and nutrition) and the public health infrastructure has been strengthened.

Additionally, an Oral Health Director provides visibility and leadership on a variety of statewide task forces, workshops, and committees. Their expertise is called upon to articulate the oral health needs of the State, as well as guide strategies to mitigate those

needs. Grantees noted that having a SOHCS fund to support their Dental Director has enabled them to increase awareness of oral health issues in the following ways:

- Recruiting home visitors to act as teachers and educate parents regarding the dental needs of their children
- Partnering with the State Dental Hygienists and Dental Associations to provide volunteers for oral health education and nutrition, preventive treatment, and restorative services
- Initiating a program which provides hygienists with limited access permits to perform screenings and fluoride varnish and rinse treatments
- Participating on a task force to lobby for the inclusion of oral health in State Children's Health Insurance Program (SCHIP) programs.

From facilitating the activities of a Statewide Oral Health Coalition to providing testimony or documentation of the oral health needs to writing and implementing the SOHCS grant programs, the leadership of Dental Director is key to improving oral health access and outcomes. A Dental Director is often the driving force behind the collaborative planning and implementation of State oral health plans.

State/Territorial Oral Health Plan

Table V.4 shows that 26 percent of grantees used SOHCS funds to support the development of State oral health plans and that a number of States had or are developing their plans outside of, but integrated with, their SOHCS program. As a component of infrastructure, the existence of a dynamic comprehensive plan with clear goals, objectives, and partners invested in and accountable for taking action and monitoring results is paramount. Therefore, the use of SOHCS funds towards these goals is appropriate. As with other oral health program activities, States exhibit various capacities in conducting and implementing a collaborative planning process, and in many cases, SOHCS funding enabled grantees to focus attention on their planning process. At the time of the evaluation, some States had revised or refined existing plans, others had convened the partners necessary to begin the planning process, and others still used this opportunity to merge various oral health plans already in existence. Texas, Florida, and Colorado engaged in particularly vigorous planning processes.

In Texas, the first year of their SOHCS funding was used to conduct "listening sessions" across the State to identify the greatest needs in the areas of oral health prevention, education, and access. These sessions used the services of a professional facilitator and included a broad range of stakeholders. More than 440 attendees participated, and participants represented the private, nonprofit, community, dental education, and private provider sectors. The State is now using an Oral Health Coalition workgroup to merge this plan with previous oral health plans.

In Florida, the sole purpose of the SOHCS grant was to develop *Florida's Oral Health Improvement Plan*. The planning process included the ongoing input of a variety of stakeholders, and the resulting plan was comprehensive so that it could be adapted and used by all partners to meet their specific target population and identified needs. The goal

of the plan is to increase access to care, with a focus on sealants, dental visits, and fluoridation. It is then up to the local sector to decide on the best approach given their situation. The plan is comprehensive, detailed, and clearly defines each agency's role in improving the oral health of all Floridians. The Plan was finalized last year, and now the goals are being modified to ensure the successful implementation of the plan. It is very much a living, working document.

In Colorado, the oral health program is in the same division as maternal and child health (MCH), and although the two programs traditionally have worked together, SOHCS provided an opportunity to integrate oral health into all of the MCH programs, including their Early Childhood Comprehensive Systems grant and other partners such as WIC and HS. SOHCS provided Colorado with an opportunity to do some strategic thinking about how these activities could complement what the agency is already doing with MCH block grant funding. The grantee noted that none of the oral health activities is carried out in isolation – when planning new programs or efforts, consideration is given to how these will be integrated into existing programs or activities. Colorado found that having an oral health plan engaged and energized foundations to become active partners.

Many States discussed their participation in other activities that supported the development of oral health planning documents such as Association of State and Territorial Dental Directors HS Oral Health Summits, National Governors Association Oral Health Policy Academies, or Robert Wood Johnson State Oral Health Access grants. These opportunities enhanced the States' capacities to create integrated oral health plans. Some of the unique planning activities funded by SOHCS described during the phone interviews and site visits were as follows:

CA	Used needs assessment data to develop recommendations and created a consensus building process involving all the "major players" to whittle down 130 oral health recommendations into 14 priorities.
KY	Convened 120 diverse partners from across the State, which used BSS data to develop a single oral health planning document.
ND	Strategically planned to integrate oral health into other MCH programs, including the Optimal Pregnancy Outcomes Program, SIDS, and WIC.
RI	Reviewed available datasets to create an oral health surveillance plan. This required the coordination and linking of datasets across agencies and programs. The State is working to integrate a variety of plans including a Coalition Plan for Oral Health.

As critical as it is to develop plans, without advocacy and policy development to implement them, systems change is not possible and the oral health infrastructure cannot be improved.

Policy and Advocacy

As discussed in the "literature review" section, there is a general lack of understanding of the importance of oral health and its relationship to overall health. This lack of awareness exists on the familial, community, provider, regulatory, and legislative levels. In order to create systems change or to implement oral health programs, grantees must increase awareness, develop new policies, and operationalize or fund these activities. In addition, changing technologies and workforce limitations often require regulatory changes to State Practice Acts or Medicaid funding policies. This confluence of factors led to half of grantees (53 percent) to use SOHCS funds to participate in some advocacy or policy development, as exhibited in Table V.4.

Table V.5 illustrates that grantees targeted a number of audiences in their policy and advocacy activities, including medical providers (34 percent) and dental providers (38 percent).

Table V.5: Percentage of Grantees That Directed Policy and Advocacy Activities by Target Audience

Target Audience	Advocacy and Policy Development
Population Group:	
Dental Providers	38%
Medical Providers	34%
Other Health and Social Service Professionals	32%
Policymakers (e.g., Legislators, State Medicaid Officials, Governor's Offices)	45%
Organization:	
Community-based Organizations	23%
Schools (K–12)	4%
WIC Programs	2%
Number of Respondents: 47	

Note: One or more responses were given by each respondent.

Grantees reported undertaking a range of policy and advocacy activities with SOHCS funds. Some of the specific policies mentioned during the interviews included Memoranda of Understanding with community-based partners and school districts, release forms for parents, interagency agreements, and procedures for data collection and analysis. Below are some examples of additional advocacy and policy activities targeting a specific audience:

Examples of Policy Activities Supported by SOHCS Grants	Audience
Emphasizing the need for the first dental visit prior to age one to reduce the incidence of Early Childhood Caries (Early Childhood Caries)	**Dental providers**
Implementing office procedures that support the application of fluoride varnish	**Medical Providers**
HS programs required new policies and procedures to implement fluoride varnish programs	**Community-based Organizations**

Numerous policies needed to be put in place to implement SOHCS activities. By far the most frequent policy issues mentioned involved State Practice Acts and Medicaid/SCHIP funding. With the advent of easily applied fluoride varnish, providers other than dentists can acquire the skills needed to conduct this clinical intervention. Whether the provider is a dental hygienist, a pediatrician, or a nurse, using nondentists often requires a legislative change. In North Dakota, legislative opposition derailed the State's initial SOHCS goals. In North Carolina, the legislature overrode opposition from the State Dental Association to change policy in this area. In virtually every State conducting fluoride varnish programs, State policies needed to be considered or modified.

Medicaid/SCHIP funding of services also required policy change if dentists or pediatricians were to be reimbursed for services. Whether this was for reimbursement for the extra time needed to see a child with special needs, as was the case in New Mexico, or changing policy so that pediatricians and even dentists can be reimbursed for the preventive application of fluoride varnish, there were both policy and budgetary implications that States encountered in the implementation of their programs.

In **Virginia**, after significant recruitment and training of pediatricians to apply fluoride varnish, their Medicaid claims were repeatedly denied. Virginia determined that the computer automatically denied dental codes for a service linked to a medical provider code. It took months to make the needed policy changes to reimburse the pediatricians for this service.

The **Iowa** grantee reported that during the 2006 session, the State legislature passed a mandate that the Department of Health and Human Services (DHHS) ensure that all children have a dental home by 2008. This top-down initiative could be attributed in part to the distribution of oral health brochures and dental training materials and videos that were purchased with SOHCS funding. It will require the mobilization of many partners to help DHHS meet this goal.

SOHCS grantees engaged in policy and advocacy activities to varying degrees and with varying degrees of success. Sometimes policy changes are driven by outside forces including consent decrees, lawsuits, or lobbying by other constituents. In those cases, SOHCS grantees must adjust or modify their activities to satisfy current laws or regulations.

Assurance

The assurance function includes activities that improve access to and availability of quality oral health care, including preventive services. Activities that fall under the assurance function guarantee the maintenance of the capacity of health agencies to provide necessary services and manage daily operations. These activities also ensure the ability of health providers to monitor the quality of oral health services and to respond to critical or emergency situations. This can be accomplished through a variety of ways, including:

- Direct service provision
- Agreements with other public and private agencies to provide services through partnerships or Oral Health Coalitions or Forums
- Enactment of regulations to require agencies to provide appropriate services and supporting the consideration of cultural factors
- Leveraging resources to ensure that services are comprehensive.

Table V.6: Assurance Activities

Core Function	Activity Funded by SOHCS Grant	Percentage That Conducted This Activity
Assurance	**A.** Clinical Services:	
	Screenings/Oral Exams	70%
	Dental Sealants	43%
	Fluoride Interventions:	47%
	Fluoride Varnish	28%
	Other Topical Fluoride (e.g., fluoride mouth rinse, foam, toothpaste)	19%
	Cleanings/Restorative Treatment	13%
	Referrals for Ongoing or Urgent Care	38%
	B. Communications and Training:	
	Oral Health Education	62%
	Training/Technical Assistance	53%
	Social Marketing	15%
	C. Formal Collaborations:	
	State/Territorial Oral Health Coalition	13%
	Other State/Territorial-level Coalition or Workgroup	19%
	Regional-level Coalition or Workgroup	11%
Number of Responses: 47		

Note: One or more responses were given by each respondent.

Table V.7: Percentage of Grantees That Directed Clinical Services Activities by Target Audience

Target Audience	Screenings/ Oral Exams	Dental Sealants	Fluoride Varnish	Other Topical Fluoride	Cleanings/ Restorative Treatment	Referrals for Care
Population Group:						
Children Ages 0–3 (i.e., Pre-K)	28%	6%	19%	4%	0%	19%
Elementary School Age Children (i.e., Grades K–5)	55%	36%	21%	13%	9%	28%
Middle and High School-age Children	19%	6%	4%	2%	4%	9%
Pregnant Women	15%	0%	0%	2%	2%	2%
Parents/Caregivers	4%	0%	0%	0%	0%	0%
Adult Consumers	6%	0%	0%	0%	0%	2%
Families	2%	0%	0%	0%	0%	2%
Organization:						
Community-based Organizations	9%	4%	2%	0%	2%	2%
EHS/HS Programs	32%	11%	17%	4%	2%	15%
WIC Programs	11%	0%	6%	0%	0%	2%
Unknown Target Population/Organization	2%	0%	2%	0%	0%	2%
Number of Respondents: 47						

Note: One or more responses were given by each respondent.

Clinical Interventions

As noted in Table V.6, a majority of grantees (70 percent) used SOHCS grants to conduct dental screenings and exams. Almost all of these programs are conducting them in the context of preventive clinical interventions, such as dental screenings and fluoride varnishes, or as part of surveillance activities. These screenings are conducted in various settings, including schools, mobile van units, and HS centers. Typically, these screenings were performed by a dentist or by a dental hygienist when permitted by the State Dental Practice Act. More than half (55 percent) of grantees conducted these screenings and exams with elementary school-age children, as shown in Table V.7. A significant portion of grantees also targeted younger children through EHS/HS (32 percent) and WIC (11 percent) programs.

Sealant Programs

Grantees mentioned the MCHB performance measure on dental sealants as guiding the selection of the target population. Almost all the sealant programs (17 out of 20) targeted children in elementary schools, primarily second- and third-graders, and a few also targeted sixth-graders. These programs were school based or school linked, serving low-income populations typically identified through the percentage of students eligible for free or reduced lunch programs within the schools. Grantees also applied sampling techniques, sometimes with the assistance of a technical consultant, to help them identify a representative sample of schools. A few grantees considered other selection criteria such as areas lacking fluoridated water systems, areas of high poverty, and areas with access issues (e.g. few dental providers).

Just as with the surveillance activities, most sealant programs used dental teams made up of dentists and hygienists to conduct the screenings. In Louisiana, teams comprised of dentists and dental hygienists conduct screenings in the schools, after which the dental hygienist returns to apply the dental sealants. Some of these dental providers are paid modest honoraria or stipends, while others volunteer their time. The State Dental Associations and State Dental Hygiene Associations have been instrumental in recruiting participants to conduct screenings on special sealant days. Some grantees have found that dentists who normally do not see Medicaid-eligible children in their practice are often willing to participate in these events.

Education partners, such as the State Department of Education and school districts, were critical in the implementation of the school-based dental programs. Typically, coordination took place at many levels to implement these programs. Standard protocol involved the approval of the Department of Education and superintendents before beginning school-based activities. Another grantee described working with the Department of Education to approve school-based programs throughout the State. An eligible dental provider interested in operating a school-based dental program must submit an application to the Department of Health. Those approved are then sent to the Department of Education for final review and approval.

Coordination also takes place with the specific schools and appropriate school staff members, most often the principal and the school nurse. One grantee described a process of having to secure formal agreements with each participating school. The grantees implementing school-based sealant programs expressed the importance of having the cooperation of the school principal and school nurse, who often has important coordinating responsibilities. In Louisiana, the Sealant Coordinator in the oral health program works closely with the school nurses to arrange dates for dental services and obtain consent forms from parents. Other grantees described a similar role played by the school nurse in facilitating this process, often serving as the point of contact in the school.

Securing the buy-in of the school principal was considered a challenge by some grantees implementing sealant

SEAL INDIANA

The program is a mobile dental van that predominantly does oral health screenings and applies sealants to the teeth of elementary school children all over **Indiana** (with the exception of Indianapolis which has its own oral health care system that serves children). The program also does oral health screenings for Head Start programs. Outreach is done by the coordinator/administrator to schools within Indiana. The coordinator works predominantly with the school nurse. If the school nurse is willing, the coordinator will send the nurse consent forms for children in the school – these are sent home with students and if active consent is obtained then the children are seen. The goal is to see children who do not have a dental home. After scheduling the visit to the community, the coordinator will contact local dentists to explain the program, explain how it is not competitive, and try to establish dental homes for the children being seen. The goal is not only to provide care but also to link children to local oral health care.

programs. A reluctance to participate on the part of the school principal was most often attributed to academic pressure related to Federal mandates and State testing requirements. Some principals feel the need to use all available instructional time to administer lesson plans and are reluctant to use this valuable "classroom time" to provide health services.

Other challenges that were mentioned by grantees pertain to the parents: obtaining required information and obtaining consent forms. One grantee that funded a sealant program in a new school found that staff members and parents needed time to understand and value fully the service that was being offered. The grantee had years of experience overseeing other school-based programs and explained that it takes time to develop the necessary relationships and to gain the trust of the school staff and parents.

Most grantees that implemented sealant programs (16 of 20 grantees) addressed the issue of continuity of care by referring to community providers and, when possible, establishing a dental home. At a minimum, programs identified referral sources in the community, which usually constituted community dentists either in private practice or in a community health center that accepts Medicaid and is willing to see children. The experience of finding providers was not an easy process. Grantees described a number of obstacles, including a lack of dentists willing to see children and a low number of dentists who accept Medicaid. The Alabama Dental Director worked with the State Dental Association and established a referral network with members of the Dental Association but then encountered problems when members withdrew from this network once they realized that they would have to become Medicaid providers.

Some grantees pursued a strategy of building relationships with local providers and persuading them to accept referrals. In Connecticut, the sealant program was designed to ensure that children were linked to a dental home within the school-based system or at a community dental clinic and referred to private providers when necessary. The two program sites located in Bridgeport and Hartford have reached out to private dentists either to locate dentists who can provide specialty dental care or to have dentists agree to see Medicaid families in their practice. In Bridgeport, they have a dental specialist that donates time on an as-needed basis. They also have identified dental specialists, including oral health surgeons to whom they can refer, although the respondents stated that they are very selective in the number of referrals they make so as not to overwhelm the dentists.

Once referrals were made, the extent to which grantees followed up on these referrals varied among grantees. In the Delaware program, the sealant program differentiates children in need of regular care from those in need of urgent care. For nonurgent cases, parents are informed of the additional dental services that are needed and then given the number for the Division of Public Health, should they require assistance in locating a dentist. The program makes greater efforts to ensure that children in need of urgent services receive care by involving the school nurse and the State program staff. The program has made special arrangements with several dentists throughout the State to treat these children at no cost if parents are unable to pay for services. Referrals are sent

Oregon ECC Program

The ECC program operates sites in three county health departments and targets Medicaid-eligible pregnant women and children ages 0–3. The program provides a range of services, including:

- Assessment and screening
- Oral health education
- Fluoride varnish application
- Identification of dental home.

Most ECC services are provided by nurses based at the county health departments or who deliver services through home visiting programs for high-risk women.

directly to these dentists and to family members, and both the school nurse and the State staff follow up with the parents to ensure that an appointment is made.

Fluoride Interventions

Twenty-two grantees (47 percent) funded programs that provided fluoride interventions. Table V.6 shows that fluoride varnish was the most commonly used fluoride intervention, with 28 percent of grantees funding this activity. Fewer grantees (19 percent) funded other fluoride interventions such as fluoride rinses or foams. Although there is some overlap with sealant activities, fluoride varnish programs generally targeted broader population groups compared to those served by the sealant programs. While 13 grantees (68 percent) with fluoride varnish programs targeted children in elementary school, almost 40 percent of fluoride varnish programs are targeted at very young children, which was not the case with the sealant programs. These children received varnish applications in settings such as HS centers, WIC programs, and pediatric offices.

Several of the SOHCS grantees that trained pediatricians or nurses to apply fluoride varnish created incentives to encourage these medical providers to incorporate this intervention during health visits, primarily by securing Medicaid reimbursement for this service. The Wisconsin SOHCS program, with the support of the Wisconsin Chapter of the American Academy of Pediatrics, lobbied for Medicaid reimbursement and felt that without it, pediatricians were unlikely to incorporate fluoride varnish applications regularly into their medical appointments.

WIC was identified as a key partner by the Minnesota program, which had the goal of expanding the use of effective oral health interventions in WIC clinics. The State distributed small grants to several WIC clinics to fund oral health education and fluoride varnish applications with young children. New Mexico described a similar initiative with its WIC program, which it supported on “special oral health days.”

Additionally, some of these grantees provided fluoride varnish services to HS families and pregnant women, especially as part of an ECC program. The ECC program in Oregon based its decision to target pregnant women and children ages 0–3 on an oral health needs assessment, recently conducted as part of its Title V Block Grant application.

Unlike other clinical interventions, the use of fluoride varnish interventions was promoted among a broad range of providers, including mid-level dental professionals;

nondental providers, such as pediatricians and nurses; and, in some cases, program staff members. Because of this, in some States or Territories, these programs faced opposition from State Dental Associations. To ease some of the concerns voiced by the private dental community, grantees stressed that these programs were targeting children aged 3 and younger, who are not typically seen by private dentists. Despite this opposition, most grantees were able to implement their programs as planned.

Communications and Training

Communication and education activities can increase recognition of oral diseases as a major health issue and equip communities, providers, and policymakers with the information needed to promote oral health and make more informed decisions about funding, policies, and services. In particular, training and technical assistance programs offer opportunities for hands-on experience using screening tools, curriculum modules, and toolkits. Similarly, individuals and families also benefit from education programs and social marketing campaigns that provide age-appropriate instruction on topics such as basic oral hygiene, emerging teeth, and nutritional guidelines that promote healthy teeth.

Table V.8: Percentage of Grantees That Directed Communications and Training Activities by Target Audience

Target Audience	Oral Health Education	Training/ Technical Assistance	Social Marketing
Population Group:			
Children Ages 0–3 (i.e., Pre-K)	30%	0%	0%
Elementary School-age Children (i.e., Grades K–5)	36%	0%	0%
Middle and High School-age Children (i.e., Grades 6–12)	9%	0%	0%
Pregnant Women	21%	2%	4%
Parents/Caregivers	26%	2%	4%
Adult Consumers	4%	2%	0%
Families	2%	0%	0%
General Population	0%	0%	13%
Dental Providers	13%	21%	4%
Medical Providers	11%	28%	4%
Other Health and Social Service Providers	17%	38%	0%
Policymakers (e.g., Legislators, State Medicaid Officials, Governor's Offices)	2%	2%	0%
Organization:			
Community-based Organizations	11%	17%	2%
EHS/HS Programs	23%	19%	0%
WIC Programs	17%	6%	0%
Number of Respondents: 47			

Note: One or more responses were given by each respondent.

Oral Health Education

Table V.6 indicated that about two-thirds (62 percent) of grantees reported implementing some form of oral health education directed at consumers, providers, and programs serving families. Some grantees used their SOHCS funding to support outreach and the education of consumers as a primary activity. The most common recipients of oral health

education were elementary school-age children (36 percent) followed by younger children (30 percent), as displayed in Table V.8. Educational activities were often carried out by program staff members who had frequent contact with consumers and families, such as HS programs or WIC staff members. Ohio used its SOHCS grant to support a home-based educational effort by adding an oral health component, which includes a risk assessment and referral to an existing home visiting program for high-risk families.

Pennsylvania used its grant to support activities targeting residents of various age groups residing in areas with dental shortages. For example, the program presented on oral health and tobacco use at teen community centers. Women of childbearing age were recipients of presentations at HS programs and parent groups, and seniors received information about oral cancer screenings at health fairs and senior centers.

Generally, clinical interventions such as dental sealant programs also included some educational component. For example, school-based sealant programs used intervention as an opportunity to educate school children on good oral hygiene habits and send educational materials home for their families.

Grantees also prioritized educational activities targeting EHS/HS programs and providers, both dental and medical, at 13 percent and 11 percent, respectively (Table V.8). Grantees used various methods for disseminating education to these target audiences. A number of programs utilized health educators to make community presentations through local health coalitions or provider groups. In efforts to target HS programs, the Mississippi program is having oral health consultants visit individual HS programs to conduct education and to review their tooth brushing programs. The grantee felt that face-to-face contact was important in establishing relationships in order to support the conduct of future surveillance work with HS programs.

Other grantees, such as Colorado, relied on direct mailings. Colorado developed materials for a prenatal packet on oral health that was distributed to prenatal providers to encourage them to counsel their patients on their oral health needs and the needs of their newborn babies. This activity was chosen based on the results of a Pregnancy Risk Assessment Monitoring System survey that found that few prenatal providers discuss oral health with their pregnant patients.

Oral Health Education in a D.C. Sealant Program

The **D.C.** Sealant Program includes a strong educational component that is provided to all children in the participating schools, grades pre-K to 6. Prior to the dental screenings and sealant applications, the dentists staffing this program meet with each class and conduct an age-appropriate oral health seminar. They conduct education in which they discuss good oral health hygiene habits and nutrition, hand out toothbrushes and floss, and talk about what to expect during their dental exam. The children have an opportunity to ask questions and inspect the dental tools that will be used while during their visit. The dentists explained that many of the children have had either limited or negative experiences with dental providers, and they feel that this educational session helps to alleviate those fears. The program also has conducted an oral health seminar for the parents during an evening session.

Some of the SOHCS grantees

partnered with other agencies that were equally interested in promoting oral health. Some Medicaid agencies, such as in Alabama and Louisiana, have taken a leadership role in promoting oral health among its providers. The Alabama Medicaid agency has been active in promoting oral health among physicians who see women during prenatal and postpartum visits. The Louisiana grantee worked with Medicaid and the MCH agency during the first SOHCS funding period to expand dental services to Medicaid-eligible pregnant women. The program produced activities that promoted oral health with prenatal providers and also informed pregnant women of how to access dental services.

Oral Health Training and Technical Assistance

In addition to providing education, as shown in Table V.6, more than half of grantees (53 percent) also supported training programs and technical assistance with their SOHCS grant. Just as in the educational activities, training and technical assistance activities were directed at programs and providers that have ongoing contact with high-risk population groups, such as children less than 3 years of age. As shown in Table V.8, 28 percent of grantees are providing training to medical providers. One interviewee noted that the decision to focus training efforts on pediatricians was made because very young children are far more likely to see a pediatrician than a dentist. The training program in Wisconsin is an example of such a model.

Wisconsin Provider Training Program

The primary activity funded by the SOHCS grant is the training of primary health care providers (pediatricians, nurses) to focus on prevention of ECC (0- to 3-year-old population). One of the program goals is to address the State's workforce shortages by expanding workforce capacity through the use of nondental providers. The training curriculum was developed with Title V funds and based on an existing model. It covers the following topics:

- Conduct of oral health screenings with children less than 3 years of age
- Application of fluoride varnish
- Administration of anticipatory guidance with families.

This training was targeted at a priority list of providers working at local health departments, community health centers/Federally Qualified Health Centers, and primary care clinics that see Medicaid children and HS programs. The intensity or length of the training is tailored to the knowledge and needs of the program staff.

In addition to medical providers, 38 percent of training efforts are directed at other health and social service providers, and 19 percent are aimed specifically at EHS/HS program staff members working with young children. Some program staff members are being trained to instruct parents on good oral hygiene habits, such as brushing and flossing, and to conduct screenings when permitted by Dental Practice Acts. Illinois provided training to WIC and HS staff members on oral health tools and hopes that these will be incorporated into the programs on an ongoing basis. Rhode Island is another example of an HS partnership, where the Oral Health Program worked with the Woonsocket HS program to provide training to parents. This training was designed to improve a parent's knowledge of oral disease prevention and to help empower parents to manage their children's

oral health issues. The grantee described this as a successful relationship and also shared that with the assistance provided by the oral health program, the Woonsocket HS Program was recently selected as one of the grantees of the HS Bureau's Oral Health Initiative.

Other grantees (21 percent) sought to develop the capacity of its dental workforce and developed training programs targeting dental providers, as displayed in Table V.8. The Colorado grantee described a training program developed to teach general dentists techniques in pediatric dentistry to improve their skill and comfort level in treating children. The daylong training was provided to 22 attendants by a pediatric dentist and included a hands-on component that the participants considered the most valuable part of the training. The grantee reported that this effort would not have happened without the support from the Primary Care Association. Because of the success of this training, Delta Dental agreed to fund additional training.

Oral Health Technical Assistance Model in Wisconsin

The SOHCS grant is partially funding the positions of several Regional Oral Health Consultants that cover the five regions of the State. They are based in each of five Department of Health and Family Services regions (Northern, Northeastern, Western, Southern, Southeastern) and serve as liaisons among the State office, regional offices, and local/county health departments. The Consultants expand infrastructure by providing education, technical assistance/training, and facilitation of oral health programs and services. Their specific activities vary by region and are tailored to the regional needs. These are identified by a grassroots process that is community driven. Some of their specific activities include provision of oral health awareness and education, assistance in surveillance and screening services, assistance of counties with fluoride varnish and sealant programs, and training of primary care providers to integrate preventive oral health measure into primary health care practice.

Of the grantees that reported providing technical assistance, most did so as part of their training activities. Two grantees that provided technical assistance separate and apart from training were Massachusetts and Missouri. Massachusetts developed a mentoring program for HS grantees to assist them in the implementation of the HS statewide oral health plan. They also are providing technical assistance to new participating school districts in the development and implementation of school-based sealant programs. Missouri provided technical support to emergency rooms and local community coalitions to develop and implement a tool to identify individuals with oral health needs and refer them to local dental providers.

Social Marketing

Social marketing activities were pursued by 15 percent of grantees, as shown in Table V.6. As displayed in Table V.8, 13 percent of grantees targeted the general population, 4 percent targeted pregnant women, 4 percent targeted dental providers, and 4 percent targeted medical providers through social marketing efforts.

Although most campaigns were trying to elevate the importance of oral health among the general public, grantees described campaigns with specific objectives and targeted messages and audiences. Louisiana used its first SOHCS grant to improve oral health among pregnant women by producing a marketing campaign to promote a Medicaid-funded program providing expanded dental services for pregnant women. The SOHCS grant supported public service announcements, a hotline, and the general promotion of the program among prenatal providers and pregnant women. Utah also targeted pregnant women and developed radio and television ads that emphasized the connection between periodontal disease and risk of preterm birth or low birth weight and stressed the importance of having young children see a dentist by their first birthday. These ads were aired in the Salt Lake area and in select high-risk areas around the State. Kansas used its SOHCS grant to supplement a large, multiprong campaign that included television ads targeting the general public in conjunction with marketing efforts directed at educating State legislators, pediatricians, and family practice physicians about pediatric oral health issues and Early and Periodic Screening, Diagnosis, and Treatment guidelines.

Formal Collaborations

In comparison to other assurance activities, fewer grantees selected to fund formal collaborative activities using their SOHCS grant, with 13 percent funding State/Territorial Oral Health Coalitions, 19 percent funding other State/Territorial-level coalitions or workgroups, and 11 percent funding regional-level coalitions or workgroups (Table V.6). Below are some examples of such activities described by grantees:

AZ	Built and supported local Oral Health Coalitions in the identification of their own oral health priorities.
DE	Held an Oral Health Summit in 2004 to spark the efforts of a coalition tasked with refining the recommendations that emerged from the summit into advocacy activities.

State agencies, including MCH, Departments of Education, and Medicaid, were often identified as partners in these activities, such as in the development of State Oral Health Coalitions and Coalition-related activities. Much of this work is taking place at the State level through oral health forums and State coalitions, such as in Oklahoma, where they use the Oral Health Coalition to engage in advocacy directed at their State legislature. Kentucky used its first SOHCS grant to support strategic planning around oral health. This process involved nearly 120 stakeholders and included representatives from State agencies. Planning activities were based on the statewide needs identified through a survey completed in 2001.

Some grantees chose to focus on particular population groups. HS was identified as an important partner in planning activities by the grantees through State Oral Health Coalitions and State Oral Health Forums, a number of which have focused on oral health and HS. These forums have involved the participation of HS programs, professional dental organizations, State agencies such as Medicaid and Title V, and other MCH stakeholders. Delaware reported that its HS Oral Health Forum resulted in the identification of several strategies to address access, provider education, and prevention.

These will require State advocacy efforts, which will be assumed by the Oral Health Coalition once it convenes. Massachusetts chose to focus on children with special health care needs and developed a task force that includes key stakeholders, in which they will develop a State oral health plan focused on this population.

Other grantees are using their funding to support coalition efforts at the local levels. Arizona and Washington State have encouraged local communities to build their infrastructure by establishing Oral Health Coalitions with the expectation that they will be more successful at promoting oral health within their communities. Arizona felt that the greatest challenge is finding an organization to lead the coalition that can engage other stakeholders and facilitate meetings effectively. Washington has suggested establishing coalitions through their county health departments and sees these as an extension of the activities pursued by the State Oral Health Coalition. When Vermont was forced to cancel a statewide Oral Health Summit, the grantee used its SOHCS grant to overcome this barrier by disseminating the plan holding “local oral health summits” in each of the 12 health districts throughout the State. Although there was less of a presence by State legislators, the State feels that this method could be more effective in promoting the importance of oral health as there was participation by major community leaders including child care programs, schools, human service agencies, and private dentists and doctors.

Local collaborations have proven to be useful in the implementation of SOHCS activities. In Connecticut, two sealant programs located in Hartford and Bridgeport were able to leverage their participation in their local Oral Health Collaboratives to obtain support and financial assistance. Some grantees reported that these local coalitions successfully have engaged local stakeholders, such as in Oregon, where the SOHCS grant supported activities organized by the ECC Prevention Coalition, which includes representation from a broad range of MCH stakeholders in these communities.

Chapter VI. Successes and Challenges

As discussed in the previous chapter, a broad and diverse array of activities was implemented through the State Oral Health Collaborative Systems (SOHCS) grants. In addition to documenting the nature and extent of these activities, the evaluation also explored the degree to which they were successful and factors that fostered or hindered success.

During the evaluation interviews, grantees were asked to assess their effectiveness in addressing the goals and objectives of their SOHCS grants. The clear majority – 85 percent – believed that their efforts in promoting oral health were "very effective." In general, grantees reported that SOHCS funds enabled their States to increase access to services and the number of people receiving dental care. They also developed new partnerships and increased oral health-related efforts at the local level. Many grantees said that while they "felt" they were effective, their data system was inadequate to provide objective measures. Those that provided direct services were able to report on measures such as the number of children screened or the number of fluoride varnish applications conducted. However, States that focused their SOHCS efforts primarily on building infrastructure rather than on providing direct services found it much harder to measure "success." For these reasons, few grantees were able to capture outcomes.

Seven grantees stated that they were not as effective as they would have liked. Reasons cited for this included lack of time, lack of staff members or infrastructure, and overambitious original goals. Particularly ambitious activities, such as engaging all health districts/counties or establishing fluoride varnish programs statewide, are still "works in progress."

This chapter examines how SOHCS grantees defined their efforts, as well as the key supports and barriers to successful implementation.

Defining Success

What were your key achievements? The answer to this question, which was posed to all grantees, provides critical insight into the role that SOHCS has played in development of oral health systems for children and families.

Almost all grantees – 46 out of 47 – reported as a key achievement that their State's oral health infrastructure was strengthened in both expected and unexpected ways. In 1988, in its landmark report *The Future of Public Health*, the Institute of Medicine emphasized the importance of strengthening the Nation's public health infrastructure to identify, monitor, and respond effectively to ongoing and emerging public health concerns. SOHCS contributions to strengthening public health infrastructure, therefore, are a critical finding.

Beyond the broad identification of infrastructure development, grantees identified a range of achievements – identified in Table VI.1 and discussed in more detail below – attributed to the SOHCS grants. While related to their original grant goals, grantees often felt that these achievements went beyond those original goals.

Table VI.1: Grantees' Report of Their Key Achievements

Key Achievements	Percentage That Cited This Achievement
Successful partnering	55%
Improved access to oral health services	55%
Increased oral health awareness	51%
Improved data systems	47%
New activities	32%
Leveraged funding	28%
Developed oral health plan	17%
Additional staffing	13%
Other	4%
Number of Respondents: 47	

Note: One or more responses were given by each respondent.

Establishment and Enhancement of Relationships and Partnerships. Grantees noted the critical nature of relationships and partnerships needed to make oral health improvements across agencies and in multiple systems, including through the establishment of coalitions and initiation of new activities. Examples of relationships and partnerships which facilitated oral health systems development cited by grantees follow:

- In Louisiana, the SOHCS funding has provided the opportunity to work with relevant State entities. Because of that opportunity, oral health has been included in the current State Preventive Health Initiative.
- In Kentucky, SOHCS has enabled a diverse group of people to come together, which resulted in the donation of two mobile dental units from Ronald McDonald House charities to the University of Kentucky.
- Head Start (HS) and State and community health centers in Missouri are now using the referral network and community coalition method developed through SOHCS.
- In North Dakota, data from the Behavioral School Survey (BSS) revealed a correlation between children with oral disease/decay and obesity. There are now efforts to include healthy choices in the school

SOHCS provided funds to support the State Oral Health Improvement Plan in **Florida**. This comprehensive and coordinated plan allowed for increased awareness of oral health issues, new partnerships, and new initiatives:

- All the partners recognize the low Medicaid reimbursement rates, and they are working together to advocate for better rates.
- Local HS offices and 22 local offices for children with special health care needs are partnering to address oral health.
- Local school nurses and school districts are calling the School Health Director for advice on how to improve oral health in their community.

vending machines. Additionally, these data can help build a stronger case for oral health to be presented before the legislature.

- In Illinois, SOHCS has helped improve relations with the State Medicaid agency and has made Medicaid more amenable to future policy changes. It also has increased the number of local health departments with oral health initiatives.
- In Nebraska, the SOHCS grant came at the beginning of the development of new local-level public health infrastructure. Without the grant, oral health likely would not have been identified as a priority for local-level decisionmakers.
- Delaware has worked closely with the Dental Association to raise awareness among private dentists. This work has resulted in an increase in the number of dentists that accept Medicaid. As a result, the utilization rates have increased from 24 to 33 percent among children during the grant period.
- Vermont now has a subcontract with the Vermont State Dental Society to examine workforce issues.

Improved Access to Services. Reaching unserved or underserved populations through creative, clinical solutions was a key aspect of SOHCS.

- In Missouri, the preventative, population-based services program was piloted in three communities, and it will be expanded to every HS program in the fall of 2006.
- Because of a pilot program begun in 1999, 84 out of 87 local health departments and 250 pediatric offices in North Carolina now provide fluoride varnishes for children aged 0–3. The SOHCS effort was integrated into the pediatric residency programs and ambulatory care clinic rotations at the University of North Carolina. More than 100,000 children have been served. At baseline, 20 percent of eligible children received dental care, and now 70 percent are receiving care.
- Oklahoma worked hand in hand with the Dental Association and the Medicaid agency to change capitated payments back to fee-for-service payments. This has resulted in an increase of 40 percent in the number of dentists accepting Medicaid, and the number of children enrolled in Medicaid receiving dental services has increased by 109.7 percent.

Increased Awareness. Raising the general public's awareness of oral health needs is critical to building momentum and improving the system of care.

- In Arkansas, the school-based dental clinic has received much attention from the newspapers, with two front-page articles in 3 months, the last of which was titled "Going the Extra Smile." Such attention helps raise awareness of the importance of oral health and increases donations made to United Way in support of the clinic.
- Upon the release of the oral health needs assessment report and the corresponding "solutions" to the issues identified, the California SOHCS grantee held seven press conferences, which were covered in every newspaper and aired more than 50 times on television. This media coverage was followed by a hearing in front of the State Assembly Health Committee. Three bills resulted from this effort.

Though raising awareness among a wide array of stakeholders was a positive accomplishment cited by many grantees, it also posed a challenge in some States. A small number of grantees discussed how the SOHCS grant raised awareness of the infrastructure and of political disagreements among the dental community. In one State, there was clear friction between the general public and the pediatric dental community. In another State, private dentists were not allowed to provide dental services in schools. In a few States, as described earlier in the report, the increased exposure and communication also highlighted philosophical disagreements on the appropriate roles of dentists, hygienists, and other nondental providers.

Enhanced Data Systems. Defining the problem and identifying solutions must be done systematically and continuously. The following are examples of State Enhanced Data Systems:

- In Kentucky, as part of a surveillance effort, the body mass index measure was added to the screening instrument. This addition was the result of collaboration with obesity and nutrition experts in Kentucky's Health Department.
- In Mississippi, collaboration on SOHCS activities has led to a strong relationship with the information technology staff in the Department of Health, resulting in the inclusion of oral health in the new patient information management system.

New Staff or Leveraged Funding. Building the human and financial resources to address oral health requires a stronger infrastructure now as well as a better chance of sustaining one in the future.

In **Wisconsin**, the SOHCS grant funds oral health consultants to strengthen local and regional infrastructure. This investment was instrumental in winning a highly competitive award of $450,000 from BlueCross BlueShield of Wisconsin to integrate oral health into public health electronic records.

Their application was strengthened because they could point to the regional oral health infrastructure already in place.

- One Arizona county has developed and funded the position of Oral Health Coordinator. This coordinator is now the "expert" for oral health in the community. She has become a local resource.
- Iowa developed a brochure highlighting their oral health successes across the State, and they were able to raise awareness among policymakers who allocated an additional $150,000 toward oral health care.
- McDowell County in West Virginia was provided a mobile dental chair, which was the infrastructure necessary to provide oral health services to children. By being able to bill third parties, this effort is now self-sustaining.

Supports and Barriers to Success

Since many grantees strived to improve infrastructure, many of the measurements of success included key factors such as the formation or strengthening of relationships in

addition to the usual outcomes of grantee activities. Partners, for example, were essential to building an effective program, and SOHCS activities resulted in the strengthening of such partnerships.

Keys to successful implementation included strong partners, availability of resources, and sound planning (Table VI.2). The reasons that these were important, as well as the barriers to implementation that their absence often created, are discussed below.

Table VI.2: Essential Supports

Input	Percentage That Cited This Input
Key Partners	73%
Resources (financial, staffing, information)	63%
Good Planning	32%
Existing Infrastructure, Policies, and Procedures (ability to hire, develop contracts, etc.)	25%
Number of Respondents: 47	

Note: One or more responses were given by each respondent.

Partnerships

Grantees discussed the importance of having the participation of partners who were politically connected, who could serve as strong advocates for oral health by informing less knowledgeable decisionmakers, and who were well-respected among their peers or in their community. In Indiana, for example, the Indiana Dental Association played a pivotal role in reaching out and engaging local dentists in SOHCS activities. Without this key partnership, the State would not have been as effective.

Partnerships were developed for a number of reasons – often to gain access to organizations and venues previously unserved. Partnerships acted as a means of expanding staff members and capabilities. This was particularly true in States with small State Oral Health Departments and fewer resources. For example, one State whose primary activity was the BSS trained and provided travel reimbursements for dental providers, who in exchange assisted in the surveillance efforts.

Also critical to the success of SOHCS implementation was collaborative and networking

SOHCS Outside of the State Organization

The **New Hampshire** SOHCS grant is overseen by the Southern New Hampshire Area Health Education Center (AHEC). The grant is being used to create branded materials as well as to develop training materials and deliver trainings to all members of pediatrician and family physician practices focusing on how to conduct oral health screenings in young children. The grantee is housed in an organization that was able to use existing partnerships with State government and private partners to develop and deliver a multifaceted program. This program works well with the portfolio of trainings and training materials utilized by the AHEC. The use of government staff members as partners rather than as grantees has permitted them to contribute in areas they know well and avoid working on issues better suited to the AHEC.

relationships. The SOHCS grant increased the opportunity for collaboration and sharing of resources, which established relationships where few or none had been before. Many States felt that supportive relationships at the local, State, and national levels were important as well. The SOHCS grantee meetings, for example, provided an opportunity for grantees to establish relationships with staff members in other States with common interests and issues.

Key partners included:

- School nurses, who often make all arrangements for school-based programs, including obtaining parental consent
- Oral Health Coalitions, who are critical partners when separate from the SOHCS structure
- State Dental Association
- Universities and schools of dentistry
- Local Health Departments
- Private dentists at the local level
- Dental suppliers
- Primary care associations.

Just as partnerships were important to successful implementation, not having the right partnerships or having unsuccessful partnerships often was a barrier to success. In fact, 18 grantees described a lack of partnerships as a barrier. The challenges faced were not specific to any type of partner but rather were due to a lack of clarity on roles and responsibilities among stakeholders. For example, one State established a network for referrals, but later learned that the dental providers did not want to participate in Medicaid – a critical element of the success of the program. In other cases, partners could not deliver on their commitments. Often school partners who wanted a school-based service lacked the time and parental cooperation or interest, and when faced with the competing pressures of their "No Child Left Behind" responsibilities, they were unable to implement an effective program.

Resources

The majority of grantees reported that financial, personnel, and informational resources were essential to successful implementation. Each of these is described below:

Financial

The SOHCS grant was flexible enough to allow grantees to use it as they thought best. This financial resource enabled the addition of important services and support, as well as providing the opportunity to leverage other funds. A few States reported how SOHCS funds came at a time when other funding sources were decreasing, which helped them prioritize oral health activities. Grantees also received funds from the Centers for Disease Control and Prevention (CDC), from private foundations, and from State earmarks, all of which supported the implementation of the SOHCS grant.

Thirteen grantees, however, reported that they lacked adequate financial resources to implement their program. A few examples of the funding constraints and the subsequent results are described below.

- Funding that supported a fluoridation specialist was lost from another source. The SOHCS grant built on the specialist's work and had to change its focus when funding was cut.
- The increase in funds through SOHCS was offset by a reduction in Title V funding, and the tight State budget pitted programs against one another for funding.
- Because of award notice timing, several States with long lead time procurement requirements had difficulty obtaining supplies due to the fact that they could not make requests prior to an official notice of award recognition in the State system.

Information

Having strong sources of information was cited as critical to successful implementation. The Association of State and Territorial Dental Directors (ASTDD) was a primary source of information. The Web site, its resources, and the ASTDD consultants were all very important to grantees. The Health Resources and Services Administration (HRSA) was also cited as a source of information; this information included previous reports, MCH Web conferences, and discussions with Mark Nehring, Director of the (HRSA) Maternal and Child Health Bureau's (MCHB) Oral Health Program. The national Oral Health Conference in particular gave many grantees the opportunity to network and obtain information on best practices and proven approaches. Some grantees also indicated that technical assistance was important to their success. More specifically, States indicated that they had received evaluation support from universities and the American Academy of Pediatrics, as well as technical assistance from the CDC in order to develop training and educational tools.

One State said that the HRSA Regional Dental Director, the CDC, the MCHB staff, and consultants presenting at the Oral Health Institutes all energized and sustained the program.

Personnel

Several sites acknowledged that personnel are the most important resources and that this work cannot be accomplished without good people. Important personnel attributes included knowledge of the oral health State system, a strong background in oral health, and dedication and thoroughness in work.

Staffing issues were cited as barriers to implementation by 27 grantees. There were a number of staffing issues, including the inability to find suitable personnel for vacant positions, the inability to hire appropriate personnel due to position elimination in the State system, and high staff turnover. Interestingly, grantees without a State Dental Director felt challenged in implementing SOHCS and other oral health activities.

Grantees identified a number of creative strategies to address staff shortages. They conducted formal solicitations for new staff members (through the Dental and Dental Hygiene Associations) as well as informal word-of-mouth solicitations. They used connections through the Outreach Coordinator to identify willing providers in the community. They also sought out volunteers to work on SOHCS programs.

Staffing and Other Challenges to Building Relationships and Promoting Oral Health Programs

One State runs a year-round school-based dental clinic for 2,200 children in six schools. It was very difficult for the State to find a dentist; it seemed that no one wanted to do this critical work. A partnership with the local hospital became critical in filling this need.

The lack of a State Dental Director slowed progress. There is a manpower shortage in the program itself, and there have been difficulties identifying volunteers in the community to participate. There are few dentists that accept Medicaid in the community. Dental hygienists are willing to participate, but there are limitations on how much hygienists can help because of the Dental Practice Act, which requires direct supervision of public health hygienists. The State Health Department is trying to amend the Dental Practice Act to give public health hygienists the ability to conduct screenings and sealants under general supervision rather than direct supervision. A bill was submitted in the past legislative session, but it was rejected, because the Dental Association had issues with the wording of the bill. It is now in the amendment process and will be reintroduced in the upcoming session. The grantee is trying to educate legislators and dentists to make them understand that this amendment will not threaten their practices. The former Director of the Oral Health Program and the Sealant Program Coordinator both play a significant role in these education efforts. The Dental Sealant Program Coordinator is involved with the Dental Hygiene Association to promote this effort. They have a Dental Health Consultant (who is a dentist and lawyer) who also is promoting this amendment.

States are looking for creative ways to expand their oral health infrastructure by expanding the range of health professionals who are legally able to bill for providing oral health services. However, the State Dental Practice Act and the dental community in general occasionally have stood in the way of implementing this effort. States that found a common solution or compromise between their own needs and those of dentists, hygienists, and policymakers felt that they were more easily able to ensure access to oral health services than States without such a compromise.

To address opposition from the dental community or oral health practice acts, grantees have done the following:

- Negotiated to obtain foundation reimbursement for oral health services performed by nondental professionals.
- Testified before the State Dental Society to explain their rationale for allowing nondental professionals and mid-level dental professionals to perform some dental clinical duties. The State Dental Society supported this rationale and told the grantee to continue to allow these providers to perform clinical duties. The Society also asked the grantees to report to it on an annual basis.

- Helped defeat a proposal brought by the State Dental Hygienist Society to bar dental hygienists from applying fluoride varnish. Grant staff members presented testimony explaining why they believed dental hygienists could apply the varnish safely. As a result, the Society has had a change of heart and now would like to expand hygienists' range of clinical duties.

Barriers

In one State, there were concerns expressed by organized dentistry about anticipatory guidance for fluoride varnish and the utilization of nondental professionals and mid-level dental professionals to apply them. Much of the opposition came from the organized dental community, which had the following fears and beliefs:

- Billing for oral health services by nondental professionals would decrease the "fixed pot" of funds to cover the cost of providing oral health services by dental professionals to young children.
- Nondental professionals lack the ability and skill to screen children's mouths and apply fluoride varnish.
- Dental hygienists are unable to instruct nondental professionals thoroughly on how to perform dental exams and apply fluoride varnish properly.
- Physicians may relegate children's oral health duties to lower-level providers within their practices.
- Dental hygienists may overstep their role and begin to perform dental exams and apply fluoride varnish, thereby violating the Dental Practice Act.

In another State, the Board of Dental Examiners (appointed by the Governor) learned of the fluoride varnish program and became concerned about the financial implications to dentists' practices. Opposition was unrelated to the fact that nondental providers would be applying the fluoride varnishes, but rather was based on the fact that the Medicaid agency only reimburses for two fluoride varnishes/year. The Board believed that dentists should have the ability to provide and be reimbursed for the maximum allowable applications in a given year.

Planning

Many grantees viewed planning as a critical element to success. Strong leadership and experienced individuals administrating programs, as well as extensive knowledge of the health care system, were necessary to establish and implement a solid plan. Grantees emphasized that developing a plan was time consuming, but having a plan, as well as a backup plan, was extremely important.

Existing Infrastructure, Policies, and Procedures

A strong existing infrastructure made it possible to move forward rapidly when SOHCS funding became available. Established contracts, open position slots, and easy-to-implement procurement procedures were all important in grant implementation.

Other keys to successful implementation included legislative changes in support of oral health activities. These bills typically were moving through the legislature prior to SOHCS, but SOHCS was able to take advantage when the legislative environment

changed. Several States indicated that oral health had a rising profile in their State and that the SOHCS grant made it possible to move forward quickly.

Twelve grantees, however, found that State restrictions constituted barriers to implementation. This included one State where the insurance credential process took 6 months, causing extensive delays. State restrictions on travel and on convening meetings impacted dissemination of oral health plans, requiring Directors to travel from region to region.

Grantees described how State bureaucracies were structured in such a way that having the ability to carry over funds in a multiyear grant was essential to program implementation. The SOHCS grant therefore addressed some of the issues caused by these bureaucratic structures and slow State systems, because the ability to carry over and use funds was critical to overcoming State inertia.

Five grantees found that oral health simply was not a State priority, as evidenced by a lack of internal support which created significant barriers to implementation. They found that competing against established health programs for funding and priority was a challenge. Tight State budgets pitted programs against one another for funding, and in at least one State, the grantee's MCH funding was reduced to offset the SOHCS grant award.

Chapter VII. Sustainability

The potentially transient nature of all grant programs makes the issue of sustainability an important one. Although some grantees use State Oral Health Collaborative Systems (SOHCS) program grants to fund short-term activities, most grantees use the funds for ongoing activities and expenses such as service delivery, salaries, and program development and support. These funds have allowed States to make progress in developing State-supported oral health infrastructures, and ideally, these programs will continue to operate without the use of additional SOHCS funding. This chapter discusses the extent to which these SOHCS grants funded initiatives and activities will continue without additional SOHCS funding.

The telephone and site visit discussions held with SOHCS grantees and their partners included a section on sustainability. Grantees and their partners were asked to discuss their plans for sustainability once the SOHCS grant program ended. They were additionally asked what would be required to support the activities that had been initiated or expanded with SOHCS funds.

SOHCS grantees and their partners were also asked to discuss how the Maternal and Child Health Bureau (MCHB) and other Federal agencies could support and sustain the efforts undertaken with the initial SOHCS grant.

Sustainability Strategies

In general, grantees identified sustainability as a key issue, because the programs they had put in place or supported with their SOHCS grants were important and ongoing. Many grantees indicated that some of their activities would not need to be sustained, because they were finite. However, all but 2 of the 47 grantees reported that there were activities currently funded with SOHCS monies that would need to be sustained. Eight of the grantees said that they expect to have to cut back on programs and activities at the end of the project, and 17 grantees said that they will have to do something else to sustain programs or activities at the end of the project.

In the majority of sites where the development of an oral health plan was a SOHCS-funded activity, the completion of the plan itself was only one identified endpoint. There were further activities associated with meeting the plan's goals that would need to be sustained beyond the expected life of the SOHCS grant.

In general, the types of sustainability strategies that SOHCS grantees were considering or initiating already to maintain programs and activities fell into one of several categories: (1) finding a way to integrate SOHCS programs and activities into other State activities or programs, (2) leveraging other resources to replace or supplement SOHCS funding, and (3) turning to other State or private sources of funding. The second of these strategies was the one most often cited by SOHCS grantees. It is important to note that these

different approaches were not viewed as being mutually exclusive; it was quite possible for a grantee to undertake several at once; in fact, many did.

The specific approaches that grantees cited as strategies for promoting program sustainability included the following:

- Sustaining progress through integration with other maternal and child health (MCH) programs or other health agencies. Fourteen grantees said that they will sustain the work by integrating oral health into other projects and programs.
- Sustaining progress through the leveraging of other resources. Thirty-eight of the 47 States included in the evaluation reported using this strategy.
- Turning to non-State sources of funding. Eighteen grantees said that they will use non-State monies from foundations, nonprofit sources, or other partners to sustain the project.
- Looking to the State legislature, Medicaid, or State Children's Health Insurance Program (SCHIP) reimbursement to help sustain SOHCS activities.

Sustaining Progress Through Integration

One approach to sustaining activities and programs developed or enhanced under SOHCS is for these to be integrated into other existing programs with stable funding sources. This could be done within the oral health office or by other agencies or departments. Due to the collaborative nature of the SOHCS program, many grantees have worked with colleagues in other offices and programs both within and outside of State government. Building on these relationships, the integration of SOHCS programs and activities is viewed by grantees as a viable approach to sustainability. In addition, the populations being served by SOHCS grant programs are similar to those being served by other government agencies or departments, further enhancing cross-program integration.

SOHCS projects have assisted in establishing State oral health baselines for surveillance, planning, performance measures, and/or future evaluation in **Kentucky**.

In **Virginia**, SOHCS projects have increased collaboration with MCH and Head Start (HS), providing possible opportunities for future collaboration and/or oral health program sustainability beyond all grant funding.

Critical findings from the grantees who reported integration as a means of sustaining progress include the following:

- Forty of the 47 grantees noted that SOHCS activities were already integrated into other existing oral health activities as part of their implementation approach.
- Twenty-nine grantees indicated that SOHCS activities were conducted in collaboration with other programs on oral health, such as Early Head Start or EPSDT.
- Fifteen grantees indicated that government program officials report SOHCS data at statewide meetings.
- Ten grantees reported that other programs used SOHCS data to justify programs and program expansion.

- Twenty-two grantees cited using the SOHCS program to form partnerships.

Fourteen of the States indicated that they would at least attempt to sustain SOHCS activities by integrating them into other programs that share an interest or already include similar activities. One question that was investigated was whether programs featuring certain activities were more likely to be integrated into existing programs than others. Another issue that was considered was whether there were any particular activities that were not seen as being able to be integrated into another program. The results indicated that there were no activities that precluded integration into other programs. Of the 14 States that cited integration as a potential method for sustaining:

- Nine funded **surveillance**
- Eight funded **infrastructure building** activities
- Seven funded the **development of training modules** (education of providers)
- Six funded **dental education**
- Five funded **fluoride varnish**
- Five funded oral **screenings and exams**
- One funded a **dental sealant** program
- One funded **cleaning/restoration** activities
- One funded a **social marketing campaign**.

States often cited the MCH program as one that might be able to integrate SOHCS activities. The MCH focus of the SOHCS grants could make the State MCH program a natural long-term home for programs initiated or expanded with SOHCS grant dollars. Additionally, oral health is an element of the Title V Needs Assessments conducted by all States in 2005.

Of the 14 States citing integration as an approach to sustainability, half indicated that they had or would attempt to integrate SOHCS activities within MCH. Several indicated that they would look to support and expand SOHCS-funded oral health activities with funds from the MCH Title V Block Grant. Others, such as Minnesota, indicated that there was a plan to integrate oral health screening into the current early childhood screening processes.

Several grantees also were turning to other health programs to examine the potential of integrating SOHCS activities for the longer term. In some cases, grantees were looking at potential matches with the epidemiology program, the oral health program (when it fell outside of the domain of MCH), and the State Health Policy Commission and across the Department of Health as a whole.

The demonstrated success of SOHCS activities and the fact that **South Dakota** was able to get Federal funding to support part of a position made the State further value the contributions of the project. MCH has indicated that they probably will be able to continue to support the program with Title V funds, if needed.

In **Virginia**, Bright Smiles has been one of the more valuable programs in recent years and the grantee indicated that they would try to sustain it. The Dental Director will seek Title V funds to support the program if needed.

Examples follow:

- In Kentucky, the oral health program is working to incorporate the State oral health surveillance into the State epidemiology system. They would like to see the Division of Epidemiology include oral health surveillance as part of its regular surveillance.
- In New Mexico, the results of surveillance conducted under SOHCS may demonstrate the need to support a salaried position through the Epidemiology department. They have started talking to the State Health Policy Commission and Department of Health Epidemiology to look for permanent support, and there are favorable signs.
- In Maine, oral health funding will support a scaled-back version of the Advisory Committee.
- In the Marshall Islands, the Ministry of Health will continue the program. By training local people using local expertise, the SOHCS grant has addressed infrastructure development in a way that will enable it to be sustainable.
- In Minnesota, the oral health program will be able to pay for regular updates to the data book.
- In Missouri, fluoride varnish will be included in basic public health programs.
- In Ohio, as a result of collaboration fostered by the SOHCS grant, other State agencies have developed skills and interests in oral health. These interests will continue with the support of a CD and previously developed materials.

Sustaining SOHCS Progress Through the Leveraging of Other Resources

The SOHCS grants consistently gave States the opportunity to put programs and practices in place that were considered valuable and worth funding. Some grantees believe that the State itself, or agencies within the State, will find a way to leverage resources that can pay for what SOHCS has established.

Of the 47 States that were included in the evaluation of the SOHCS grant program, 38 stated that they would attempt to sustain their current SOHCS-funded progress and programs by leveraging the success of the SOHCS activities to obtain further funds either from the State or other sources. Specifically:

- Seven States planned to leverage State monies (Arizona, Kentucky, Marshall Islands, New York, North Carolina, Vermont, and West Virginia) to support SOHCS activities
- Eighteen States plan to leverage funding from other sources (Colorado, Connecticut, Washington, D.C., Delaware, Georgia, Illinois, Indiana, Louisiana, Maine, Nebraska, Nevada, New Hampshire, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, and Washington State)
- Twelve States intend to leverage funding from both State and other sources (California, Florida, Maryland, Massachusetts, Missouri, New Mexico, South Dakota, Utah, Virginia, Wisconsin, and Wyoming).

When SOHCS grantees indicated that State monies would be used to sustain SOHCS activities, there was little consistency regarding who would provide the funding. For the most part, State agencies or programs developed new funding that would include SOHCS programs among their own or they were absorbing salary costs that previously had been paid for with SOHCS grant monies. There were very few instances where the programs had become self-sustaining. Possible sources for State funds are shown in Table VII.1 below:

Table VII.1: Examples of State Monies to Sustain SOHCS Activities

State	
Arizona	Title V dollars or State dollars. The coalitions fund small projects (like needs assessments) from Title V.
Kentucky	Division of Epidemiology. They believe that this will take $100,000 per year.
Marshall Islands	Ministry of Health.
New York	All provider sites are sustainable because services are billable. The position of Statewide School-based Program Coordinator will be funded through other State funding. They are in the process of requesting this funding now.
North Carolina	The State Health Director is in favor of the project. The State has partnerships with pediatricians and policymakers and a “never say die” attitude. They are not positive where the money will come from if it isn’t the MCHB, but they are certain the program will continue. (The new HS Oral Health Grant will provide services to older children.)
Vermont	The legislature may fund the district health positions; if so, it will have 12 new half-time positions in district offices. Dental hygienists in each district office are the contacts for oral health summits. The Governor proposed an oral health initiative that would fund these positions with State money. That would provide the infrastructure to help put some of the plan into place.
West Virginia	McDowell County is already on its own with funding from the Primary Care Association. The other two counties can be sustained once SOHCS funding ends.

Turning to Non-State Sources of Funding

Eighteen States indicated that they would turn to non-State sources of funding to sustain or attempt to sustain SOHCS activities. Most of these States are looking for support from private foundations to support their programs. Although many of these States have strong track records seeking and receiving foundation funding, this is not universally true. What does typify this group of grantees is that for the most part, they are looking at sustainability on a year-by-year (or short-to-midterm) basis. The most common approaches are as follows:

- Look to foundations for funding for the programs as they currently exist.
- Set up their programs as nonprofits and apply for funding.
- Approach counties and local governments for funding.
- Use partners and connections to appeal and apply for funding.

Examples of sources from which States will attempt to sustain their SOHCS activities are shown in Table VII.2.

Table VII.2: Examples of Non-State Funding Sources to Sustain SOHCS Activities

Connecticut	The State is expecting the data to demonstrate that this is an effective program (increasing sealants applied and link to dental home). They plan to use these data to apply for other funds to support expansion of programs. Two counties have been very successful at looking for local funding opportunities (municipalities, school systems, foundations) to sustain programs as well.
Delaware	They are looking for other funding opportunities to sustain other (nonsealant) activities; the plan is that the Oral Health Coalition will be a nonprofit organization.
Illinois	The overarching goal for this SOHCS grant was to institutionalize its activities. External foundation support has helped ensure sustainability into the future.
Maine	They will look for other sources of funding for the child health survey with oral health questions – they do not believe they will obtain State funding without help from non-State sources. They want to keep supporting the Dental Access Coalition, but they may want to look for other sources and will look to sustain SOHCS activities through other grants and sources.
Nebraska	They are working with the Dental Association to put together an oral health package to approach the State legislature. The Dental association wants a mechanism for certain cost-of-living increases for Medicaid cost reimbursement. Also included in the package would be monies to replace old equipment in the drinking water program, and the salary for the State Oral Health Director's office assistant. If funding for the entire package is not secured, then the Association is committed to helping find the money for at least the salary of the office assistant.
New Hampshire	The Southern New Hampshire Area Health Education Center (AHEC), together with the Northern New Hampshire AHEC, is in the process of writing grants applications to foundations to expand their work in the north and sustain it in the south. They are considering expanding the focus to include older children. They believe that this will make them more appealing to organizations providing funds.
Oklahoma	Their corporate partners, foundations, and professional organizations are very influential and their connections with them will help in sustainability and expansion efforts.
Oregon	Each site has an internal sustainability plan to continue their programs – it was a condition of their grant application to the State.
Pennsylvania	The Chester County Community Dental Program (nonprofit) does generate revenue and so some of those funds are available to them, but they are already exploring options for outside funding. They have brought in a development team to build their donor base and are in the process of applying for grants (local foundation, the American Dental Association, private corporations). They will continue to rely heavily on their volunteer staff.
Rhode Island	The coalitions are doing a good job, but they do not have their own separate administrative structure and funding (or 501(C)(3) status.) It takes time to build infrastructure – they are still building. They are aggressive in seeking resources whenever they have been made available – Association for State and Territorial Dental Directors mini-grants, SENIOR grant funding, etc. Whenever possible, they have partnered with others to get support.
Texas	The State Dental Director is determined to find monies to continue the program. The State Dental Director believes that the monies won't be made available by HS or from MCH sources, but believes that they will be obtained.
Washington State	They are working to plan by having the data and partners available so that future grant applications will be more lucrative and successful.
Washington, DC	They anticipate receiving funding from the BlueCross BlueShield Foundation to sustain the program at least for another year.

Using a Combination Approach to Program Sustainability

Twelve States were approaching sustainability by looking for both State and non-State resources. These grantees were usually pursuing one fairly certain source of funding and several less-certain sources. Many States are looking to their legislature for funding for oral health programs. While some of the approaches to the legislature are to fund programs separately from services, most often the legislation offered is either to change rates that can be billed for oral health services or to expand the types of health care providers (e.g., physicians) who can bill for the provision of oral health services. Sometimes even when the State has agreed to billing changes, appeals for funds must be made to change Medicaid and SCHIP billing systems to enable them to accept oral health charges from nontraditional providers.

> An attempt currently is being made in **Virginia** to put in place a Medicaid billing system to permit physicians to be able to bill for screening and sealant activities.

Examples of the multiple approaches that SOHCS grantees are taking or propose to take to sustain current activities are shown in Table VII.3. Because SOHCS grants have provided funding for various demonstration periods, programs are given an opportunity to develop and flourish, making them much more appealing to both public and private funding organizations.

Table VII.3: Examples of Multiple Approaches to Sustain SOHCS Activities

State	
California	Their original goal was to establish legislation around these issues. They have listed the conduct of a needs assessment as a policy recommendation. Given that they have recently conducted a needs assessment, they cannot ask for an additional one for another 2 years. Having State funds would be helpful, and they continue to seek other funding sources as well.
Florida	They hope that their State oral health plan can become a nonprofit coalition. They have created a URL for it and have placed local profiles, the Plan, and updates on the Web site. They would like to be independent so that they can solicit their own funds. They will continue to use State funds as they are made available.
Massachusetts	Smart Smiles will move forward: half of all schools are already involved, and partnerships will continue. Financial reimbursement is through Medicaid. They are not certain about HS funding. They have a nondental professional oral health assessment training this summer for children aged 0–3 on oral health education and disease prevention; this will be funded by a grant. They are hopeful that they will get the State to pay for this training so that it can be repeated.
New Mexico	The Governor's Council may have some sustainability ideas, in addition to what they are hoping will be funded by State dollars.
South Dakota	Receiving the SOHCS grant legitimized oral health as an important issue, and it is now seen as a priority by State legislators. The SOHCS grant has strengthened the Delta Dental grant application.
Utah	They recently secured an additional $10,000 in funding from Medicaid and a private foundation to continue the campaign. They will continue to find more funding sources. They will maintain existing contacts with media partners and continue to work with Baby Your Baby on more media outreach. They also will

State	
	be contributing oral health information to Baby Your Baby's educational materials.
Virginia	HS has expressed a commitment to continuing the program. A representative from the HS Collaboration Office who is also on a national bank's HS Advisory Committee (they volunteer in HS programs) received a grant from the bank to continue the program.
Wisconsin	The SOHCS grant was instrumental in winning a highly competitive award from the BlueCross BlueShield of Wisconsin Foundation. They point to the regional oral health infrastructure as already being in place. They were also able to obtain Medicaid reimbursement. Within the Bureau of Health Information Policy, a policy analyst functions as a grant writer and has already identified some private funding sources. Oral health consultants have been able to secure additional funding from Delta Dental and AHEC grants.
Wyoming	The State legislature recently approved funding to expand the pilot program statewide. Outside funding was secured to keep printing the Gilly the Gator series. They are looking for funding to support quarterly coalition meetings; funding has not yet been secured, but they are working on it.

Are Sustainability Efforts Taking Place?

There is a high degree of variation among the States regarding the extent to which they proactively are undertaking initiatives to promote sustainability, including States in which sustainability is being considered but without much emphasis. These variations include differing approaches to integration, seeking permanent State funding solutions, and going outside the State for grants and private partners. Many States have taken preliminary steps but appear to be waiting to see if funding will continue to be available. States with ambitious programs, grant writing capacity, and connected partners are the most likely to seek ways to secure additional or non-Federal funding.

In **Louisiana**, the State Oral Health Director plans to pursue relationships with partners (Schools of Dentistry and Dental Hygiene) and use faculty members, dental residents, and dental hygiene students to provide these services as well.

Potential Ways MCHB and Other Agencies Can Support Sustainability Efforts

Attempting to build sustainability into a program can be a time-consuming and difficult undertaking. For that reason, and to enhance the likelihood that programs, activities, and the outcomes of SOHCS-funded efforts can be sustained beyond the existence of SOHCS grants, it is important to establish the roles MCHB and others play in sustainability efforts.

In general, States did see several ways for MCHB to support the sustainability of SOHCS grant undertakings through further funding, the structure of the grant, and other MCHB activities. Not surprisingly, the most frequently cited suggestion from grantees on ways to help sustain SOHCS activities was for MCHB to provide more funding. Seventeen of the States felt that further funding through SOHCS grants as well as other oral health funding opportunities would enhance the sustainability of SOHCS activities.

States also saw ways that MCHB could improve the sustainability of SOHCS grant activities by modifying or changing the requirements for the grants. Twelve States felt that it would be easier to sustain SOHCS grant activities and enhance the support for oral health activities in general, if MCHB would make oral health a priority in all MCH programs. Respondents felt that the MCH programs in their States would be more responsive and supportive of SOHCS and other oral health activities if (1) there was a clearer and more consistent message from MCHB that oral health was a priority and (2) that this priority was reflected with mandates to address oral health in all programs that used MCHB dollars.

Four States recommended that the SOHCS grant be modified to require measured outcome objectives as part of the SOHCS grant activities. These States all found that having data from their undertakings enhanced the acceptability and value of their programs within their States and made it possible for them to find funding and "homes" for them.

Grantees saw other Federal agencies, such as the Centers for Disease Control, the HS Bureau, and the Centers for Medicare and Medicaid Services, as also being able to play a role in supporting the sustainability of the activities that were initiated with the SOHCS grants. These roles were very similar to some of the roles identified for MCHB, starting with funding support. Many grantees felt that the offering of additional grants addressing oral health would be supportive of sustaining SOHCS work. Additionally, many grantees believed that if agencies articulated oral health as a priority, or at least as an important health issue, this would help establish permanence for SOHCS undertakings.

The ability to have unspent grant funds available for use in a subsequent year of the grant was highly valued. As discussed previously, carryover was typically due to contracting and hiring delays rather than a lack of planning. Projects depended on their ability to carry over funds. Six of the sites said that they would have to discontinue their projects if carryover requests were not granted, while others said that without carryover, they would have been unable to honor their contracts, or that it would have affected purchasing resources and equipment. Several said that they would be unable to expand as planned if carryover requests were not granted. Although most sites did not anticipate needing a final no-cost extension, six grantees did anticipate such an extension and six were not certain.

One of the very clear messages from all data collected is that, for the most part, the dollars from the SOHCS grant are seriously needed to carry out oral health work and strengthen oral health infrastructure across the United States.

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Chapter VIII. Grantee Feedback

All 47 respondents were given the opportunity to make feedback to the Maternal and Child Health Bureau (MCHB). Grantees were asked to share their experiences with the State Oral Health Collaborative Systems (SOHCS) grant process as well as their suggestions for future MCHB oral health initiatives. This feedback is provided with the intent of informing the MCHB of the States' ideas on how to enhance their ability to "develop, implement, or otherwise strengthen State oral health collaborative strategies that increase access to oral health services."[2]

MCHB Guidance and Application Process

Above all, grantees expressed their appreciation and gratitude to the MCHB for offering funding that allowed them to focus on oral health in the MCH population. Grantees reported that the flexibility of the grant allowed them to pursue a broad scope of activities, and that flexibility was regarded as the key strength to this initiative. Nonetheless, grantees offered many suggestions for improving the SOHCS grant process and future oral health initiatives.

Although many of the grantees (45 percent) interviewed felt that the application guidance provided by the MCHB was helpful in planning their program, more than half of the grantees (53 percent) offered suggestions to make the grant application guidance more useful and the process more practical.

1. **Increase communication with grantees**
   Grantees emphasized that MCHB could be more readily available to answer questions about the application process and the guidance. Grantees reported that they found some of the language in the guidance to be confusing and unclear and that they were unable to make contact with the MCHB in a timely manner.

2. **Improve clarity**
   Discussions with grantees indicate that the grant application guidance could be made more user friendly. Several grantees suggested that MCHB compose guidance with consistent language and common terms in order to make it as straightforward as possible.

3. **Streamline process**
   Several grantees suggested developing a more streamlined process with less paperwork.

[2] Request for Task Order Proposal number HRSA-05-N240-5281-MLM

4. **Look to other grant initiatives' guidance for ways to be more clear and helpful**

Many of the respondents have received grants from other agencies and felt that those other agencies provided more comprehensible application guidance. It was suggested that MCHB look to other agencies for direction on how to write the SOHCS guidance.

Program Reporting System and Requirements

SOHCS grantees are required to submit a range of reports to the MCHB, including progress reports, payment management system quarterly reports, and financial status reports. During interviews, grantees were invited to talk about their experiences with the reporting requirements of the MCHB.

Grantees had mixed opinions about the MCHB reporting system and requirements. While most grantees (67 percent) were satisfied with the program reporting requirements, a small number cited frustrations with the electronic reporting system. They had a difficult time accessing the Web site because of mistaken names and passwords, and they reported frustration with MCHB's response time in resolving these issues. Additionally, many grantees felt that the system was hard to navigate, but they believed that the process could be smoother with additional training on use of the Electronic Handbook. While respondents found most features of the system to be challenging, many grantees appreciated the Electronic Handbook's self-correcting feature.

The following are grantee stated areas for improvement:

1. **Increase communication**

A common request was that MCHB improve their availability to answer questions, thereby improving response time. Additionally, grantees suggested that the reporting process could be improved by having the Health Resources and Services Administration help center work longer hours to accommodate grantees in the various time zones.

2. **Offer technical assistance (TA) on the Electronic Handbook reporting system**

Grantees largely reported that additional intensive training and continued support on operating and using the Electronic Handbook would be beneficial.

3. **Increase funding**

Several respondents stated that the program reporting requirements took a large amount of time to complete and therefore took money away from oral health activities. Increased funding would help to cover the costs of administrative responsibilities without taking away from programming.

4. **Extend timelines**
Many grantees reported that in order to avoid interruption of program activities, timelines should be extended. Grantees reported that short application and/or reporting deadlines were an issue. Also, some grantees encountered technical difficulties with the electronic handbook, which made it difficult to meet deadlines.

Feedback Regarding the SOHCS Grant Program

Many grantees expressed their appreciation for the SOHCS grant program, which for some States serves as the only source of funding for oral health activities. In order to help MCHB in its efforts to improve the SOHCS program, several grantees (29/47) offered the following general observations:

1. **Facilitate the sharing of best practices**
Most grantees indicated that they often learned at meetings or through informal channels that they were struggling with the same issues as their fellow grantees. These grantees indicated their desire that MCHB use its unique position to help facilitate communications between grantees and to help coordinate joint activities. Grantees assumed that MCHB was aware of each State's program and felt that it was easier from their centralized position to bring together similar projects. Grantees repeatedly emphasized that the opportunity to learn from and about the other grantee programs is extremely valuable.

2. **Improve communication**
Several grantees suggested that MCHB improve their communication channels by reducing response times and providing live telephone support. Additionally, grantees suggested that MCHB followup with the State programs to review expectations and requirements for the SOHCS grant immediately after grantees are awarded the grant.

3. **Increase funding**
Not surprisingly, grantees most often suggested that MCHB increase SOHCS grant funding to improve the program. Not only would additional funding allow for enhanced programming, but expanding the size of the grant would also allow grantees to support full-time oral health consultants. Furthermore, an evaluation component then would be viable.

Feedback Regarding Future MCHB Oral Health Initiatives

In addition to offering suggestions specifically for the SOHCS grant program, grantees were afforded the opportunity to provide comments and make suggestions regarding any future MCHB oral health initiatives. Approximately half of the grantees (23/47) provided suggestions; the ones most frequently mentioned are as follows:

1. **Provide leadership at the Federal level**

Most grantees look to MCHB to take a leadership role and offer specific direction for State initiatives. Grantees emphasized that such leadership would help give SOHCS and other oral health activities more legitimacy when trying to justify their program to other MCH programs. Respondents felt that the MCH programs would be more responsive and supportive if there was a clearer and more consistent message from MCHB that oral health is a priority.

Furthermore, grantees recommended that MCHB review and compile State-level products to distribute to all State Dental Directors. One grantee noted that the National MCH Oral Health Resource Center has been helpful in getting out materials, but that it is from a primarily national perspective, which is not as useful for States.

2. **Continue offering flexible grants**

The majority of grantees (74 percent) felt that the flexibility was the greatest strength of the SOHCS grant. While grantees would like MCHB to continue to offer flexible grants, they also expressed an interest in more outcome-oriented grants. Four grantees recommended that MCHB modify the SOHCS grant to require that outcome objectives as part of the SOHCS grant activities. These grantees found that the data from their activities enhanced the acceptability and value of their programs within their States.

3. **Offer more grants addressing oral health**

Grantees suggested that MCHB expand initiatives for special populations, such as pregnant and postpartum women. Additionally, grantees recommended that MCHB explore using the Learning Collaborative Model to help improve the nondental and dental workforce's ability to serve children with special health care needs effectively and engage their families more actively.

4. **Continue and increase funding for oral health initiatives**

Respondents suggested that MCHB change the formula allotting MCH funds to grantees. These respondents felt that grants should be multiyear grants, because oral health is a large issue that cannot be improved in a short period.

5. **Incorporate oral health into all aspects of MCHB-funded initiatives rather than creating more stand-alone oral health initiatives**

Grantees suggested that MCHB consider methods of integrating oral health programs with other child health policy initiatives and academic institutions.

TA Needs of Grantees

More than half (28) of the State grantees reported that they either had past TA needs or have current technical assistance needs. TA topics that were most frequently mentioned by these grantees include help with using the electronic handbook, surveillance, and

program evaluation. Various other topics were additionally referenced and are highlighted in the Table VIII.1.

Table VIII.1 TA Needs of Grantees

Grantee	Reported TA Needs
Mississippi	Would appreciate help in developing an oral health plan.
Minnesota	Needs assistance on successfully documenting the link between inputs and outcomes
Oklahoma	Wants TA on how to encourage nondental providers to address oral health issues with their patients
Palau	Needs training on grants management and reporting
Maine	Would like assistance in financial management and also on developing realistic objectives
Alaska	Would like TA on using Microsoft Excel or other computer programs to present data
Rhode Island	Interested in learning how to engage nondental professionals in oral health issues

Although these examples are very specific, many grantees also expressed a strong desire for MCHB to publish a general best practices guide for grantees. Grantees provided examples of what could be included in this general guide:

- Exemplary programs that can serve as models for other MCHB-funded programs
- Templates of oral health and surveillance plans
- A list of MCHB available resources and expertise.

A critical point for MCHB to understand is that not only can MCHB address grantees' TA needs, but other grantees may be able to assist in providing TA. In fact, a number of grantees already have provided TA to other grantees (39 percent), and many grantees (36 percent) feel that they are well-equipped to provide TA, although they have not done so yet.

Examples of State grantees that have provided TA:

- **Alaska** presented at both the 2005 and 2006 Northwest Occupational Health Conference roundtables about Basic Screening Survey data collection method and issues. They also presented at a 2005 MCH epidemiology meeting by teleconference on the development of a surveillance plan.
- **Arkansas** presented at a SOHCS grantee meeting on school dental clinics and at a local conference.
- **Massachusetts** provided TA on school-based sealant programs to three communities outside of Boston.
- **New York** assisted Maine and Louisiana with the preparation to implement a statewide school-based dental program.
- **New Mexico** presented at the SOHCS grantee meeting on how to increase sealant programs in schools and enrollment in Medicaid and the State Children's Health Insurance Program.

- **The District of Colombia** often has been asked to discuss their experience with implementing school-based sealant programs.

The grantees that reported being capable of providing TA to other grantees offered very specific subject areas for which they could provide assistance. A few examples of these topics are listed in the table below:

Table VIII.2 TA Topics that Grantees Could Provide

Grantee	TA Topic that Program Could Provide
California	Organizing oral health coalitions
Iowa	Infrastructure building
Louisiana	Building collaborations and engaging partners and also on implementing sealant programs
North Carolina	Implementing fluoride varnish programs in pediatrician's offices
Nebraska	Web page development
Oregon	State plan development and early childhood caries prevention models
Pennsylvania	Program implementation
Vermont	Establishing dental homes
Mississippi	Use of Web applications for surveillance and data collection

Overall, grantees perceived the SOHCS grant program as a unique opportunity that allowed them to focus specifically on and address the oral health needs of the MCH population within their State or Territory. Although many grantees offered constructive suggestions on how MCHB could improve the program, it is safe to say that no grantee would want this program to disappear.

Chapter IX. Key Findings and Conclusions

States have been receiving State Oral Health Collaborative Systems (SOHCS) grant funding since the program's first funding cycle in 2003. The grants were issued to address State-specific oral health infrastructure needs. In particular, stated goals of the SOHCS Grant Program are to:

- Help stabilize State oral health program activity
- Integrate oral health into State maternal and child health (MCH) programs better
- Address Maternal and Child Health Bureau (MCHB) performance measures
- Implement the Surgeon General's Call to Action to Promote Oral Health as it affects women and children.

The goal of this evaluation has been to analyze the impacts that the SOHCS grants have had on the grantees and on the oral health infrastructure of their States. The evaluation has been structured to focus on two key evaluation questions:

- Have the grantees been successful in achieving the goals that they initially had proposed?
- How has the SOHCS grant contributed to the development of an oral health system of care?

The evaluation questions were addressed using both secondary data drawn from the State SOHCS applications and grant reports and primary data collected through interviews, be they by telephone or in person. It is important to note when discussing the conclusions drawn from this study that the self-report data were not subjected to corroboration.

The results of this evaluation indicate that most of the grantees have been successful in achieving the goals that they initially had proposed. The evaluation documents some setbacks that were encountered and issues that arose that changed timelines, types of staff members working on projects, and the speed at which monies were used. However, it was only in rare cases that initial goals had to be completely altered because of a change in environment or other circumstances that would render them impossible, unnecessary, or less than useful. Indeed, most grantees felt successful; 85 percent believed that their activities funded with the SOHCS grant had been very effective.

The evaluation documents the many ways in which the SOHCS grants were used to develop a State-level oral health system of care. While in some cases the SOHCS grants were used to support existing programs or initiatives, more often the grants were used to address directly issues, problems, or situations that previously had remained unaddressed due to funding shortages or inflexibility. Forty of the 47 grantees reported that their SOHCS grant activities were closely related to other oral health activities in their State. SOHCS grants often funded personnel who could devote themselves to MCH oral health issues. These personnel worked on activities that fell under assessment, policy

development, and assurance. With SOHCS grants, oral health plans were written and disseminated; networks and partnerships were built to support oral health care for the MCH population; education was conducted for health care providers and the public; services such as oral health screenings, sealant applications, and topical fluoride applications were delivered; oral health technical assistance (TA) was provided; and monitoring and evaluation systems that contribute to enhanced reporting on MCHB's performance measures were enhanced to include oral health better.

In this chapter, we will synthesize the findings from the evaluation data and, based on these data and the evaluation as a whole, will offer some ideas for MCHB to consideration lessons learned from this evaluation.

Conclusions from Evaluation Data

Grantee planning activities

SOHCS grant activities were planned to be closely related to other oral health activities in the State. Almost all States reported that they were using their SOHCS grant to expand or maintain existing programs or to strengthen planning or systems building; that is, they were working, to the extent possible in their State, within an existing oral health framework and, to the extent that there were other oral health activities in the State, with consideration of other oral health activities. The grantees had relationships with the Title V agency, albeit some that were closer than others. Not all of the grantees receive funding from the Title V agency. They most frequently work together around the annual update and 5-year needs assessment as well as the MCHB performance measures related to oral health.

The grant application process was typically a straightforward one. The grant application process did not pose problems for many of the grantees. The grant provided an opportunity to bring people together to formulate goals. Many States were looking for ways to fund the strengthening of their oral health program and so they had been thinking about the issues – the SOHCS grant provided a much desired opportunity. The most typical problems included difficulty bringing together the people necessary to formulate the grant response or plan for the grant response, State policies that were cumbersome to navigate, and insufficient time because of a too-short turnaround time when considering State bureaucratic procedures – although none of these were mentioned by more than 15 percent of the respondents. An unexpected issue arose when discussing the grant application process: while there was the impression that the process had been relatively straightforward, in many States the individuals responsible for writing the original SOHCS grant applications were no longer available.

Goal setting was often data driven. The goals that were set for the SOHCS grants by the States were typically data driven – either using State or national data (e.g., surveillance data, Basic Screening Survey). In approximately half of the grantee States, the goals were modeled on evidence-based practices endorsed by leading health organizations (e.g., the Association for State and Territorial Dental Directors [ASTDD], the American Academy of Pediatrics, the American Academy of Pediatric Dentists, the

American Dental Association). Approximately half of the States (but not an identical set) used their State data to establish their goals for the SOHCS grants.

Implementation

States were able to use the SOHCS grants to address a broad range of needs. Due to funding flexibility, grantees implemented a broad range of activities to expand oral health infrastructure. The SOHCS grant monies were typically used by a single State to address multiple ASTDD core functions; States often addressed two functions, such as assessment and policy development or assessment and assurance. For example, with some fluoride varnish programs, there was an educational component, thus combining assessment and assurance. The most commonly reported activities that were funded using the SOHCS grants were screenings/oral exams (70 percent), oral health education (62 percent), advocacy and policy development (53 percent), and surveillance (47 percent).

Partners played a critical role in planning and implementing SOHCS-funded activities. No matter the SOHCS activity being implemented, partners were found to play a critical role. Typically, it was asserted that the oral health staff within the State government was unable to be successful in any arena without partners. Because this grant, in particular, was to build infrastructure, most grantees brought together people and organizations in support of its goals. The use of a collaborative process to work and plan requires labor intensive management. The SOHCS grant was able to be used to procure the necessary personnel to support these activities. Because of the broad range of activities undertaken, many types of partners were mentioned. Most frequently mentioned were the State MCH agency and programs; other State agencies such as Education or Medicaid; Head Start (HS); schools; the dental community and the medical community.

When surveillance activities were conducted they usually enhanced reporting on MCHB performance measures or involved oral health screenings of early childhood populations. Some fairly traditional surveillance activities with elementary school students were conducted with SOHCS grant money – although States indicated that without this funding these activities would not have occurred or would have been far reduced. The conduct of these activities provided data that was used to support expansion of State oral health programs. Surveillance in the early childhood population, predominantly working through HS was an opportunity that was able to be taken advantage of with SOHCS funding. This permitted the quantification of need among groups of children at particularly high risk for poor oral health.

Using SOHCS funds to support the salary of a staff position dedicated to the conduct oral health program activities or the development of a State Oral Health Plan raised the stature of oral health and the visibility of oral health issues. Fifteen percent of the States used SOHCS funds to support the salary of a State oral health official (e.g., State Dental Director, SOHCS director) while 26 percent used the funds to support the development of a State oral health plan. When funding the State SOHCS director, the SOHCS grant provided the oral health program the opportunity to focus on oral health and liaise with others, strengthening the program and raising its visibility. The process of developing a State oral health plan requires the engagement of a State and

community leaders. This process of engagement heightened these individuals' awareness of the importance of oral health and criticality of the oral health issues that their State faces.

SOHCS funds have been used to simplify and coordinate the oral health infrastructure of States. Many states suffer not from not having a strategic oral health plan but rather from having too many. One State can be trying to ameliorate the directions of a State oral health plan, a HS oral health plan, oral health discussed in a State chronic disease plan and a regional oral health plan. The SOHCS funds were used by some States to consolidate and coordinate the plans by working together all parties to develop a single focus.

SOHCS grants were often used to support the delivery of oral health clinical services – sometimes in innovative ways. As noted, 70 percent of the grantees used their SOHCS grants to conduct dental screenings and exams. The most typical services delivered were screenings, sealant application and fluoride varnish application. Most services were provided to children, and more than half were provided to elementary school children. Often the services were delivered where the children were – on site in schools through the use of mobile equipment or mobile dental vans. Services were also delivered at HS and Women, Infants, and Children sites. These programs also typically contained an educational component – often for the parents as well as the children.

Many States used their grant to support oral health awareness, promotion, or advocacy campaigns implementing oral health education and social marketing strategies, often in conjunction with other infrastructure-building activities. States educated parents, lawmakers, children, and the general public about the importance of oral health through SOHCS grant activities. In developing and disseminating literature, messages and providing targeted education, the SOHCS funding was used to provide clear information about oral health and what must be done at the individual and community levels to ensure oral health for all.

Training programs were also an important focus of SOHCS grant activities, and many grantees sought to expand oral health infrastructure by reaching out to pediatricians, primary care doctors, nurses, or child care providers. Several of the grantees developed training programs to train non-oral health professionals to contribute to the oral health infrastructure by conducting screenings of young children. Often motivated by extreme oral health workforce shortages, the training of these individuals was also logically tied to the fact that child care workers and primary care providers interacted with children far more frequently, irrespective of workforce shortages, than oral health providers typically would.

Successes and Challenges

While SOHCS grantees felt that they had been successful, it was difficult for those who were not providing direct services to demonstrate this concretely. Sites considered their activities funded with the SOHCS grant to be highly successful. They cited stronger relationships, increased visibility and valuation of oral health in their State, new activities, and an increased ability to form partnerships in addition to service delivery to an increased number of children. Measuring these types of successes, however, is difficult. Most sites relied on process measures to demonstrate activity and increased activity over time. Sites lacked staff members with skills in techniques such as cost-benefit analysis that might have been used to demonstrate the value of programs and initiatives.

Success was seen in many areas. The successes of SOHCS were both in anticipated and unanticipated areas. Grantees were surprised at the extent to which they were able to form new partnerships, change attitudes, and increase awareness among key stakeholders. They were, as they expected, able to increase access to services and add new staff members, but they often found that they were able to leverage initial SOHCS grant investment with other sources of funding – sometimes from the State. The SOHCS grant and the activities conducted allowed the opportunity to interact more with dentists in the State, and improved relationships with them were one of the successes attributed to SOHCS.

The ability to find and hire qualified staff members was one of the major barriers encountered in grant program implementation. Because of the complexity of hiring within State systems, staffing SOHCS grant projects was one of the major barriers encountered. The process of getting approval to post a position, posting the position, and then waiting to see if appropriate people even apply was frustrating to many. And this was not always something that could be handled by starting earlier – there were States that did not permit posting positions without a confirmed funding source. Typically, State staffing issues were something that only impacted the program at the onset. Sometimes, not all sources of hiring difficulty were anticipated. Programs found that it was more difficult than expected to find appropriate staff members – something that not all anticipated. Carryover funding was typically requested because of hiring issues.

State practice acts often made it difficult to increase the oral health workforce. The impact of State practice acts was often a consideration in the development of State plans and the approaches to workforce expansion that were undertaken. In many States, nondentists or non-oral health professionals were prohibited from performing procedures such as oral health screenings or topical fluoride applications for reimbursement. Because of litigation, States are understandably unwilling to push the envelope too far. Developing a collaborative relationship with the State Dental Association appears to be a necessary step in the pursuit to expand the oral health workforce – but not one that ensures success.

Funding will remain a challenge. Even if initiatives are able to be fully or partially sustained after the advent of SOHCS, funding will remain a challenge. This is in part true

because of the limited number of States that permit reimbursement for oral health screenings performed by non-oral health professionals. Additionally, because some States have very low oral health procedure reimbursement rates for Medicaid and the State Children's Health Insurance Program, the reimbursement is not always adequate to support practices solely serving a population with this source of insurance.

Sustainability

Most programs believe that they will be able to sustain some of the activities supported by the SOHCS grant. Very few of the States believe that in the absence of the SOHCS grant, that they will have to stop conducting all funded activities. SOHCS funding made it possible to bring something concrete to other funders – including those inside the State government. Most programs believe that the ability to put something into place and demonstrate its worth – as SOHCS permitted – will make funding easier to obtain. Many have commitments from other funding sources within State government to continue some activities. It is, however, important to note that there was no initial planning for sustainability among the grantees; they have developed as the grant period is coming to an end.

States want MCHB to continue to make oral health a priority in all MCH programs – believing that this will enhance sustainability of this and all other oral health efforts. Outside of providing funding, the States felt that the activities undertaken with the SOHCS grant would most likely be sustained (through integration with other programs) if oral health was viewed as a priority. States would like MCHB to help make this happen by making oral health a priority in all MCH grants and contracts, including Title V. With MCHB taking on this leadership role the importance of the SOHCS work would be better appreciated and, they believe, would receive more appropriate funding.

Cross-cutting findings

Programs were able to use the money to further their State-specific oral health goals and fund or leverage funding to fill holes in their infrastructure. SOHCS grants appear to have been a positive mechanism for strengthening the oral health infrastructure in States. With the exception of very large States and States with well-developed oral health programs and multisource oral health budgets, the SOHCS grant provided monies that were badly needed. In some small number of cases, the SOHCS grant gave oral health in the State a toehold that it had not had before and might not have in the future without this or a similar grant; as one State claimed, SOHCS is the oral health program for the state. In the cases of the larger or better funded programs, the grant funding was used to expand access and take on specialized projects. The projects that were put into place helped States move oral health infrastructure forward and also broadened awareness of oral health, particularly oral health for the MCH population and the status of the oral health infrastructure in a particular State. These grant monies were sometimes presented to other State offices as evidence that the Federal government considers oral health to be of high priority. It helped legitimize oral health as a focus and brought made new and/or stronger partnerships and collaborations possible.

The flexibility of the funding made it possible for some grantees to address several issues in their oral health infrastructure at the same time. As is noted in the findings section of this report, very few grantees undertook only one activity with their SOHCS grant. In fact, to address goals related to building and strengthening oral health infrastructure, 29 pursued four or more activities – with greater or lesser success. The flexibility of the SOHCS grant was highly valued by the grantees, because it made it possible to take the steps they saw as being necessary to undertake all aspects of what was necessary to address and meet oral health goals.

For grantees with less well-developed oral health programs, or from smaller States, the structure of the grant program and SOHCS grantee annual meetings were invaluable for building contacts and learning more about possible programs. Because the SOHCS grant was made widely available to the States and Territories, despite the fact that this lessened the amount given to each grantee, the SOHCS grant helped to form an expanded oral health learning community and created and/or strengthened a network of oral health professionals. The simultaneous funding of grantees at so many levels of development of their oral health infrastructure ensured that there were States to network with who had faced and overcome similar issues and problems in their past. So, while the number of grantees reduced what each grantee received, the inclusion of the large mixed group of grantees helped accelerate the ability of some of the less developed grantees to move forward and develop successfully. While some grantees are well-connected to a national oral health network of colleagues (e.g., Centers for Disease Control and Prevention oral health grantees, ASTDD, Robert Wood Johnson grants) and have a strong in-State group of collaborators and colleagues as well, other grantees were not in the same position. The SOHCS grantee meetings afforded these individuals the opportunity to make connections with others in similar situations facing parallel issues. It also was a forum for sharing approaches to overcoming barriers, information, and ideas. While not the intent of the SOHCS grant program, the building of relationships between State Oral Health Directors and other State oral health personnel strengthens the national infrastructure for the delivery of oral health in its own right.

Areas to Explore for Program Enhancement

The SOHCS grant program generally appears to be functioning smoothly and permits grantees to address a variety of oral health infrastructure issues. However, remarks from the grantees, observations by evaluators and the analysis of qualitative data indicate some possibilities for program enhancement.

Review grant applications for feasibility of the plans for hiring staff or recruiting volunteers. One of the major issues heard was the problem faced in hiring staff members to implement project activities. Many of these issues were bureaucratic and able to be solved but required time. Others were related to workforce issues that are more difficult to assess. Additionally, calendar mismatches between schools and Federal funding can also cause problems in spending money. These issues are ones that are known to the applicant when applying for the grant. MCHB should ask for an assessment of the degree to which these will apply to a grantee and steps that will be taken to address them.

Help States with cost-benefit analysis to support their being able to make the case for the value of what they are doing. It is to the benefit of both SOHCS grantees and MCHB that grantees are able to make a strong case that they are making progress and that they are being effective. TA or external resources should be made available that will help States determine what they can and should measure.

Provide more structured opportunities for grantees to meet, either physically or virtually. While there are listservs for grantees, they do not seem to afford the opportunity that is desired to exchange information, solve problems, or collaborate. Forums that would make this possible would be strongly supportive of grantee efforts, high quality of programs in each of the States, and the development of strong oral health leaders in each of the States. Additionally, it should be mandated that a certain part of the budget should be used for conference and workshop attendance to maximize the usefulness of the grant.

MCHB should continue to include oral health as a priority in the grants and contracts that it funds. As was suggested by many grantees, MCHB can help to strengthen the oral health infrastructure within States by continuing to play a leadership role. It can be more supportive of the public health oral health work force by ensuring that oral health is included as a priority in all of the programs that it funds – including its administration of the Title V Block Grants. By MCHB stressing that oral health is a critical component of overall health for all MCH populations, it will help the States develop and maintain strong oral health infrastructures. The States believe that this will lead to their State MCH programs providing them with some funding to address oral health as a higher priority need.

Appendix A: Logic Model for Evaluation of State Oral Health Collaborative System Grant Program

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Appendix A: Logic Model for Evaluation of State Oral Health Collaborative Systems Grant Program

Input	Activities	Output	Goals	Outcome
State level data, funding and surveillance Child Health Survey Federal grant program funds Legislative proposals affecting oral health policy Proceedings for the national conference *Building Partnerships to Improve Children's Access to Medicaid Oral Health Services* *Office of the Inspector General Report: Children's Dental Service Under Medicaid Access and Utilization* *Oral Health in America: A Report of the Surgeon General* *A National Call to Action to Promote Oral Health* Maternal and Child Health Bureau (MCHB) performance measures	Grass roots advocacy/champions involved in public education/awareness Medic campaigns designed to increase knowledge of oral health issues Political response to improve oral health issues	Presence of State Oral Health program and full time Program Director Formation of State oral health coalition(s) Up-to-date Statewide oral health assessments Public/Private oral health partnerships Formalized agreements among oral health stakeholders Resource sharing/leveraging/allocation Availability of technical assistance Policy development	State written strategic plans containing a minimum of 5 essential services (maximum equals 10) as recommended by ASTDD guideline Integration of oral health into existing systems of care (criteria needed)	Intermediate: Increased access to oral health services for women and children Final: Improved oral health in MCH populations

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Appendix B: SOCHS Grantee Evaluation Interview Guide

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Appendix B: SOHCS Grantee Evaluation Interview Guide

Name: _____ **Date: _____**

Phone: _____ **Time: _____**

Hello, my name is _____ and I am with Health Systems Research, Inc. HSR is conducting an evaluation of SOHCS grant program for HRSA.

The evaluation is intended to:

- Describe the goals and activities of each of the grantees and what has supported and impeded their ability to meet their goals;
- Analyze the impact of all aspects of the program and the program's ability to be continued and disseminated.

The information obtained from this evaluation will provide information to inform future programmatic and funding decisions by MCHB.

Any answers you provide for this study will be kept confidential and your name will not be identified with any answers you provide. We appreciate your being as candid as possible during this discussion – your responses will help MCHB determine the most effective ways to support its grantees as well as make a case for further funding for this program. The success you have achieved, the challenges you have faced and the lessons you have learned are all important for this purpose.

The estimated amount of time required to complete this interview is between 60 and 90 minutes. I want to thank you for taking the time today to talk to me.

Site Information: **Before conducting this interview put together the following information and send it to the site. The first step of this interview can be going through this information to make corrections as necessary.**

Program Goals:

Program Partners (if any):

Did the Site Make Requests for Carryover? (circle one) Yes No

Does State Have: (check those that exist)

- ☐ CDC Oral Health grant
- ☐ State Oral Health Plan
- ☐ State Oral Health Coalition
- ☐ State Oral Health Director

I. Planning and Development of Goals

In this section we want to collect basic information about the SOHCS grant. We want to know who is responsible for its oversight and how this decision was made. We want to learn why goals were selected and if changed over time, why this was the case.

A. Background (5 Minutes)

NOTE: Begin with the following intro before proceeding with the interview and compare with the information listed in the abstraction.

I have reviewed your program description and goals that you've included in past grant applications but would find it helpful if you could first provide me with a brief overview of your program. Then I would like to review with you some of your planning activities.

1. Tell me whether your State/community had an Oral Health Coalition prior to receiving this grant.

   Probes:
   a. Membership
   b. Conveners
   c. Funding source

2. Tell me about which agency or department houses the SOHCS grant.

3. Discuss the process that determined the goals and objectives of the SOHCS grant.

4. *Probes:*
   a. Issues during planning
   b. Strategies used to resolve conflicts
   c. Satisfaction with the process.

5. Often during the implementation of a grant the goals evolve and change over time. Describe any changes in the goals of this grant over time.
   Probes:
   a. 2003 vs. 2004 – 07
   b. Rationale for changes
   c. Realistic

B. MCHB Guidance (5 minutes)

1. Let me remind you of the MCHB's goals for the SOHCS grants.

> *Purpose of the SOHCS Grants (MCHB)*
>
> - Support states in developing, implementing or enhancing efforts to integrate oral health into state Maternal and Child Health programs;
> - Address Maternal and Child Health Bureau performance measures in oral health; and
> - Stimulate action toward implementation of the Surgeon General's "National Call to Act to Promote Oral Health" as it affects women and children.

Describe the relationship between these goals and your chosen activities
Probe:
a. Reasonable
b. Achieveable

2. Tell me about the usefulness of the application guidance provided by the MCHB in planning your program.

II. PROGRAM ACTIVITIES, ACHIEVEMENTS, AND CHALLENGES (25 minutes)

In this section of the interview we want to find out what how goals evolved into the program activities. We want to know about your key partners and the degree to which activities built and/or strengthened the Oral Health Infrastructure in your State. We also want to discuss key achievements, resources used, and the issues faced during implementation. We additionally want to explore in which ways the MCHB could have been more helpful.

Program Activities (15 minutes)

1. Describe the main activities or critical elements of your program.

   ASTDD and other leading dental organizations have identified integral components of a strong oral health infrastructure. Tell me if your SOHCS grant funds or support these items.

   Probe:
   a. Salary of the State Dental Director
   b. Development of an Oral Health Plan?
   c. Work of a State Oral Health Coalition?
   d. Leverage additional funding from the State?
   e. Collection and monitoring of State-based oral health data or surveillance system?
   f. Population-based interventions (water fluoridation, sealant programs)?

2. Described the process used to determine grant activites.
   Probe:
   a. data used
   b. best practices considered
   c. experts consulted
   d. decision on the target population/activity

   For surveillance/needs assessment grantees:
   e. Name any gaps this additional data fills
   f. The relationship between SOHCs data collection efforts and other surveillance work, for example CDC and Title V

   For Sealant focused grantees:
   g. Strategies used to address continuity of care
   h. Establishing a dental home or referral for restorative services and follow up
   i. Management plan anticipated or developed after implementation
   j. Reimbursement or billing issues for Medicaid and private insured kids.

3. How was the target audience for your activity identified.

4. *Probe:*

   a. How did manage any issues surrounding the culturally appropriateness of your activities.

5. Describe the staffing for your SOHCS grant activities. Such as specific roles and responsibilities and any changes over time.

   If not already mentioned, ask the following:
   a. Collaboration with non-dental professionals
   b. Selection process for partners
   c. Relationship between activities and State practice acts regarding screenings and treatment
   d. Strategies used to overcome any policy barriers

6. Using additional partners or agencies in program activities is an important component of infrastructure building. What partners are involved and how did you identify, recruit and manage them and any reasons for their noninvolvement.

   If not already mentioned, ask the following:
   a. Dental schools or schools of dental hygiene.
   b. State Dental Association
   c. Pediatricians
   d. Private dentists

7. Tell me about the relationship between SOHCS and the MCH/Title V agency in your State.
   Probe:
   a. Oral health a Title V priority need
   b. Oral health performance measures
   c. Your contribution to the most recent Title V Needs Assessment

8. Describe how SOHCS activities are integrated with other Oral Health activities in the State.

Achievements and Challenges (10 minutes)

1. Please list your key achievements and accomplishments.

2. Discuss any important activities, partners, infrastructure, resources related to the successful implementation of your grant.

3. Specific resources are often helpful. Tell me about your sources of resources, information, support, personnel, supplies, and financial information.

If not already mentioned, ask if the following resources were helpful:

a. SOHCS Project Officer or MCHB personnel
b. State MCH/Title V personnel
c. Technical assistance (Probe for source, such as CDC)
d. Training (Probe for funding source)
e. Networking (Probe for whether they attended an Oral Health Institute)
f. Listservs (Probe for National MCHB Oral Health Resource Center listserv)

4. Tell me about any barriers and challenges you faced in program implementation and any strategies you used to address them.

If not already mentioned, ask if the following were barriers:

a. Cultural differences working with target population
b. Working with or mobilizing partners
c. Work force or staffing issues
d. Availability of materials or resources
e. Delay in funding

5. If a carryover request was made, tell me the reasons behind the delay that resulted in this request.

6. In retrospect, how could your program implementation have been improved? What resources other than funding could the MCHB provide to you.

III. PROGRAM OUTCOMES, MONITORING, AND SUSTAINABILITY (15 minutes)

In this section of the interview we want to know what happened as a result of the SOHCS grant. It can be discrete things or they can be supportive of other efforts. We want to probe for how the outcomes and impacts supported the development and/or expansion of Oral Health infrastructure within your State. We also want to establish the permanence of the effort funded by SOHCS and whether it will go away once the MCHB funding ends.

1. Describe how effective were you in meeting your program goals and objectives.

2. Discuss what measures you used to gauge your progress towards program objectives and outcomes.

Probe:
   a. Specific monitoring
   b. Use of data
   c. Individuals involved

3. Tell me about any unintended impacts that resulted of your program either positive or negative.

4. Describe how this grant enabled you to strengthen the oral health infrastructure in your State and how you know.

5. Discuss the ways you monitor progress.

   Probe:
   a. Challenges in implementing monitoring system
   b. Development of progress reports

6. The MCHB has instituted new program reporting requirements. Describe your experience with these reports.
   Probe
   a. Elements you would modify
   b. Strengths, weaknesses
   c. Issues with and uses for HRSA Electronic Handbook and MCHB financial reports, year end reports

7. Tell me about your sustainability plan for when the grant program ends especially what elements are needed to support these activities.

   If carry over requests have been made, ask the following:
   a. Tell me what would have happened to your program if you had not been able to carry over those funds
   b. Level of anticipation re a no-cost extension at the end of the grant period
   c. Consequences of the MCHB being unable to approve a no-cost extension

8. The MCHB wants to support your sustainability efforts although future funding is uncertain. What other resources could be of help to you from the MCHB or other Federal agencies (CDC, Head Start Bureau, CMS) to support sustainability efforts.

IV. RECOMMENDATIONS FOR THE MCHB (10 minutes)

In this final section of the interview we would like to know about any recommendations you have regarding the SOHCS grant process or any future MCHB oral health initiatives. We are also interested in hearing about any needs in technical assistance or training that would be helpful to grantees as well as your final comments about the grant program.

1. Give me your suggestions on how to improve the following resources.
    a. MCHB SOHCS grant application guidance
    b. Program reporting requirements

2. Tell me about any technical assistance or training needs you have now or received TA on in the past. What topics would be useful.

3. Do you have topics on which you feel comfortable to provide TA to other grantees. Tell me about any instances where you have provided TA on these topics and what were the outcomes.

4. Feel free to share with me any additional comments or recommendations regarding the SOHCS grant program.

5. Tell me what other comments or recommendations regarding future MCHB oral health initiatives.

THANK THE INTERVIEWEE FOR HIS/HER TIME.

(Mention that you would like to be able to recontact them if, while writing up the interview, you find some questions remain.) Send out a thank you email after conducting the interview.

Appendix C: Case Study Summaries

District of Columbia
Florida
Georgia
Indiana
New Hampshire
South Dakota
Texas
Virginia
Wisconsin

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Appendix C: State Case Studies

STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

WASHINGTON, DC
May 9–10, 2006
Anne Hopewell and Sandra Silva

State Contact Person: Twana Dinnall, Dental Coordinator, Oral Health Division
State Dental Director: Emanuel Finn, D.D.S., M.S., Chief, Oral Health Division, emanuel.finn@dc.gov

Interviewees:

Emanuel Finn, Chief, Oral Health Division
Carlos Cano, Maternal & Health Officer, Maternal and Child Health Administration
Colleen Whitmore, Interim Bureau Chief, Child, Adolescent, School Health Bureau (original SOHCS applicant)
Jennifer Ragins, Health Officer, D.C. Public Schools (responsible for memorandums of understanding with the School District)
Twana Dinnall, Dental Coordinator, Oral Health Division (provided day to day management of the SOHCS grant)
Iris Morton, Volunteer Dentist (provides clinical services; e.g., sealants)
Almeta Hawkins, School Principal, Anthony Bowen Elementary School
Candace Mitchell, Volunteer, Past Chair, Oral Health Coalition
Jacqueline Watson, Founder and President, Health Concepts International, Inc. (consultant with the District regarding MCH and school health certificate programs)

Description of SOHCS Activities:

Throughout the SOHCS Initiative, the District of Columbia maintained the same goals, although the activities undertaken to achieve the objectives varied slightly by year and were progressive in nature:

- Strengthen existing oral health programs throughout the district.
- Build new systems where they do not exist and are needed to support the health and well-being of children, especially those in Medicaid and SCHIP.

The objectives outlined by the grantee included the following:

Objective 1:
Begin testing oral health surveillance system.

Objective 2:
Provide oral health services to all schools covered under the Memorandum of Understanding. Extend the program to other elementary schools and Head Start programs.

Objective 3:
Increase the active membership of the Oral Health Coalition.
Develop a community evaluation to assess the effectiveness of the Oral Health Coalition.

Objective 4:
Increase oral health promotion and education targeting low-income D.C. residents by 15 percent.

Objective 5:
Provide at least 30 percent of the underserved population with information on where they can access oral health services. Have an agreement with at least 10 dentists to provide care for the underserved D.C. population.

The first year of funding was used to plan and conduct an Oral Health Summit to build awareness of the oral health needs and access challenges faced by children in the District of Columbia. The purpose of this Summit was to engage community partners to participate in future planning activities. The Summit was well-attended but did not generate momentum towards the founding of a viable coalition. (The District now is trying to support the efforts of a nonprofit organization to lead the Coalition.)

The Dental Director also wanted to participate in a citywide surveillance program. However, the contractor hired to create the software was unable to deliver a viable product, so that objective was unable to be achieved.

The objective with which D.C. had the most success was Objective #2 – the establishment of a school-based dental sealant program. Beginning with three elementary schools in 2003 and expanding to 14 schools in 2006, the school-based sealant component of the program is reaching many high-risk, low-income children in the District of Columbia and is viewed as a model program for an urban school system. Approximately 1,000 sealants were placed in the 2005–2006 school year.

Key Partners:

D.C. Public Schools; CMS; D.C. Chartered Schools Association; D.C. Head Start; University of the District of Columbia; Children's National Medical Center Dental Clinic; Children's Health Projects; Non-profit Clinic Consortium; Amerigroup Corporation; Family USA; Health Right Inc; Americaid Community Care; Spanish Catholic Center; Chartered Health Plan; George Washington University Medical Center; Greater Southeast Hospital; Capital Dental Associates; Hospital for Sick Children; DC Health Care Alliance; Community health Clinics; Howard University College of Dentistry, and others

Planning Process – Issues/Strategies/Promising Approaches:

Prior to the SOHCS grant, the District had been without a Dental Director since 1981.

Therefore, the initial 2003 SOHCS application was written by the Interim Bureau Chief of the Child, Adolescent, and School Health Bureau with minimal consultation from Emanuel Finn, who was later hired to manage the project. The planning activities were done with little input from outside partners. However, a previous grant for $2.1 million through the Kellogg Foundation's *Community Voices Project* provided a foundation of data for the planning of this grant.

In later years, SOHCS activities dovetailed with a mayoral initiative called *Transformation Schools* so that there was media/press attention being paid to the health needs of school-aged children from the highest level of city government. The schools that were designated as transformation schools were eligible to receive additional health services. Dr. Finn targeted Jefferson Davis School in Ward 7 to inaugurate the sealant effort, because it was a transformation school. Once again, data collected for the Mayor's initiative was used to support the implementation of the SOHCS grant.

Implementation Process – Issues/Strategies/Promising Approaches:

Although some of the following issues related to the implementation of a school-based health program were anticipated, the time frame for their resolution was greater than initially envisioned.

One of the overarching challenges faced by the D.C. Oral Health Program is the lack of staff members to conduct and manage activities. In addition to Dr. Finn, Twana Dinnall, who serves as the Dental Coordinator for the Oral Health Division, also has to devote some of her time to other Health Department tasks. With a staff of fewer than two full-time employees, progress toward goals was slower than it might have been if additional personnel had been available to the project. Fortunately, a dedicated cadre of volunteer dentists has been available to assist with the clinical services.

There were also some initial issues to obtaining buy-in from the school principals. The cooperation of the principal and school nurse is important to the success of these programs, because children do miss class time while receiving services and some principals cited academic pressure as a reason for not participating. Also, schools must identify appropriate space for these services. At Bowen Elementary, the program uses library space where the children have access to books while waiting. Another school offered a storage closet as the dental space. Space limitations and constraints require flexibility on the part of the volunteer dentists.

Lastly, setting up the Memoranda of Understanding and managing HIPAA regulations involved oversight by city lawyers. Fortunately, there was a Health Officer for D.C. Public Schools to oversee that process.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

The D.C. Oral Health Program is skillful in collecting lots of data and writing project

summaries. The number of sealants placed by the program are tracked for each school as well as the number of decayed/filled primary and permanent teeth. It is understood that data helps with funding requests and that the Oral Health Program will need to seek outside funding continuously if it wants to maintain its sealant program. Kathy Phipps, who is a consultant with ASTDD, and a volunteer dentist were credited with helping with data collection process. The Program Coordinator collated and maintained the data. Among the measures collected are:

- Assessments and surveys
- Pretest/posttest studies
- Longitudinal data studies
- Annual outside evaluations.

With regard to the Electronic Handbook, the Dental Director expressed some concern regarding the security of the information but otherwise credited it with being a good system that is easy to use once it is set up.

Sustainability Process – Issues/Strategies/Promising Approaches:

At the time of the evaluation, it was unclear whether the sealant program could be funded in future years without the SOHCS grant. Due to a high degree of turnover for the Public Health Director/Chief Health Officer position at the Department of Health (this position has been turned over approximately every 8 months), the Oral Health Program's placement within the department has been restructured several times since the grant was awarded. This makes it hard for a program without its own budget to gain traction.

The District currently is facing a lawsuit filed against BlueCross BlueShield regarding lack of investment in the city's charitable care from their conversion to for-profit tax status. A request for $50,000 has been submitted, but any award is uncertain.

Also, the City Council provided $175,000 for the upcoming year, which should be enough to maintain the State Dental Director and some staff members to continue to address oral health issues. At present, there is no Title V Block Grant funding to support future efforts. It is hoped that future advocacy provided by a reenergized Oral Health Coalition located within a nonprofit organization may be successful in gaining additional attention/consideration from the City Council in the future.

Feedback to MCHB:

The Oral Health Program staff would appreciate a train-the-trainer opportunity or curriculum to educate school nurses on the importance of oral health and basic screenings. In addition, assistance in evaluation design and implementation regarding what data to collect and how to measure program outcomes within the constraints of a limited budget is considered especially important with regard to future funding applications.

Other Comments:

This program has thrived despite a number of bureaucratic and political obstacles. The sheer tenacity of the Dental Director and the cooperation of the school principals and nurses have allowed for successful implementation. Also, the commitment of the volunteer dentists staffing this program has been critical. However, there is not a history of support for oral health programs within the public health system, and private dentists have yet to be engaged effectively due to low reimbursement rates. The City struggles with a lack of broad-based collaborations to address chronic health issues, and the lack of secure funding for staff is an issue that remains unresolved.

In the Nation's capital, the need for services is very clear, but gaining attention for oral health issues in a city facing many health and human service issues remains a challenge. The Dental Director is thinking strategically that for future planning, oral health should join forces with another health issue such as obesity or low birth weight for greater visibility. Until then, this very successful program will remain vulnerable.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

FLORIDA
May 18–19, 2006
Jodi Anthony

State Contact Person: Joyce Hughes, SOHCS Coordinator
State Dental Director: Harry Davis, D.D.S., Dental Director

Interviewees:

Joyce Hughes, SOHCS Coordinator, Dental SOHCS
Tobi Goodman, Florida Department of Health (DOH), Children's Medical Services, Internal Partner
Harry Davis, D.D.S., DOH Dental Director, Dental Program
Karen Pelham, Elder Affairs, External Partner
Sylvia Byrd, DOH School Health, Internal Partner
Bob MacDonald, Florida Dental Association, External Partner
Cindy Holmes, Florida Dental Association, External Partner
Laura Levine, DOH Maternal and Child Health, Internal Partner
Lilli Copp, Head Start, External Partner

Description of SOHCS Activities:

The purpose of the SOHCS grant was to develop a strategic plan, *Florida State Oral Health Improvement Plan (SOHIP)*. The planning process included the ongoing input of a variety of stakeholders, and the resulting Plan was comprehensive so that it could be adapted and used by all partners to meet their specific target population and identified needs.

The goal of the Plan is to increase access to care, with a focus on sealants, dental visits, and fluoridation. It is then up to the local implementers and program partners to decide on the best approach given their context and target population.

The specific goals as identified in Florida's application are as follows:

In 2003:

1. Increase collaboration, communication, and support of common goals in efforts to reduce oral health disparities.

In 2004 & 2005:

1. Coordinate and facilitate Florida's Oral Health Improvement Plan for Disadvantaged Persons.
2. Integrate oral health into all appropriate DOH programs.

Although the 2003 goal is phrased in broad language, the 2003 project objectives specify the creation of the State Oral Health Improvement Plan referenced in the 2004 and 2005 goals. The 2004 and 2005 projects, therefore, represent a continuation of the 2003 project.

Key Partners:

There were a wide variety of public and private partners, including the Florida Dental Association and other bureaus and offices in State government. They also had ongoing participation of the counties, private dentists, hygienists, and schools.

Planning Process – Issues/Strategies/Promising Approaches:

The Oral Health Coalition began meeting in 1998, and while they would meet regularly to share information, they lacked common goals and strategies for how to address oral health as well as a common understanding of each partner's roles and responsibilities. The Coalition realized that to develop this common framework, they needed "glue money" to move from information-sharing meetings to the development and implementation of a plan. The timing of the SOHCS grant was perfect, because they could use the dollars to broaden the scope of the Coalition and develop a statewide plan.

Given that this need was already identified, the decision on how to use SOHCS dollars was easy and no issues were encountered in the planning process.

Implementation Process – Issues/Strategies/Promising Approaches:

The grantee set out to develop a detailed and comprehensive plan with mechanisms for coordination and clear "marching orders" for each partner. It was also very important for them to identify and plan for evidence-based practices. Not only did they want to ensure that the work they were doing was grounded in best practice, but it also helped to legitimize the process and ensure partner support. To be both broadly inclusive and rigorous required a great deal of time and effort for both the grantee and partnering programs and agencies.

The grantee was able to develop a common vision among stakeholders on the purpose of the SOHIP. In part, this occurred because the plan documented and integrated all the current oral health activities of each of the stakeholders. The plan identified specific responsibilities/activities for each partner by building on what already existed and helping partners define where they want to go in the future. As one interviewee stated, "Everyone was trying to do their own thing but didn't have the momentum or data to support their needs. Now with SOHIP, we're able to clearly describe the issues, with the hope that they'll have an impact."

The Head Consultant was a doctor of philosophy in communication and facilitation. She trained others in leading the workgroups. These skills were key in ensuring the successful participation of partners.

Other supports to the implementation of the planning process were the clear buy-in from the highest levels in the Florida DOH and in the private dental community.

SOHIP is not a plan that is sitting on a shelf. Rather, it is the framework for which all oral health activities are implemented. Before starting a new oral health initiative or deciding whether to maintain a current activity, said interviewees, high-level decisionmakers would ask, "So how does this fit in SOHIP?"

Perhaps, given that there is buy-in at a high level, partners wanted to participate. Many interviewees described that they were very happy to be at the table to ensure that the oral health issues particular to the population they served (such as seniors, or people with disabilities) would be addressed.

Similarly, the Plan is not seen as a Government Plan but as a State Plan, with the clear support of the Dental Association. This was important for engaging private stakeholders.

Since the completion of the Plan, a number of additional activities have been implemented by partners with the assistance of the SOHCS Team. New activities have included holding one forum for early childhood carries, one for minority health, and one for senior oral health.

The challenge for the future is to maintain momentum and ensure that partners at the State and local levels implement their identified strategies. If the Plan identifies new activities to be undertaken, partners need to identify the resources for implementation. Similarly, there was broad local-level involvement in SOHIP, but implementing the Plan at the local level with limited resources is the next challenging step.

To address this challenge, the grantee will work with local communities to identify their needs and then to determine which of the strategies in SOHIP is appropriate to their context. As part of this process, the grantee conducted a survey of partners to determine the technical assistance or support they would need to implement their oral health interventions (as described in the Plan). They saw this as a systematic way of identifying needs and supports. They also created a shared activity database so that local-level counties can receive ideas on how to move forward.

A universal and serious challenge is the low Medicaid reimbursement rate for oral health services. Many people are not able to access care because dentists will not accept Medicaid. In addition, many services are not included in Medicaid, and instead they require the patients to pay, many of whom cannot afford it. Interviewees were hopeful that with a unified voice, and with the increased attention to oral health due to SOHIP, the low reimbursement rates were more likely to be addressed.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

The grantee measured its success by the completion of the State Plan. They also are tracking the number and activities of local coalitions and partnering agencies. In the future, they intend to add "milestones" to the Web site to keep all stakeholders on track and aware of activities to date.

The electronic handbook worked fine for the grantee.

Sustainability Process – Issues/Strategies to Resolve:

The Plan, which was the project funded by SOHCS, is self-sustaining for the next few years. Priorities, strategies, roles, and responsibilities are clear. However, it is the implementation of the plan which most likely will require additional resources. They will need to find funds to support the SOHCS coordinator to provide outreach and technical assistance to local communities and partners.

The grantee hopes that SOHIP can become a nonprofit coalition. They would like to become independent so they can solicit their own funds. They've created an independent Web site in preparation: www.oralhealthflorida.com. It has local profiles, the Plan, updates, and more.

Feedback to MCHB:

The Dental Director appreciated the flexibility in the SOHCS grant because it allows the State to match funding to need.

The School Health Director wanted practical tips/guide for nurses and educators on how to take care of a child once the tooth gets knocked out (through fights or falls). She was also interested in learning about evaluation efforts that indicate a decrease in school absentee days once oral health services were provided to students.

The Dental Association feels strongly that a priority should be to improve dental (and health) literacy.

A few partners suggested that dentists should be trained on how to serve children with special health care needs.

Finally, one interviewee wants to integrate dental health into well-child and prenatal medical checks.

Other Comments:

Through the SOHCS efforts, Florida was able to:

- Bring together a broad base of stakeholders to address dental issues
- Achieve consensus on important goals and strategies in each sector
- Create a template that local-level decisionmakers could draw from to create their own plans
- Provided a role for all stakeholders to promote and improve oral health.

STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

GEORGIA

June 29–30, 2006; Atlanta, GA

Amy Brown

State Contact Person: Linda L. Koskela
State Dental Director: Thomas Duval, teduval2@dhr.state.ga.us

Interviewees:

Linda Koskella, Director of Oral Health Prevention Program
Thomas Duval, Georgia State Dental Director
Marsha Pierce, R.N., School Health Coordinator, Savannah/Brunswick District
Grier Godfrey, Macon/Bibb District Dental Director
Shubha Rao, Data Manager for Family Health Branch
Bernard Pohlmann, Augusta District Dental Director
Debra Smith Dublin, Waycross District Dental Director

Description of SOHCS Activities:

The SOHCS grant in Georgia has been used to continue and expand upon on previous statewide oral health initiatives. The predominant activities have been an RFP program to distribute funds among the health districts to support a variety of clinical and nonclinical activities, oral health surveillance, social marketing campaigns, and a statewide school-based health program. Georgia's program provides dental services, education, training, and technical assistance to a wide audience, including children, families, dental and medical providers, and district dental office staff members. Linda Koskella and Thomas Duval oversee these programs, but a variety of staff members at both the State and district levels help plan and administer the program components.

Four of the five goals were consistent throughout all 3 years of the grant period. The fifth goal, which focuses on outreach efforts to increase use of oral health services, was added in the third year. In addition, the scope of the project was reduced after the first year by limiting the size and number of district projects to ensure the successful management of local projects.

Key Partners:

Many of the public and private partners working on the SOHCS grant also participated in the previous Georgia Access to Dental Services (GADS) I grant activities or oral health conference, or are current members of the Georgia Oral Health Coalition. These partners include Oral Health American, the Georgia Spit Tobacco Education Program, the AAP-GA Chapter, Delta Dental Insurance, the Georgia Academy of Dentistry, the Georgia Association for Primary Care, the Georgia Dental Association, the Georgia Dental Hygienists' Association, the Georgia Dental Society, the Georgia Department of Human Resources, the Georgia Hospital Association, Hughes Spalding Children's Hospital, the

Georgia Nurses Association, the Georgia Association of School Nurses, the Healthy Mothers Healthy Babies Coalition of Georgia, the Medical Association of Georgia, Georgia State University, the Morehouse University Prevention Center, the State Office of Rural Health, the State Medicaid Office, and the Medical College of Georgia School of Dentistry.

Planning Process – Issues/Strategies/Promising Approaches:

Georgia participated in a policy academy hosted by the National Governors Association in 2001 and developed some oral health goals there. They also collaborated with the Georgia State University Policy Center to define the characteristics of an effective dental health program. They have also hosted a Georgia Oral Health Summit with nearly 130 private and public sector stakeholders to conduct a SWOT analysis to discuss oral health goals. These activities led to the first statewide oral health initiative, GADS I, which completed three systems-building pilot projects. The goals for the SOHCS grant were developed as part of an evolutionary process based on their experiences with these past oral health efforts. The SOHCS grant and the GADS I grant projects complement and supplement one another, providing community support and development activities that strengthen infrastructure, increase collaboration, address needs assessment, and strategic planning.

In addition, the idea for creating an RFP small-grant application process to distribute the funds across the public health dental districts is intended to address Georgia's independent nature. The overall purpose of this process was to give each district control over the planning and implementation of oral health promotion activities that address local needs and existing levels of infrastructure.

In the initial planning for the use of Georgia's SOHCS grant, staff in the Oral Health Section faced a major statewide challenge of recruiting dental professionals to provide clinical and education services due to noncompetitive salaries and a lack of pediatric dentistry residents in many areas. Due to recent budget constraints, county health departments also have recently under pressure come from the State legislature to focus more revenue generating activities. As a result, it has become increasingly difficult to justify investing in oral health infrastructure-building activities at the local level.

Implementation Process – Issues/Strategies/Promising Approaches:

For the small-grant program, an RFP was sent to all districts alerting them of the availability of the new SOHCS funding. Interested districts responded with a proposal for funding that addressed the oral health needs which they felt were important in their own district. For example, the Savannah/Brunswick District used its SOHCS grant to address the challenges of providing adequate access to dental care in rural, low-income communities with high levels of need. The district staff relied on prior connections to key stakeholders like school officials and the statewide social services network, Family Connections, to increase buy-in for their projects and used mobile dental units to bring oral health care services to underserved areas. In Macon-Bibb County, their prior oral

health promotion efforts had focused primarily on direct dental services. The SOHCS grant allowed them to begin focusing on basic infrastructure-building activities like providing oral health training and education and raising the profile of oral health as an important public health issue. The Augusta District recognized that other districts across Georgia were having trouble keeping their mobile dental units in good working order and decided that it would be beneficial to share the expertise of their staff person who was knowledgeable in maintenance and repair.

A couple of districts faced difficulty finding health professionals to promote and administer oral health services through their small grant programs, either because of a shortage of qualified providers in the area or because local providers did not consider oral health to be an urgent need. In these districts, intensive recruitment needed to occur prior to the start of service delivery, as well as a great deal of outreach to raise awareness among providers of the need for oral health services targeted at the MCH population. Another common challenge was figuring out how to use the relatively small amount of funds allotted to each district to accomplish all the goals successfully. In Augusta, the staff decided that they could afford to conduct the site visits only once a year and that they needed to find additional district funds to supplement costs, because the SOHCS funds covered only about a quarter of total costs.

There was no statewide baseline data for children's health prior to the SOHCS grant support of the survey of third-grade children. The third-grade oral health survey was modeled after the ASTDD recommendations for statewide children's oral health data collection. The survey data have since indicated that low-income children in GA have lower oral health status and are less likely to receive oral health care.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

Each district was required to submit information on key achievements, both by providing a brief narrative outlining accomplishments and by submitting data. In general, the office tracks service use, the number of clients served, the number of referrals, the number of treatments, etc. in a statewide database. However, this large statewide database does not identify which of these services were paid for with SOHCS funds, which does make it difficult to track and document the impact of SOHCS funds on access to oral health services, particularly clinical services.

Still, interviews with district health staff did provide concrete outcomes that are indicative of program success. The Savannah/Brunswick District reached at least 5,526 students with the Oral Health Education Program Lead by school nurses and provided outreach to more than 125 local private Medicaid providers to encourage participation in Medicaid. The Waycross District provided fluoride mouth rinse to nearly 1,200 schoolchildren on a weekly basis.

Sustainability Process – Issues/Strategies/Promising Approaches:

Georgia has been able to work with partners to find innovative ways to stretch limited resources. After funding the small grant proposals, they have found that many districts have been able to take ownership of the activities. This has led many districts to take the next step of leveraging additional resources and integrating these projects into existing oral health infrastructure to maintain them into the future. Lastly, the SOHCS grant is part of a long-term incremental approach to building the oral health infrastructure in Georgia, which they feel has been a good strategy in their context.

The Oral Health Section has enough funds to continue the oral health survey, the oral health poster contest, and the school-based oral health prevention program beyond the grant period. In addition, they will continue to distribute information on best practices throughout the State. Finally, they will continue the RFP program *if* they can secure additional funds.

Feedback to MCHB:

MCHB could help grantees increase public awareness and visibility of their oral health programs. It also would be helpful if MCHB provided SOHCS grantees with information about existing Federal oral health resources, such as the HRSA Oral Health Bulletin and the National MCHB Oral Health Resources Center listserv, as early as possible so that the grantees can use the resources during the initial planning and development process. In addition, Georgia's district staff would like technical assistance or training to help dental and nondental providers to follow oral health best practices.

Georgia also offered a number of recommendations for future MCHB oral health initiatives, including the following:

- Continue supporting the SOHCS grant into the future and consider allowing grantees to directly fund delivery of clinical services and the salary of staff members.
- Support more school-based oral health initiatives.
- State agencies could use assistance in applying as HPSA Dental Shortage Regions.
- MCHB should require States to have a State Office of Health and/or a State Dental Director as a condition of MCHB funding.
- MCHB should require a statewide oral health survey every 3 years ad provide funds to help.
- Require parents to bring their children in for preventive dental visits as a condition of continuing to receive public health benefits.
- Offer public health training opportunities to dental and pediatric dental students. They need rotations in public dental clinics.
- Offer best-practice education guides and videos on fluoride varnish.
- Produce a video on primary caregivers' basic screening methods.
- Provide funding for pilot rural centers of excellence in oral health.

- Provide training and education to dentists on the importance of public oral health, how to apply for grants to start public health programs, the importance of data collection, and population-based initiatives.
- Offer initiatives that support care coordination services.

Other Comments:

Overall, Oral Health Section staff members felt that they were very effective in meeting all of the five program goals. In addition, each of the interviewed district staff members felt that all their goals for their small-grant projects were met. Only one district's project could not be implemented as planned, and that was due to family illness.

The SOHCS grant activities have helped establish legitimacy of the Oral Health Section and increased its profile as a necessary force in improving access to oral health services around the state. It also has helped spread the word about the wide range of resources and services that the office can provide to the public and private sectors. The grant helped establish surveillance and monitoring activities across all populations, not just those at highest risk.

The SOHCS grant activities demonstrated that consumers and providers who were previously unaware about the importance of oral health can be encouraged to recognize oral health as a priority health issue. Many districts also learned that they could stretch a relatively small grant award to fund a wide range of activities and build momentum to garner additional resources to expand these activities beyond their original scope.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

INDIANA

May 8–9, 2006; Indianapolis, IN

Rebecca Ledsky

State Contact Person: Mark E. Mallatt, D.D.S., M.S.D.
State Dental Director: Mark E. Mallatt, D.D.S., M.S.D., State Oral Health Director

Interviewees:

Mark E. Mallatt, D.D.S., M.S.D., State Oral Health Director
Karen M. Yoder, Director, Indiana University School of Dentistry, Division of Community Dentistry
Jan Miller, SEAL INDIANA Program Manager
Edward Bloom, Director, Maternal and Children's Special Health Care Services
Lawrence I. Goldblatt, Dean, Indiana University School of Dentistry
Douglas M. Bush, Executive Director, Indiana Dental Association
G. Edward Popcheff, Director of Governmental Affairs, Indiana Dental Association

Description of SOHCS Activities:

The program is a mobile dental van that predominantly does oral health screenings and applies sealants to the teeth of elementary school children all over Indiana (with the exception of Indianapolis, which has its own oral health care system that serves children). The program also does oral health screenings for Head Start programs. SOHCS funding is used to pay the salary of the Program Manager. Outreach is done by the Program Manager to schools within Indiana. The Program Manager works predominantly with the school nurse. If the school nurse is willing, the coordinator will send the nurse consent forms for children in the school – these are sent home with students, and if active consent is obtained, then the children are seen. The goal is to see children who do not have a dental home. After scheduling the visit to the community, the coordinator will contact local dentists to explain the program, explain how it is not competitive, and try to establish dental homes for the children being seen. The goal is not only to provide care but to link children to local oral health care.

Prior to the initiation of the mobile dental van program, the State Oral Health Director, together with the Indiana Dental Association and Indiana University, worked to increase the Medicaid reimbursement rates for oral health care so that reimbursement rates that were too low would not be an issue.

Key Partners:

Indiana University School of Dentistry
Indiana Dental Association

Planning Process – Issues/Strategies/Promising Approaches:

The SOHCS grant goals were selected to address the needs of a new component of the oral health infrastructure in Indiana. The van had been purchased and the program was in operation prior to the SOHCS grant. But the advent of the SOHCS grant made it possible for the program to be more focused and for the outreach to be systematic. The SOHCS goals were selected because they were considered to be associated with an essential program that needed support – a program that was a critical element of the infrastructure for delivering oral health care in rural and underserved areas of Indiana. The SEAL INDIANA project was already a collaborative one: it included the State Oral Health Director and Indiana University and was endorsed and promoted by the Indiana Dental Association.

No issues were encountered and planning and development of the grant application – the grant application was written by the State Oral Health Director and was reviewed by all other parties.

Implementation Process – Issues/Strategies/Promising Approaches:

Implementation was not an issue with this modification to an existing program. The necessary activities were determined prior to the grant when the SEAL INDIANA program was initially being put into place. Some activities, such as expanded community outreach (after getting the SOHCS grant) and having the Spanish-speaking dentist do direct followup with parents, were undertaken after the SEAL INDIANA staff and advisors reviewed activities and issues that arose after initial implementation.

The major issue that had to be overcome in order to implement this program successfully, and which continues to have to be addressed, is the sense of market intrusion felt by local dentists. For-profit dental vans continue to come into rural Indiana and "take" patients from local dentists. These for-profit vans are seen as providing poor care and for starting a treatment program but then dropping the patients after the easy work has been completed. Local dentists viewed/view this SEAL INDIANA van in the same way – this is part of the reason why the outreach activities undertaken by the Program Manager are so essential and why there is such a strong effort being made to engage local providers and link the children served to local providers who can provide them with a permanent dental home.

It has been possible, for the most part, to alleviate the sense of competition by recognizing the problem up front and making sure to work with the dentists prior to providing services in the community.

A second issue has been the variability in the engagement of school nurses. School nurses are critical because they make all of the arrangements for obtaining parental permission to see the students. The additional administrative SOHCS staff have made it possible to work more closely with these critical stakeholders.

It is felt that the connection of the program to Indiana University is a strong positive factor in its acceptability. The University has a very good reputation, and its connection gives the program less of a "public health" flavor.

Data Collection-Evaluation Process – Issues/Strategies/Promising Approaches:

The program is seen as being very effective – it is at near capacity in that it is booked for 75 percent of available days.

Outcomes are predominantly measured in the number of children being served. Other outcomes that are captured include data from dental students who go out on the van about the value of the experience. The program is looking at ways to capture information about establishment of a dental home but has not been successful yet.

Sustainability Process – Issues/Strategies/Promising Approaches:

First, they hope that the SOHCS grant program does not end so that they can continue to fund what is viewed as a critical position in the SEAL INDIANA operation. The State Oral Health Program currently gets a small amount of money from their MCH Title V Block Grant, but it is not sufficient to cover the potential loss; they would like more. They will look for foundation funding, because they do not believe that they will get funding from within the State, from MCH, through legislation, or from the University.

Feedback to MCHB:

The chief recommendations to MCHB were financial. They would like to see the SOHCS grant made permanent, and they would like to see more oral health grants being made available.

Other Comments:

All interviewees reported that the grant has had a big impact in the functioning of the SEAL INDIANA program. The ability to have a focused Program Manager has meant that the outreach has been able to be very focused and that new communities are able to be included in the outreach process. The addition of this individual also has meant the ability to work more closely with the school nurses at each of the participating school sites. This has been important, because these individuals responsible for getting permission for student participation.

The program overall has been highly successful, and the SOHCS grant has provided needed funding.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

NEW HAMPSHIRE

May 22–23, 2006; Manchester, Concord, and Raymond, NH

Rebecca Ledsky

State Contact Person: Paula Smith, Executive Director, Southern New Hampshire Area Health Education Center
Nancy Martin, R.D.H., M.S., Manager Oral Health Program Officer, Office of Community and Public Health
Paula Smith, M.B.A., Executive Director, Southern New Hampshire Area Health Education Center (SNHAHEC)
State Dental Director: Margaret Snow, D.M.D., M.B.A., M.P.H., Dental Director, mmsnow@dhhs.state.nh.us

Interviewees:

Paula Smith, Executive Director, Southern New Hampshire Area Health Education Center, SOHCS Project Director – current SOHCS grant
Nancy Martin, R.D.H., M.S., Manager, Oral Health Program, Office of Community and Public Health, SOHCS Project Director – SOHCS grant and State official who works most closely with SNHAHEC
Chris Smith, New Hampshire Minority Health Coalition – conducted formative research in support of SOHCS activities (including report) and will conduct evaluation activities
Margaret Snow, State Dental Director – provides input to the SOHCS grant activities
Hope Saltmarsh, R.D.H. – together with another contractor (Russell Jones, M.D.), developed educational materials and trained primary care providers and their staff to conduct oral health screenings on young children
Lucinda Colburn – conducts outreach to health care providers and assists in the delivery of the trainings
Ashley Grant – conducts outreach to health care providers and assists in the delivery of the trainings
Stacy Plourde, Lamprey Health Center – discussed how oral health can be integrated with primary care in this CHC setting
Sandy Harrington, Lamprey Health Center – discussed how oral health can be integrated with primary care in this CHC setting

Description of SOHCS Activities:

The initial SOHCS grant activities focused on providing oral health education and screening services by hygienists to pregnant woman who were at risk for dental disease. Two contractors, a medical doctor and a dental hygienist, developed materials to conduct education sessions with prenatal providers, hygienists, and dentists during dinner meetings; they also conducted these sessions. The meetings were used to train the health professionals about the impacts of dental disease on pregnant women and the children they were carrying. Also discussed was how to work with their clients to increase their

awareness of dental disease and its impacts and to increase a client's likelihood of seeking appropriate treatment. As a reinforcing factor, the grant was used to provide oral health "gift baskets" to the clients – these were highly prized.

Because of first-year successes and the recognition that there was an extreme lack of oral health care available for children under the age of 3 – an absence that would be intensified if the mothers from the first grant cycle started pushing for oral health assessments for their new infants – the second grant application, using some of the same approaches, sought to expand oral health assessment for this population. The grant activities included formative research (focus groups and surveys) with women in underserved groups and primary care providers and dentists to determine needs, education, and materials content and approach; the collection, development, and branding of oral health tools and education materials for parents and primary care providers; the development of a curriculum to be delivered in a primary care practice or facility; the delivery of the "Lunch and Learn" curriculum; and the development of an evaluation plan.

Additionally activities included establishing an advisory committee to address the State's problem with access to care in this age group and looking for solutions that included legislation and reimbursement changes. The education program contained information about the importance of oral health; taught (through demonstration and visual aids) primary care providers and their staff how to conduct oral health screening for a child aged 0–3, as well as the value of and how to apply fluoride varnish; and provided them with educational points to make to parents and information on how to refer them for oral health care.

The desired outcomes for the grant were to be preliminarily measured by the number of primary care providers trained, willing, and providing oral health prevention and limited treatment services leading to a reduced rate of dental disease.

Key Partners:

This project was carried out through the direct collaboration between SNHAHEC and the Department of Health's Office of Community and Public Health and with the input of the State Dental Director. Although they were a subcontractor, the New Hampshire Minority Health Coalition also functioned as a partner. Other partners included the New Hampshire Office of Medicaid Business and Policy, AAP, the New Hampshire Academy of Family Physicians, the New Hampshire Dental Society, the New Hampshire Dental Hygienists Association, Lampry Health Care, the Capital Region Family Health Center, the Manchester Community Health Center, the Families First Health and Support Center, and the Endowment for Health.

Planning Process – Issues/Strategies/Promising Approaches:

All planning activities constituted natural outgrowths of collaborative working experiences among these same individuals and groups. Many of the key players in this grant project had been part of the process to develop the State's oral health plan, underwritten by the Endowment for Health. Much of the core of the approach being taken, training health care professionals and clients, followed an approach frequently used in the SNHAHEC to address other health issues; they commonly hold "Lunch and Learn" sessions about a wide range of health care topics and issues. The movement with the second grant application toward a greater management role for SNHAHEC reflects recognition of the strengths that this organization brought to the table, including administrative simplification.

The planning process for the grant was collaborative – the second grant application was predominantly written by SNHAHEC, with input and review by some other key partners but most particularly by the Office of Community and Public Health. The individuals from these organizations have a strong, productive working relationship, which enhanced the planning process.

Implementation Process – Issues/Strategies/Promising Approaches:

The implementation process for this grant, to a great extent, has gone according to plan, with some barriers that were or could have been expected. The initial formative research was to be conducted with focus groups and surveys. The formative research was done to contribute to the development of curricular materials as well as the parent and provider tools that this program sought to develop and brand. Because of very low survey response rates, a great portion of the formative research conducted with primary care and oral health providers was ultimately conducted using telephone interviews. While not what had been planned, the formative research was conducted successfully.

Following the conduct and using the results of the formative research, which pointed out that the first grant's curriculum was too long and complex, the curriculum to teach primary care providers and their staff to do oral health screenings with 0- to 3-year-olds was developed. The formative research also helped to identify what was needed with regard to tools. This grant created two tools for distribution – one for primary care providers that has eight points for screening and one for clients that enumerates 10 steps to oral health. This was done after determining through the research that existing tools did not address issues identified in the formative research and that existing tools for providers, such as the Bright Futures Oral Health guide and attendant tools, were too complex to be practically useful. These will be ready for distribution in the third year of the grant.

SNHAHEC conducted outreach to primary care providers – one of their natural constituencies – to sign up practices to be trained. Response has been initially slow, but demand is being built. The trainings are conducted, for the most part, by a physician and a hygienist. Initially, it was thought that the physician was the most critical trainer, but

the ability of the hygienist to model confidently how to hold and conduct the screening has proven to be critical for the training success. The trainings are typically conducted at the physicians' site, over lunch, and with all of the staff. After the trainings, the SNHAHEC SOHCS grant staff is available for onsite technical assistance, redemonstrating how to conduct the screenings. This has not been as successful as anticipated, because more often than not, the SOHCS grant staff is used to conduct the screenings, not to show others on site how to conduct them.

One issue that hampers implementation is the lack of specific, additional reimbursement available to the physicians and their staff for conducted oral health screenings and fluoride varnish. However, it is encouraging to note that one pediatrician, after hearing how inexpensive fluoride varnish is, is planning to apply it without reimbursement.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

The project keeps track of the number of sites contacted, the number of sites trained, and the number of people trained. It does not track the number of children subsequently screened in the sites trained.

This project is in the process of developing a fuller evaluation plan for this grant project. This additionally will explore supports and barriers to implementation.

Sustainability Process – Issues/Strategies/Promising Approaches:

The SNHAHEC staff – particularly the Director, who is also the SOHCS Director – is very adept at writing grant applications. In fact, this is a typical way for them to obtain funding. They have had some success, getting additional grant money to run a similar program in the Lamprey Community Health Center. The SOHCS project staff is also hopeful that MCHB will continue the grant program and perhaps make others available.

Feedback to MCHB:

They are very appreciative of the opportunities that the SOHCS grant has afforded them to develop a formative, research-based curriculum and a series of materials for primary care providers and clients. This process; the demand that exists for training in this curriculum, both in Southern New Hampshire and in the northern part of the State; and the need to involve primary care providers in the oral health of older children makes them wish that the grant was larger or that other grant funds could be made available.

They would like MCHB to obligate the State MCH program to provide some Title V money to oral health.

Other Comments:

All interviewees reported that the grant has had a big impact in the State. Not only has it developed a concrete program to deliver to primary care providers and tested materials for both providers and mothers, but it has strengthened working ties between persons in a rather large group of organizations. Because New Hampshire does face a dental shortage, particularly acute with regard to those who will see very young children, it is critical not only to have ongoing programs but to build a network of people and organizations who are looking for opportunities to address and solve the problem.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

SOUTH DAKOTA

June 1–2, 2006; Pierre, SD

Sandra Silva

State Contact Person: Julie Ellingson, R.D.H.
State Dental Director: Julie Ellingson, R.D.H., OH Program Coordinator, Julie.Ellingson@state.sd.us

Interviewees:

Julie Ellingson, OH Program Coordinator, SOHCS Grant Administrator
Gail Gray, Division Director of Health and Medical Services
Colleen Winter, Administrator, Office of Health Promotion
Teri Christensen, Tobacco Control Program Project Director
Jacy Clarke, Chronic Disease Epidemiologist
Darlene Bergelleen, Administrator, Community Health Services
Connie Halverson, Public Benefit Coordinator, Delta Dental
Carrie Mikkonen, Philanthropic Fund Manager, Ronald McDonald Care Mobile
Paul Knecht, Executive Director, South Dakota Dental Association
Melissa Stech, Childcare Services, Early Childhood Enrichment
Betsy Pollock, HS Collaboration Director
Kayla Tinker, MCH Director, Family Health
Mitch Bernstein, Aberdeen Area IHS Dental Director

Description of SOHCS Activities:

The SOHCS grant partially supports Julie Ellingson's salary and also funded two primary activities in South Dakota:

- The administration of statewide BSS with third-graders
- Education of nondental providers working with children 5 years old and younger.

In addition to these primary activities, Dr. Ellingson has provided support to several organizations (Delta Dental-Ronald McDonald Care Mobile) and programs (HS, WIC, MCH/CSHCN, early childhood program) by developing, reviewing, and distributing OH materials.

The decision to administer the BSS to third-graders was made based on the MCH performance measure relating to sealants. The BSS was completed twice over the course of the SOHCS grant, in the 2002–2003 and 2005–2006 school years.

The decision to fund the education of nondental providers was due to the difficulty accessing dental services. Access is a major issue across the State due to a shortage of dentists in many counties as well as additional barriers. Half of the dentists in the State are located in the two largest counties, leaving some counties without a dentist. This situation has led the Department of Health to use other systems of care to address OH

education and OH needs of young children.

Key Partners:

The OH Program worked with the Department of Education to implement the BSS activities in the schools. They report having a good working relationship with them. The South Dakota Dental Association was also an active partner and assisted in the recruitment of volunteer dentists to conduct the dental screenings. The Association provided them with a list of members and also sent out a joint letter requesting volunteers. They have a reasonable response and sufficient dentists to staff the activities. For those selected schools within reservations, Mitch Bernstein also assigned staff dentists within IHS to conduct the screenings.

The HS and WIC/MCH (including network of community health nurses) were mentioned as key partners in the implementation of the education activities, because this education focused on nondental providers working with young children. These nurses and program staff members were the target audiences for this training.

Having someone in the position of OH Coordinator has expanded OH efforts and the ability of the OH Program to promote OH by partnering with other programs in the Department of Health (oral cancer, smoking cessation, diabetes, and nutrition).

Planning Process – Issues/Strategies/Promising Approaches:

Planning decisions were driven by the Health Department. The OH Coalition (in place prior to SOHCS grant) a few years earlier had reviewed available data and identified several OH needs – specifically, the need for additional OH data and difficulty accessing care, especially among the Medicaid-eligible population. Although the Coalition did not play a direct role in planning grant activities, these areas of need did influence the planning process, as the key members of the Coalition are involved in implementing all OH activities throughout the State and Dr. Ellingson participates in the Steering Committee.

No major issues emerged during the planning process. Key stakeholders in South Dakota have a history of working well together and everyone was in support of this initiative, especially the South Dakota Dental Association.

Implementation Process – Issues/Strategies/Promising Approaches:

Partnerships were very helpful during implementation because of the limited capacity of the OH Program. Dr. Ellingson also has relied heavily on the resources (technical assistance, mentoring) provided by ASTDD.

The SOHCS grant funded the administration of the BSS in 2002–2003 and 2005–2006 and was coordinated with the Department of Education. In the 2002–2003 school year, they visited 35 schools and screened 710 students. The dental screenings were conducted

by volunteer dentists. Students were also provided with education, toothbrushes, and toothpaste as part of the screening. There were challenges when conducting the BSS. Some schools did not want to participate and did not see the value of conducting screenings. Other schools were concerned about removing students from the classroom and felt that conducting screenings would detract from valuable classroom time. Gaining the full participation of school nurses was a challenge, because they had limited time to coordinate the screening process and obtain signed consent forms from parents, which was reported by some schools to be difficult as well.

Part of the followup to the screening is ensuring that children in need of additional dental services receive those services. During implementation of the first BSS, community health nurses followed up with each child that needed care, a process that was found to be very time intensive. As a result, the followup during the most recent administration of the BSS was more limited. Instead, the program will provide referral information to the parents and will focus its followup efforts on the students in greatest need of services. For parents having difficulty locating a provider, Delta Dental does have referral assistance that they provide its members. Delta Dental is a strong partner in South Dakota and a member of the OH Coalition, has agreed to provide this referral assistance to families, and has compiled a list of dentists who have agreed to accept referrals for urgent care to ensure that these children are seen immediately. In some parts of the State, the Ronald McDonald Dental Care Mobile is able to see some of these children that require care.

The OH educational component was provided to HS and WIC program staff members and to the 90 community health nurses through seven regional trainings conducted by volunteer dentists in each region. The education sessions lasted about 1.5 hours and covered the transmission of early childhood caries and basic oral hygiene habits (e.g., how to brush and floss effectively). Resource manuals including this information were disseminated and found to be useful. The expectation of the training is that participants would be able to identify the early stages in caries and integrate education into regular clinic visits. It was not designed to be a comprehensive screening training (e.g., "Lift the Lip") but rather was designed to be something that could be easily incorporated by the staff.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

Generally, all interviewees felt they were effective in achieving their grant goals. The program analyzes BSS data, which will be used to monitor OH outcomes. Once the second BSS's data are available, these OH outcomes will be compared to the baseline data collected in 2002–2003. There are attempts to integrate its collection of OH data. In addition to the BSS, they also collect OH data by questions included in the BRFSS, YRBS, and Perinatal Surveys. They oversample the BRFSS to ensure that they have enough families with children. According to Dr. Ellingson, OH data are probably not integrated.

Beyond this review of data, all other progress has been reported anecdotally.

Sustainability Process – Issues/Strategies/Promising Approaches:

It was reported that Title V funding most likely will be able to sustain current funding levels provided by the SOHCS grant.

Several interviewees noted that receiving this grant from HRSA to support OH activities facilitates their ability to leverage funding for OH efforts, especially through their State legislature. Having Federal support legitimizes OH as a health priority, which can impact funding decisions, especially among those legislators unaware of health issues. Also, the SOHCS grant expanded the tracking of data outcomes, which then can be used to strengthen other applications for funding, such as in the case where the Delta Dental grant successfully secured the funding of the CareMobile.

Feedback to MCHB:

The MCHB goals and guidance were considered to be very broad and general. Staff members did remark that the benefit of having broad goals was that they were not restricted in their choice of activities. Although this flexibility was appreciated, some felt that as a relatively new OH Program, it would have benefited from more specific guidance from the MCHB. For example, it was suggested that the goals remain broad, but that examples of specific activities that could be undertaken be included for each goal.

Another comment was that MCHB distribute best/promising practices organized by topic, population, or age group. Interviewees were interested in learning more about OH activities undertaken by other States and would have found more contact with other grantees to be useful.

Other Comments:

All interviewees reported that the grant has had a big impact in the state, by supporting the position of OH Coordinator, a position which was described as integral to the infrastructure of OH activities. In the past, contractors were used to conduct OH activities, but interviewees reported that these efforts were not well-coordinated and that getting buy-in from other agencies was challenging. As a fully funded position, the OH Coordinator (Dr. Ellingson) has been able to serve as a point of contact for the OH Program and expand the capacity and reach of the OH Program through the development of relationships and distribution of educational materials. This grant has allowed Dr. Ellingson to raise the visibility of OH as a liaison with other programs and participating on the OH Coalition. The development of partnerships has been a major achievement, especially with local dentists conducting the BSS screenings. Dr. Ellingson has partnered with other health programs (oral cancer, smoking cessation, diabetes, and nutrition) to expand efforts to promote OH.

OH information also has been integrated into other programs. They have distributed educational materials focused on early childhood caries and OH resources (toothbrushes, floss) to the WIC program and child care centers. As a result, they now get continuous

requests for OH information and materials. The MCH program has been able to be more systematic in its incorporation of OH into MCH program populations (CSHCN, pregnant women) that did not exist prior to this grant. The OH education has been incorporated into WIC and HS curriculums. Also, some OH information has been incorporated into the Early Childhood Enrichment, which is the office of child care that provides education to child care workers and day care centers. The OH Program has worked with them to develop an OH curriculum and train Early Childhood Enrichment staff members through its training network (training technicians located in five DSS regions). There have been 23 training classes, which have reached about 300 children.

Through the administration of the BSS, they have expanded their data collection efforts. The BSS was also useful in generating an interest in OH at the local level, by raising the awareness of the issue.

The OH education targeting the community health nurses has strengthened the capacity of the public health infrastructure. These community health nurses are the implementation arm of the family health, disease prevention, and health promotion programs. They were seeing tremendous OH needs throughout the State but did not have a way to address these problems. They are now better informed about what information to share with parents (anticipatory guidance) and how to refer to services. The participants that received the OH training reported positive feedback and reported feeling better informed about OH issues and the process of referring to services. Even though some field staff members still have some concerns about access to care, they do feel that they are in a better position to help clients access needed dental services.

South Dakota is a good example of a State turning to an existing system of care and nondental providers to address OH issues. Although these providers (WIC and HS staff members) are not expected to conduct comprehensive screenings, they are trained to provide anticipatory guidance and to identify the cases when a child is most in need of care. They also have been provided with some resources to assist them in locating a dentist willing to see the child in need of dental care.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

TEXAS

May 30–31, 2006; Austin, San Marcos, and San Antonio, TX

Anne Hopewell

State Contact Person: Sandy Tesch, Oral Health Program Specialist
State Dental Director: Linda Altenhoff, D.S.S., Director, Texas Health Steps/Medical Transportation/Oral Health, Linda.Altenhoff@tdh.state.tx.us

Interviewees:

Margaret Bruch, Manager, Health Screening and Case Management Unit
Maria Vega, Steps Manager
Sharon DiFelice, Oral Health Program Specialist
Sandy Tesch, Oral Health Program Specialist
Fouad Berrahou, Title V Director
Terri Patrick, TDHA Representative
Dorothy Calhoun, Head Start Collaboration Office
William Gray, Regional Dentist, HSR 5s/6/7
Alicia Grant, Chair, Texas Oral Health Coalition
Regina Henderson, Health Coordinator, Community Action of Hays, Caldwell and Blanco Counties Head Start
Dr. Williams and Deleese Brock, R.D.H., Region 8 Office
Sandy Tesch and Kathy Geurink, Department of Dental Hygiene, University of Texas

Description of SOHCS Activities:

The stated goals for the Texas SOHCS Grant included the following:

In 2003:

- Develop an initial evidence-based oral health plan in Texas through a collaborative process.
- Activate a statewide oral health network to promote oral health improvements.
- Hold a State oral health workshop to refine and disseminate an evidence-based and collaborative oral health plan in Texas.

In 2004–2005:

- Develop collaborations with Early Head Start (EHS)/Head Start (HS) centers, schools of dental hygiene, and WIC clinics.
- Conduct surveillance in order to obtain baseline dental disease burden data on infants through 5 years and pregnant women.
- Institute a preventative oral health project for selected EHS/HS centers and WIC clinic populations.
- Increase dental Medicaid participation rates in the 1- to 5-year-old age groups.

In the first year, the goal was to conduct listening sessions around the State to identify oral health needs, generate interest and "buy-in," and use consultants to draft an initial

oral health plan. Texas was very successful in this regard. They conducted Oral Health Listening Sessions across the State to get input from the public on oral health needs. The response to the sessions was very enthusiastic, and the participation was very interactive. More than 440 attendees accepted invitations that were sent out to a broad range of current and potential stakeholders. A professional facilitator was paid through the grant to conduct the sessions and draft the initial Oral Health Plan.

The first year helped to identify the SOHCS goals for future applications. The majority of subsequent SOHCS resources went to the development and sustaining of a fluoride varnish program with HS programs. Although there were goals to expand fluoride varnish programs into EHS and WIC programs, the State was less successful in achieving those goals.

Key Partners:

Partners from include the Texas Department of Health UTHSCSA Houston Dental Branch, the LBJ School of Public Affairs–UT Austin, the Center for South Texas Health Programs, the Community Voices–Kellogg Foundation Initiative in El Paso, the Texas Association of Community Health Centers, the UTHSCSA Dental School, the Baylor TAMU College of Dentistry, the City of Austin/Travis County, the Children's Defense Fund of Texas, and the Center for Public Policy Priorities.

Partners from 2004–2005 include local EHS/HS centers, local WIC clinics, local dental hygiene schools, the Texas Dental Hygiene Association, the Texas Dental Association, the Texas Academy of Pediatric Dentists, the Texas Dental Hygiene Educators' Association, and the Texas Health and Human Services Commission.

Planning Process – Issues/Strategies/Promising Approaches:

There was a leadership transition during the course of the SOHCS grant program. The current State Dental Director was not involved with the initial application. Fortunately, a long-standing relationship with the University of Texas, San Antonio's School of Dental Hygiene helped with the identification of a consultant who wrote the first application.

In following years, the new Dental Director really focused on grant writing and worked independently on completing the applications. At the time of the evaluation, she was unexpectedly out on medical leave and there was a lack of institutional knowledge about the planning process.

After the conduct of the listening sessions, a 2-day Statewide Oral Health Summit was conducted to share results and identify Oral Health Coalition structure and membership. The input gathered during the initial year of SOHCS funding provided a basis for future activities. In addition, a very active Dental Hygiene Association, a strong partnership with the HS Collaborative Office, and close involvement with the dental hygiene program at the University of Texas Austin helped to identify the activities to be conducted from 2004 to 2007.

Currently, the Coalition is working to merge and refine several oral health plans for increased effectiveness.

The SOHCS grant goal of instituting a fluoride varnish program with HS was influenced by:

- A pilot study conducted by the Texas Dental Hygienists Association involving three Dallas HS programs with fluoride donated from four private companies
- HS data documenting high need for services and a Program Needs Survey indicating oral health as an unmet need for HS children
- Long-standing relationships with regional dentists and programs
- Evidence-based practice substantiating the effectiveness of fluoride varnish to prevent dental caries.

Implementation Process – Issues/Strategies/Promising Approaches:

Implementing the fluoride varnish program required significant preparation. Memoranda of Understanding were needed with each HS program, as well as parental consent forms that needed to be developed at a third-grade reading level in both in English and Spanish. Scheduling time for the dentist and hygienist to come to the center was also challenging, since the HS programs have very busy schedules and it was necessary to collect the consent forms, conduct an assessment, apply the varnish, and document activities often at several centers in a single day. One strategy being implemented to circumvent scheduling issues is to conduct/include the fluoride varnish application during the registration process.

Since private dentists could have objections to the program (especially those with long-standing relationships with their community HS Programs), the State Dental Director, who previously served as a dentist in one of the State's regional offices, personally called the dentists who already had relationships with HS and asked how they could work together. In some cases, the local dentists were glad to help with the fluoride varnish program; in others, they were glad to have a regional dentist provide the screening and varnish and refer children requiring treatment. In addition, the program was structured in such a way that a dentist was present at the HS site, and this mitigated issues regarding supervision of hygienists. The history of a well-staffed and drained State Office for Oral Health also was reassuring to State and local partners as the program got off the ground.

The services are provided by regional and/or volunteer dentists with the assistance of a hygienist or other HS program staff member. The greatest challenge is that some of the regional dentist positions are unfilled and two of the dentists currently providing these services are being called up to Iraq as reservists. Texas is a big State, and fewer dentists are being required to cover additional regions/HS programs. At the time of the evaluation, there was concern about a real staff deficit at the start of the school year, although the regional dentists planned to try to get the screenings and varnish application completed as part of enrollment process.

Finally, the initial goals for the grant in included expanding the program into WIC. Although WIC did fund an oral health video to be shown in their clinics at the time of the evaluation it was unlikely that the WIC/Oral Health partnership would extend into fluoride varnish applications or other dental education. Demand is still high and unmet in many HS programs, and an interest has been expressed to expand into EHS. In the future, the Dental Director would like to expand into Medicaid funded child care programs, since relatively few of the eligible children are enrolled in HS.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

HS programs are data driven, as is the need to collect data on this population for the State. Currently, the dentist fills out a form indicating the child's level of need for oral health services, the number of diseased, missing and filled teeth, and the need for referral/treatment plan. One of the Regional Dentists modified Nevada fluoride program consent and data collection forms for this purpose. This data was helpful to the State MCH program as well. In addition, HS also had a Dental Health Screening Form that includes BSS data, insurance status, and any allergies. The State also conducted a cost benefit analysis:

Using the published fees from the 2003 ADA Fee Survey (50th percentile of the general dentists in the West South Central region of which Texas is one of the states), the 2006 National Dental Advisory Service, the Texas Medicaid Program dental fee schedule, and the Texas CHIP dental fee schedule for the CDT codes for the services provided the Texas State Dental Director calculated an average fee for the services being provided through the SOHCS grant. Specifically, preventive dental services were provided in 19 counties, involving 47 participating EHS/HS programs with 87 individual sites from September 2005 through May 2006. In all, 3,093 children ranging in age from 6 months to 5 years received oral examinations, and 3,075 of these children received preventive dental services, which included topical fluoride varnish applications. As of July 1, 2006, the amount of $65,000 provided services with an estimated return on investment valued at $233,403, or an estimated 359 percent return on the dollars invested from the grant.

Sustainability Process – Issues/Strategies/Promising Approaches:

At the time of the evaluation, there was no firm commitment for continued funding of the fluoride varnish program at the end of the SOHCS grant initiative. However, the program has been so successful and cost effective, and the data measuring this effectiveness have been so persuasive, that the Dental Director is sure that funding will become available from the State, HS, or a community foundation.

Feedback to MCHB:

The Dental Director felt the MCHB encourage additional collaboration with State Medicaid programs and to urge block grant funding of oral health services.

The new State MCH Director wanted the Bureau to do a better job disseminating cutting-edge research/data on oral health issues.

Other Comments:

This is a strong program that really benefits from longstanding relationships with a network of committed statewide partners. It struggles with the lack of available Medicaid dentists to treat needs being identified during fluoride varnish application. Parents and other siblings also need treatment that is unavailable. In retrospect, the grantee realized that the target audience should have included more EHS programs.

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STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

VIRGINIA

May 22–23, 2006; Richmond, VA

Beth Zimmerman and Anne Hopewell

State Contact Person: Karen Day
State Dental Director: Karen Day, Director, Division of Dental Health, Virginia Department of Health (VDH), karen.day@vdh.virginia.gov

Interviewees:

Karen C. Day, Director, Division of Dental Health, VDH
Susan Pharr, Maternal and Early Child Oral Health Coordinator, Division of Dental Health, VDH
Terry Dickinson, Executive Director, Virginia Dental Association
Tegwyn Brickhouse, Associate Professor, Department of Pediatric Dentistry, Virginia Commonwealth University, School of Dentistry
Joanne Wakeham, Director, Public Health Nursing, Community Health Services, VDH
Lisa Armstrong, Nutrition Manager, Division of WIC and Community Nutrition Services, VDH
Linda Foster, Healthy Start Coordinator, Division of Women's & Infants' Health, VDH
Theresa Taylor, Perinatal Nurse Consultant, Division of Women's & Infants' Health, VDH
Sherry Hughes, Norge Early Head Start Program
Sue Frankel, Roanoke Early Head Start Program
Kristine Enright, Public Health Dentist, Alleghany and Roanoke Health Districts, VDH
Diane Pappas, Physician and Faculty, University of Virginia, Department of Pediatrics
Stacey Hinderliter, Physician and Staff , Lynchburg City Health Department, VDH
David Suttle, Maternal and Child Health Director, Office of Family Health Services, VDH
Tanisha Dorsey, Head Start Collaborative Project
Jean Collins, Department of Social Services
Lisa Bilik, Dental Contract Manager, Department of Medical Assistance Services

Description of SOHCS Activities:

The SOHCS grant in Virginia has been used to develop, implement, and evaluate an early oral screening/risk assessment, anticipatory guidance, and fluoride varnish program for infants and toddlers under the age of 3, which is called "Bright Smiles for Babies." The target program for the fluoride varnish program is children aged 0–3, with anticipatory guidance focused on their caregivers, including pregnant women. The children are being reached through various sites including Early Head Start; university-based clinics; and local health department clinics, including WIC. The State intends the program to be implemented flexibly (e.g., with or without program the fluoride varnish component) by different communities depending on available resources. A focus of the grant is strengthening linkages between the medical and dental spheres by providing more continuous care to young children, primarily by increasing the role of nondental providers in addressing young children's oral health needs.

The initial 1-year planning grant was used to develop and pilot-test training materials, and the

subsequent 3-year grant has been used to develop the program further and implement it more broadly, especially its collaboration with Early Head Start, as well as to conduct evaluation activities.

Planning Process – Issues/Strategies/Promising Approaches:

The development of the SOHCS grant addressed the prevalence of dental decay among children, the disproportionate burden of decay in low-income and minority children, and the lack of adequate access to Medicaid dental providers as factors behind the program. Prior to the release of the SOHCS grant, the VDH, VDA, and VCU had started to explore funding opportunities to address the need for improved integration of medical and dental care to improve the oral health of young children. An impetus was a call received by the VDA Director from a very frustrated pediatrician who had a 3-year-old patient who was going to have to have all her decayed teeth removed. The SOHCS grant allowed the State to build on their original smaller proposal to develop an approach for improving medical-dental collaboration around children's oral health, especially through increasing the role of nondental providers in applying fluoride varnish to young children's teeth. The anticipatory guidance piece is also a critical component of the program; in some cases where there is not the capacity to do fluoride varnish, anticipatory guidance is the only intervention or a first step before varnish is implemented.

Implementation Process – Issues/Strategies/Promising Approaches:

The Grant Program Coordinator is a dental hygienist who conducts Bright Smiles trainings. Numerous broad presentations have been done on the program to increase awareness about the program and training resources, and requests for the training to implement the fluoride varnish/anticipatory guidance program stem from these. Training has been provided to local/district health departments, WIC clinics, and Early Head Start sites around the State. Another component of the program is training of pediatric medical residents by a faculty pediatric dentist to apply fluoride varnish and conduct anticipatory guidance in clinics and in their later practice. Issues addressed and strategies for addressing them during the implementation process included the following:

Hiring the Grant Coordinator took much longer than expected. While the hiring process was going on, the Dental Director assumed a greater role in the grant and also contracted with a pediatric dentist at VCU to help with Early Head Start screenings, data collection, and the provision of training on how to apply fluoride varnish.

Medical practice acts did not include fluoride varnish applications by public health nurses. The Board of Medicine had to change the protocol for public health nurses to allow them to apply fluoride varnish without an individual patient prescription or physician order.

There were reimbursement issues. (1) Medicaid did not recognize medical providers as appropriate providers for dental services. The Project Coordinator and Medicaid worked closely together to resolve these problems. (2) Fluoride varnish by medical providers within Medicaid is reimbursable only through a Medicaid fee for service (FFS) and by one of the State's eight medical HMOs (the one dental HMO also reimburses for varnish by dentists). The other seven

medical HMOs do not cover this service. Medicaid is reviewing the use experience under FFS and the one HMO to inform its inclusion in future contracts.

Demand for training is greater than expected. The evaluation protocol which calls for phasing in Early Head Start programs to the Bright Smiles project has been adjusted to allow for a faster phase-in of programs. The program is trying to respond to greater than expected demand from other groups, as well, for Bright Smiles training.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

An epidemiologist was hired with grant funds to conduct the SOHCS evaluation, which is ongoing. The evaluation is focusing on oral health assessments being conducted on all children in Early Head Start. Initially, the plan was to phase in three groups to have different levels of exposure over the 3 years, but due to high demand for the program, the groups are being phased in over the course of 1.5 years instead.

Data is collected through several means:

A *risk assessment form* captures data related to dental status/dental disease: clinical risk factors; nonclinical risk factors; and, if receiving fluoride varnish, contraindications for application. It also includes places for results of risk assessment, followup plans, and the tracking over time of risk factors and varnish applications.

Provider questionnaires include (1) a dental health baseline questionnaire to identify the types of dental problems that the provider observes in practice and current interventions and (2) a followup dental health questionnaire for providers.

A *caregiver survey, "Questions About Your Child's Teeth,"* is completed by a parent or someone who lives with the child. It provides information regarding the child's oral health care and nutrition and assesses basic oral health knowledge of the parent/caregiver and basic demographic information to help assess the populations being reached by the program. There is also a *feedback form* for the training packet including a *CD-ROM*.

Evaluation results, while not yet available, will help to monitor oral health status among Early Head Start children.

The grantee had not used the Electronic Handbook yet.

Sustainability Process – Issues/Strategies/Promising Approaches:

There is strong support at the State and local levels for maintaining the Bright Smiles program. VDH is committed to keeping it going and providing ongoing support to local programs that need it. VCU medical and dental school leadership are also very supportive; VCU already covers the cost of the varnish for their clinics, but the grant covers the VCU staff time and supplies for the university's role in the Early Head Start component of the project. Head Start

has expressed commitment to continue the program. The evaluation data is expected to be a valuable tool for efforts to seek additional funding.
Feedback to MCHB: Positive feedback was given regarding the grant guidance and the flexibility of the grant. Placing a bigger focus on oral health within the broader MCH world, including AMCHP, was noted as a strategy for limiting the need to "sell" oral health as much as currently is the case.
Other Comments: The grant was reported to have strengthened the State's capacity to address the oral health needs of young children and enhance prevention efforts by bringing nondental providers into the effort to promote children's oral health. Providers (e.g., in local health departments, in university medical clinics) who previously were not involved in assessing and addressing children's oral health are now integrating it into practice, and anticipatory guidance related to oral health is being provided in many venues. The health professionals training programs also have increased focus on training providers about how to identify and address young children's oral health needs.

STATE ORAL HEALTH COLLABORATIVE SYSTEMS GRANT SITE VISIT CASE STUDY

WISCONSIN

June 5–6, 2006; Madison, WI

Sandra Silva

State Contact Person: Nancy McKenney, R.D.H., CDHC, State Dental Hygiene Officer
State Dental Director: Warren Lemay, D.D.S., M.P.H., Chief Dental Officer, lemaywr@dhfs.state.wi.us

Interviewees:

Nancy McKenney, State Dental Hygiene Officer
Murray Katcher, Chief Medical Officer, MCH Agency
Millie Lindsey, Director, Bayfield County Health Department
Nancy Rublee, Regional OH Consultant
Diane Leibenthal, Program Supervisor, Sheboygan County
Matt Crespin, Regional OH Consultant
Greg Nycz, Executive Director, Marshfield Clinic System
Nancy Rublee, Regional OH Consultant
Kevin Wymore, Policy Analyst
Robert Glaza, Nurse Manager, Clark County Health Department
Anne Hvizdak Regional OH Consultant
Eva Scheppa, Clinical Services Manager, Family Health Center, Marshfield Clinic System
Grace Heitsch, General Pediatrician, Redcliff Community Health Center, Bayfield County
Bonnie Kuhr, Administrator, Brown County
Carrie Stempski, Regional OH Consultant

Description of SOHCS Activities:

The SOHCS grant partially supports the positions of the seven Regional OH Consultants that cover the five regions of the State. Their primary SOHCS activity is to train primary health care providers (e.g., pediatricians, nurses) to focus on prevention of early childhood caries (0- to 3-year-old population). This training curriculum was developed with Title V funds and based on a model developed by the State of Nevada. It was reviewed by a broad team and piloted in 3 demonstration projects. The training curriculum covers the following topics:

- How to conduct OH screenings with children under the age of 3 years
- Application of fluoride varnish
- Administration of anticipatory guidance with families.

The decision to focus on the training curriculum was based on the State's need to address workforce shortages. Needs had been identified through data collection ("Make Your Smile Count Survey") and through the OH Coalition. The goal of the program was to

expand workforce capacity through the use of nondental providers.

In addition to this training, the OH Consultants also conduct education and provide technical assistance (TA)/training and facilitation of OH programs and services. These specific activities vary by region and are tailored to the regional needs. These are identified by a grassroots process that is community driven. There is a lot of importance placed on the role of the local/county health departments, which are really considered partners in this process, because the State office sees them as the experts in their region. Some of their specific activities include providing OH awareness and education, assisting in data collection and screening services, assisting health departments to implement fluoride varnish and sealant programs, and training primary care providers to integrate preventive OH measure into primary health care practice.

Key Partners:

At the State level, the following key partners were identified:

- Local health departments and community clinics
- The Wisconsin Chapter of AAP
- Medicaid
- The Children's Health Alliance
- The Wisconsin Primary Health Care Association
- The University of Wisconsin (UW) Hospital Residency Program
- The College of Nursing/Wisconsin Technical College System
- The Division of Disability
- CSHCN regional centers
- The HS Association
- The UW Partnership for Healthy Future (BCBS grant)
- United Way.

These relationships are really fostered at the county level through the efforts of the county health departments. State health administrators really see the county health departments as partners and rely on their input and community needs to determine activities and TA.

Planning Process – Issues/Strategies/Promising Approaches:

The decision to focus on the training curriculum was based on the State's need to address workforce shortages. The goal of the program was to expand workforce capacity through the use of nondental providers, such as pediatricians. As part of the planning process, Nancy McKenney and Murray Katcher met with the Executive Committee of the Wisconsin Chapter of the AAP. Dr. Katcher (Chief Medical Officer, MCH Agency) championed this initiative among pediatricians and played an instrumental role as an AAP member, because he is very well respected among his colleagues and holds an appointment at the UW-Madison School of Public Health and School of Medicine. They presented the preventive benefit of fluoride varnish applications. While the response from

the pediatric community was very positive, there was concern about having the time to incorporate this given already present time constraints. It was communicated that making the fluoride application a Medicaid reimbursable service would increase the likelihood of practitioners incorporating this into their practice.

Overall, few challenges were reported in the planning process. The biggest challenge of the planning process was making the financial case to the Governor and approving this (application of fluoride varnish for physicians) as a reimbursable service. The AAP and the Academy of General Practitioners united in advocacy efforts and working with the OH program were able to get the support of the Health Secretary. Dr. McKenney and Warren Lemay (Chief Dental Officer) met with the State Dental Association and the State Dental Hygiene Association to discuss the curriculum and training plan and ensure that they would not oppose this effort. Ultimately, the approval process took about 6 months.

Implementation Process – Issues/Strategies/Promising Approaches:

The Regional OH Consultants have provided training to a priority list of providers working at local health departments, community health centers/FQHCs, primary care clinics that see Medicaid children, and HS programs. The intensity or length of the training is tailored to the needs of the individual county staff members. The providers that have undergone the training have provided positive feedback on the training and report placing a greater emphasis on the prevention of baby bottle tooth decay, providing more anticipatory guidance, but do find it difficult to incorporate the fluoride varnish application due to time constraints.

State staff point to Medicaid reimbursement for fluoride varnish treatments (for physicians) and the training/TA provided by the Regional OH Consultants as important to successful implementation of grant activities. Physicians are now able to get Medicaid reimbursement for fluoride varnish treatments. The training has been essential in ensuring that providers feel comfortable treating young children.

Those working at the local/county level mentioned a number of resources that were helpful in the implementation process, including:

- Training and TA provided by the OH Consultants
- State guidance
- Buy-in from local partners (WIC, HS, providers).

All of the counties have been very happy with the high level of training and TA that has been provided and report feeling confident in their ability to conduct the screenings and apply fluoride varnish as a result of the training. The county health officials remarked on the leadership and guidance provided by State officials and feel very well informed and find State administrators to be helpful and responsive. Some of the guidance offered to counties includes issuing standard orders, establishing standards through their procedure manual, and providing templates that can be modified based on county needs.

Success also has been contingent on buy-in from the health departments, clinics, and providers. Their readiness to accept the training does impact the success of such a program. Having an individual that can coordinate and champion this initiative also contributes to success. The health departments across the State have expanded OH programming further by reaching out to community programs and agencies interested in collaborating on OH.

The following were identified as challenges during implementation of activities:

- High number of TA/training requests
- Maintaining current funding levels
- Turnover in clinic staffs
- Ensuring timely followup care
- Getting buy-in from private dentists
- Motivating the pediatricians and PCPs.

Dr. McKenney is responsible for managing the requests for training and TA submitted by the county health departments and reports that the Regional OH Consultants are not able to meet the high level of training requests. Some also felt that the staff and provider turnover and leadership changes in the clinics and county health departments have made it difficult to sustain continuity and maintain buy-in from clinic staff members. This turnover makes it difficult to sustain the impact of the training if they have to return to a clinic site regularly to conduct training sessions. Turnover rates are especially high among providers working at the Tribal health centers. It has been challenging, because some centers have higher provider turnover rates.

Everyone interviewed consistently referenced the shortage of dental providers and how this has limited access to dental services. As the participation of pediatricians and other providers are raising OH screening rates, greater numbers of children in need of dental services also are being identified. To address this, some health departments have established their own dental clinics with assistance from the Regional OH Consultants. These clinics report that once they begin offering OH services, they experience too large a demand for these services to be met. Some departments without dental services have established referral agreements with dental clinics to see children that are identified as having urgent needs. The largest clinic system in Wisconsin, the Marshfield Clinic System, is offering competitive salaries in an effort to recruit new dental graduates in the field of public health dentistry.

Some counties have faced challenges in getting buy-in from the dental society and private dental health professionals. Some private dental professionals have resisted the expansion of publicly funded dental services and contested the effectiveness of preventive clinical interventions, such as dental sealants and fluoride varnish treatment. The Regional OH Consultants have worked with private dentists in each of these counties to address resistance. Having dental expertise has given them legitimacy in the private dental community. They have shared data and research with providers and facilitated better relationships. The Regional OH Consultants have been able to provide education and ease concerns.

While the Regional OH Consultants have reported that most of the practitioners have been open to the training on OH issues, some have had difficulty motivating pediatricians to incorporate the fluoride varnish applications consistently into their visits. The physicians report that as a result of the training, they now place greater emphasis on the prevention of baby bottle tooth decay and provide more anticipatory guidance but find it difficult to incorporate the fluoride varnish application due to time constraints.

Data Collection/Evaluation Process – Issues/Strategies/Promising Approaches:

All those involved in the SOHCS grant activities believe that they have been highly effective in meeting their goals and objectives and feel that they have transformed the public health dental system.

The grant has allowed them to increase surveillance capacity and increase the provision of direct services. The program is capturing the number of providers that are receiving training and are also capturing increased screening data, when available. Some health departments and clinics have collected data but this process has been difficult. The largest clinic system in the State, the Marshfield Clinic System, has included dental screening data into the electronic medical record. This screening data captures the condition of the child's teeth and is required before a fluoride varnish application.

Sustainability Process – Issues/Strategies/Promising Approaches:

Within the Bureau of Health Information and Policy, a policy analyst functions as the grant writer and also looks for funding opportunities. He has identified some private funding sources through philanthropic organizations.

The SOHCS grant has been important in leveraging a significant amount of funds to expand OH efforts and was instrumental in winning a highly competitive award of $450,000 from the BCBS of Wisconsin Foundation. The infrastructure set in place through the OH Consultants strengthened their application and increases their ability to implement OH activities. The OH Consultants also have helped leveraging of additional OH funding at the local levels by working with health centers and health departments to apply for grants.

Furthermore, the Medicaid reimbursement (fluoride varnish application) for physicians is important to the sustainability of the program.

Feedback to the MCHB:

The OH program reports that assistance with surveillance and data (data gathered by local health departments) would be helpful in improving their surveillance capacity.

Interviewees appreciated the flexibility of the grant but stressed the need to expand the size of the grant, to support more training and TA activities. Having the grant include an evaluation component was also mentioned during the site visit, which some felt would be

important to evaluate long-term outcomes. There is also an interest on obtaining information on successful service delivery models and reimbursement models implemented in other States.

Other Comments:

The following were identified as key achievements:

- Transformed the public health dental system
- Leveraged other resources
- Increased access (through primary care and public health providers)
- Established dental homes for children
- Expanded OH infrastructure.

The training has been successful in increasing awareness of OH among primary care physicians, who report that they did not receive this information in medical school. The Consultants feel that OH fits well into the medical model and that using providers improves access and is an efficient use of funds.

From the county perspective, the grant has expanded the OH infrastructure; as a result, the provision of direct services. The local health departments have recognized for a long time that OH is one of the greatest public health needs, but until this program, they have felt unable to address the need. Some county health departments established oral heath programs with the TA and training provided through this grant. Some County Health Department Officials expressed that they would not have implemented OH programs without this TA because they lacked the background and expertise in OH.

Another county reports they have incorporated fluoride varnish successfully into the clinic flow and offer it with immunizations during the WIC clinic. A few nurses have been trained to apply them and are now very efficient at it. This service really has spread through word of mouth, and patients now are coming in and requesting the fluoride varnish applications, just as they would immunizations for their child.

Appendix D: Codebook for Qualitative Data

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Appendix D. Codebook for Qualitative Data

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
NA1		Prof_car	Requests for carryover were made	Prof_car_NA1A	No		Legitimate skip = Not applicable Missing = Not asked
				Prof_car_NA1B	Yes		
				Prof_car_NA197	Don't know		
				Prof_car_NA198	Legitimate skip		
				Prof_car_NA199	Missing		
NA2		Prof_struc	Does State have: CDC Oral Health grant	Prof_struc_NA2A	No		
				Prof_struc_NA2B	Yes		
				Prof_struc_NA297	Don't know		
				Prof_struc_NA299	Missing		
NA3		Prof_struc	Does State have: State Oral Health Plan	Prof_struc_NA3A	No		
				Prof_struc_NA3B	Yes		
				Prof_struc_NA397	Don't know		
				Prof_struc_NA399	Missing		
NA4		Prof_struc	Does State have: State Oral Health Coalition	Prof_struc_NA4A	No		
				Prof_struc_NA4B	Yes		
				Prof_struc_NA497	Don't know		
				Prof_struc_NA499	Missing		
NA5		Prof_struc	Does State have: State Oral Health Director	Prof_struc_NA5A	No		
				Prof_struc_NA5B	Yes		
				Prof_struc_NA597	Don't know		
				Prof_struc_NA599	Missing		
1	1	Back	Had coalition	Back_1A	No		
				Back_1B	Yes		
				Back_197	Don't know		
				Back_198	Legitimate skip		
				Back_199	Missing		
1a		Back	Coalition conveners	Back_1aA	Public	(Office of Oral Health, Associations)	
				Back_1aB	Private		
				Back_1a97	Don't know		
				Back_1a98	Legitimate skip		
				Back_1a99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
1b		Back	Coalition funding	Back_1bA	None, done on volunteer basis		
				Back_1bB	MCHB money		
				Back_1bC	Foundations		
				Back_1bD	Key stakeholders	(Dental society, dental plans)	
				Back_1bE	Other		
				Back_1b97	Don't know		
				Back_1b98	Legitimate skip		
				Back_1b99	Missing		
2	2	Back	Grant housed	Back_2A	Schools/Universities		
				Back_2B	MCH programs	(family health, CSHCN, health systems)	
				Back_2C	Offices of Oral Health	(includes dental hygienists office)	
				Back_2D	Preventative Health	(Chronic disease, health promotion)	
				Back_2E	Other	(additional bureaus, divisions, foundations	
				Back_297	Don't know		
				Back_298	Legitimate skip		
				Back_299	Missing		
2_1		Back	Why	Back_2_1A	Not captured		
				Back_2_1EX	Examples provided		
				Back_2_197	Don't know		
				Back_2_199	Missing		
3	3	Back	Goal development	Back_3A	Internal group input		
				Back_3B	External group input		
				Back_3C	Needs assessment	(surveys)	
				Back_3D	Expansion of existing activities		
				Back_3E	Based on previous goals/ideas		
				Back_3F	Other		
				Back_397	Don't know		
				Back_398	Legitimate skip		
				Back_399	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
4		Back	Issues encountered during planning/development	Back_4A	Insufficient time		
				Back_4B	Delays due to state bureaucracy		
				Back_4C	Delay due to policy issues		
				Back_4D	Delay due to funding		
				Back_4E	Delay to calendar differences	(Federal vs State)	
				Back_4F	Infrastructure		
				Back_4G	Not having the "right" people invloved		
				Back_4H	No issues identified		
				Back_4I	Other		
				Back_497	Don't know		
				Back_498	Legitimate skip		
				Back_499	Missing		
4_1		Back	How were issues handled	Back_4_1A	Identify person to be responsible for program		
				Back_4_1B	Not captured		
				Back_4_1EX	Examples provided		
				Back_4_197	Don't know		
				Back_4_198	Legitimate skip		
				Back_4_199	Missing		
5	4	Back	Goals change	Back_5A	No		
				Back_5B	Yes		
				Back_597	Don't know		
				Back_598	Legitimate skip		
				Back_599	Missing		
5_1		Back	If yes, why	Back_5_1A	Insufficient staff		
				Back_5_1B	Unrealistic, too broad		
				Back_5_1C	Unrealistic, not broad enough		
				Back_5_1D	Emphasis shift between 2003 vs 2004-07		
				Back_5_1E	Emphasis shift within 2004-07		
				Back_5_1F	Other		
				Back_5_197	Don't know		
				Back_5_198	Legitimate skip		
				Back_5_199	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
6	1	Guid	MCHB's goals for SOHCS grants reasonable	Guid_6A	No		
				Guid_6B	Yes		
				Guid_6C	Not familiar with goals		
				Guid_697	Don't know		
				Guid_698	Legitimate skip		
				Guid_699	Missing		
6a		Guid	Why/Why Not	Guid_6aA	Insufficient funding		
				Guid_6aB	States had opportunity to define goals to suit their own needs		
				Guid_6aC	Successful partnerships		
				Guid_6aD	Other		
				Guid_6a97	Don't know		
				Guid_6a99	Missing		
7	2	Guid	Application guidance provided by MCHB helpful in planning program	Guid_7A	No		
				Guid_7B	Yes		
				Guid_797	Don't know		
				Guid_798	Legitimate skip		
				Guid_799	Missing		
8	1	PA	Critical elements	PA_8A	Dental sealant		
				PA_8B	Infrastructure building		
				PA_8C	Surveillance	(data collection)	
				PA_8D	Fluoride varnish		
				PA_8E	Cleaning/restorative		
				PA_8F	Screening/oral exams		
				PA_8G	Dental education	(ECC, Head Start)	
				PA_8H	Social marketing campaign		
				PA_8I	Develop training modules	Education of providers	
				PA_8J	Advocacy/policy making		
				PA_8K	Other		
				PA_897	Don't know		
				PA_898	Legitimate skip		
				PA_899	Missing		
			SOHCS grant support of identified integral components of oral health infrastructure				
8a		PA	Director salary	PA_8aA	No		
				PA_8aB	Yes	Includes full and partial funding	
				PA_8a97	Don't know		
				PA_8a98	Legitimate skip		
				PA_8a99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
8b		PA	Plan development	PA_8bA	No		
				PA_8bB	Yes		
				PA_8b97	Don't know		
				PA_8b98	Legitimate skip		
				PA_8b99	Missing		
8c		PA	Coalition work	PA_8cA	No		
				PA_8cB	Yes		
				PA_8c97	Don't know		
				PA_8c98	Legitimate skip		
				PA_8c99	Missing		
8d		PA	Funding leverage	PA_8dA	No		
				PA_8dB	Yes, from State		
				PA_8dC	Yes, from local		
				PA_8dD	Yes, from Foundation		
				PA_8dE	Yes, from other		
				PA_8d97	Don't Know		
				PA_8d98	Legitimate skip		
				PA_8d99	Missing		
8e		PA	Surveillance	PA_8eA	No		
				PA_8eB	Yes		
				PA_8e97	Don't know		
				PA_8e98	Legitimate skip		
				PA_8e99	Missing		
8f		PA	Population- based interventions	PA_8fA	No		
				PA_8fB	Yes		
				PA_8f97	Don't know		
				PA_8f98	Legitimate skip		
				PA_8f99	Missing		
9	2	PA	Determination of activities	PA_9A	Use of data		
				PA_9B	Best practices		
				PA_9C	Evidence-based		
				PA_9D	Expert consultation		
				PA_9E	Contractors determined activites		
				PA_9F	Coalition determined		
				PA_9G	Dental Director determined		
				PA_9H	Other		
				PA_997	Don't know		
				PA_998	Legitimate skip		
				PA_999	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
9_1		PA	Describe the process involved	PA_9_1A	Needs assessment		
				PA_9_1B	Not captured		
				PA_9_1EX	Examples provided		
				PA_9_197	Don't know		
				PA_9_199	Missing		
9a		PA	Data gaps	PA_9aA	Establish best practices		
				PA_9aB	Other		
				PA_9a97	Don't know		
				PA_9a98	Legitimate skip		
				PA_9a99	Missing		
9b		PA	Integration	PA_9bA	No		
				PA_9bB	Yes		
				PA_9b97	Don't know		
				PA_9b98	Legitimate skip		
				PA_9b99	Missing		
9c		PA	Continuity	PA_9cA	No		
				PA_9cB	Yes		
				PA_9c97	Don't know		
				PA_9c98	Legitimate skip		
				PA_9c99	Missing		
9d		PA	If not, how are these being managed	PA_9dA	Not captured		
				PA_9dEX	Examples provided		
				PA_9d97	Don't know		
				PA_9d98	Legitimate skip		
				PA_9d99	Missing		
9e		PA	Reimbursement and billing issues	PA_9eA	Honorariums		
				PA_9eB	Bill insurance	(Medicaid)	
				PA_9eC	Other		
				PA_9e97	Don't know		
				PA_9e98	Legitimate skip		
				PA_9e99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
10	3	PA	Target audience	PA_10A_1A	Low income population- Dental sealants	(children and/or adults)	
				PA_10A_1B	Low income population-Infrastructure building		
				PA_10A_1C	Low income population-Surveillance		
				PA_10A_1D	Low income population-Fluoride varnish		
				PA_10A_1E	Low income population-Cleaning/restorative		
				PA_10A_1F	Low income population-Screening/oral exams		
				PA_10A_1G	Low income population-Dental education		
				PA_10A_1H	Low income population-Social marketing campaign		
				PA_10A_1I	Low income population-Develop training modules		
				PA_10A_1J	Low income population-Advocacy/policy making		
				PA_10A_1K	Low income population- Other		
				PA_10B_1A	Children 0-pre k Dental sealants		
				PA_10B_1B	Children 0-pre k Infrastructure building		
				PA_10B_1C	Children 0-pre k Surveillance		
				PA_10B_1D	Children 0-pre k Fluoride varnish		
				PA_10B_1E	Children 0-pre k Cleaning/restorative		
				PA_10B_1F	Children 0-pre k Screening/oral exams		
				PA_10B_1G	Children 0-pre k Dental education		
				PA_10B_1H	Children 0-pre k Social marketing campaign		
				PA_10B_1I	Children 0-pre k Develop training modules		
				PA_10B_1J	Children 0-pre k Advocacy/policy making		
				PA_10B_1K	Children 0-pre k Other		
				PA_10C_1A	Children grades k-5- Dental sealants	(Elementary)	

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10C_1B	Children grades k-5- Infrastructure building		
				PA_10C_1C	Children grades k-5- Surveillance		
				PA_10C_1D	Children grades k-5- Fluoride varnish		
				PA_10C_1E	Children grades k-5- Cleaning/restorative		
				PA_10C_1F	Children grades k-5- Screening/oral exams		
				PA_10C_1G	Children grades k-5- Dental education		
				PA_10C_1H	Children grades k-5- Social marketing campaign		
				PA_10C_1I	Children grades k-5- Develop training modules		
				PA_10C_1J	Children grades k-5- Advocacy/policy making		
				PA_10C_1K	Children grades k-5- Other		
				PA_10D_1A	Children grades 6-8 - Dental sealants	(Middle)	
				PA_10D_1B	Children grades 6-8 - Infrastructure building		
				PA_10D_1C	Children grades 6-8 - Surveillance		
				PA_10D_1D	Children grades 6-8 - Fluoride varnish		
				PA_10D_1E	Children grades 6-8 - Cleaning/restorative		
				PA_10D_1F	Children grades 6-8 - Screening/oral exams		
				PA_10D_1G	Children grades 6-8 - Dental education		
				PA_10D_1H	Children grades 6-8 - Social marketing campaign		
				PA_10D_1I	Children grades 6-8 - Develop training modules		
				PA_10D_1J	Children grades 6-8 - Advocacy/policy making		
				PA_10D_1K	Children grades 6-8 - Other		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10G_1A	Head Start - Dental sealants	(Includes EHS)	
				PA_10G_1B	Head Start Infrastructure building		
				PA_10G_1C	Head Start Surveillance		
				PA_10G_1D	Head Start Fluoride varnish		
				PA_10G_1E	Head Start Cleaning/restorative		
				PA_10G_1F	Head Start Screening/oral exams		
				PA_10G_1G	Head Start Dental education		
				PA_10G_1H	Head Start Social marketing campaign		
				PA_10G_1I	Head Start Develop training modules		
				PA_10G_1J	Head Start Advocacy/policy making		
				PA_10G_1K	Head Start - Other		
				PA_10H_1A	Head Start families- Dental sealants	(Includes EHS families)	
				PA_10H_1B	Head Start families Infrastructure building		
				PA_10H_1C	Head Start families Surveillance		
				PA_10H_1D	Head Start families Fluoride varnish		
				PA_10H_1E	Head Start families Cleaning/restorative		
				PA_10H_1F	Head Start families Screening/oral exams		
				PA_10H_1G	Head Start families Dental education		
				PA_10H_1H	Head Start families Social marketing campaign		
				PA_10H_1I	Head Start families Develop training modules		
				PA_10H_1J	Head Start families Advocacy/policy making		
				PA_10H_1K	Head Start families - Other		
				PA_10I_1A	Oral health providers- Dental sealants	(dentists, dental hygienists, etc)	

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10I_1B	Oral health providers Infrastructure building		
				PA_10I_1C	Oral health providers Surveillance		
				PA_10I_1D	Oral health providers Fluoride varnish		
				PA_10I_1E	Oral health providers Cleaning/restorative		
				PA_10I_1F	Oral health providers Screening/oral exams		
				PA_10I_1G	Oral health providers Dental education		
				PA_10I_1H	Oral health providers Social marketing campaign		
				PA_10I_1I	Oral health providers Develop training modules		
				PA_10I_1J	Oral health providers Advocacy/policy making		
				PA_10I_1K	Oral health providers- Other		
				PA_10J_1A	Non-oral health medical providers- Dental sealants	(ob/gyn, family practice, pediatricians)	
				PA_10J_1B	Non-oral health medical providers Infrastructure building		
				PA_10J_1C	Non-oral health medical providers Surveillance		
				PA_10J_1D	Non-oral health medical providers Fluoride varnish		
				PA_10J_1E	Non-oral health medical providers Cleaning/restorative		
				PA_10J_1F	Non-oral health medical providers Screening/oral exams		
				PA_10J_1G	Non-oral health medical providers Dental education		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10J_1H	Non-oral health medical providers Social marketing campaign		
				PA_10J_1I	Non-oral health medical providers Develop training modules		
				PA_10J_1J	Non-oral health medical providers Advocacy/policy making		
				PA_10J_1K	Non-oral health medical providers Other		
				PA_10K_1A	Non-medical providers- Dental sealants	(caregivers, educators)	
				PA_10K_1B	Non-medical providers Infrastructure building		
				PA_10K_1C	Non-medical providers Surveillance		
				PA_10K_1D	Non-medical providers Fluoride varnish		
				PA_10K_1E	Non-medical providers Cleaning/restorative		
				PA_10K_1F	Non-medical providers Screening/oral exams		
				PA_10K_1G	Non-medical providers Dental education		
				PA_10K_1H	Non-medical providers Social marketing campaign		
				PA_10K_1I	Non-medical providers Develop training modules		
				PA_10K_1J	Non-medical providers Advocacy/policy making		
				PA_10K_1K	Non-medical providers Other		
				PA_10L_1A	Pregnant women- Dental sealants		
				PA_10L_1B	Pregnant women Infrastructure building		
				PA_10L_1C	Pregnant women Surveillance		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10L_1D	Pregnant women Fluoride varnish		
				PA_10L_1E	Pregnant women Cleaning/restorative		
				PA_10L_1F	Pregnant women Screening/oral exams		
				PA_10L_1G	Pregnant women Dental education		
				PA_10L_1H	Pregnant women Social marketing campaign		
				PA_10L_1I	Pregnant women Develop training modules		
				PA_10L_1J	Pregnant women Advocacy/policy making		
				PA_10L_1K	Pregnant women Other		
				PA_10M_1A	Other consumers - Dental sealants	(consumer of ins plan, etc)	
				PA_10M_1B	Other consumers Infrastructure building		
				PA_10M_1C	Other consumers Surveillance		
				PA_10M_1D	Other consumers Fluoride varnish		
				PA_10M_1E	Other consumers Cleaning/restorative		
				PA_10M_1F	Other consumers Screening/oral exams		
				PA_10M_1G	Other consumers Dental education		
				PA_10M_1H	Other consumers Social marketing campaign		
				PA_10M_1I	Other consumers Develop training modules		
				PA_10M_1J	Other consumers Advocacy/policy making		
				PA_10M_1K	Other consumers Other		
				PA_10N_1A	WIC agency- Dental sealants		
				PA_10N_1B	WIC agency Infrastructure building		
				PA_10N_1C	WIC agency Surveillance		
				PA_10N_1D	WIC agency Fluoride varnish		
				PA_10N_1E	WIC agency Cleaning/restorative		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10N_1F	WIC agency Screening/oral exams		
				PA_10N_1G	WIC agency Dental education		
				PA_10N_1H	WIC agency Social marketing campaign		
				PA_10N_1I	WIC agency Develop training modules		
				PA_10N_1J	WIC agency Advocacy/policy making		
				PA_10N_1K	WIC Agency Other		
				PA_10O_1A	MCH agency- Dental sealants		
				PA_10O_1B	MCH agency Infrastructure building		
				PA_10O_1C	MCH agency Surveillance		
				PA_10O_1D	MCH agency Fluoride varnish		
				PA_10O_1E	MCH agency Cleaning/restorative		
				PA_10O_1F	MCH agency Screening/oral exams		
				PA_10O_1G	MCH agency Dental education		
				PA_10O_1H	MCH agency Social marketing campaign		
				PA_10O_1I	MCH agency Develop training modules		
				PA_10O_1J	MCH agency Advocacy/policy making		
				PA_10O_1K	MCH agency Other		
				PA_10P_1A	CSHCN agency- Dental sealants		
				PA_10P_1B	CSHCN agency Infrastructure building		
				PA_10P_1C	CSHCN agency Surveillance		
				PA_10P_1D	CSHCN agency Fluoride varnish		
				PA_10P_1E	CSHCN agency Cleaning/restorative		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10P_1F	CSHCN agency Screening/oral exams		
				PA_10P_1G	CSHCN agency Dental education		
				PA_10P_1H	CSHCN agency Social marketing campaign		
				PA_10P_1I	CSHCN agency Develop training modules		
				PA_10P_1J	CSHCN agency Advocacy/policy making		
				PA_10P_1K	CSHCN agency Other		
				PA_10Q_1A	Department of Education- Dental sealants		
				PA_10Q_1B	Department of Education Infrastructure building		
				PA_10Q_1C	Department of Education Surveillance		
				PA_10Q_1D	Department of Education Fluoride varnish		
				PA_10Q_1E	Department of Education Cleaning/restorative		
				PA_10Q_1F	Department of Education Screening/oral exams		
				PA_10Q_1G	Department of Education Dental education		
				PA_10Q_1H	Department of Education Social marketing campaign		
				PA_10Q_1I	Department of Education Develop training modules		
				PA_10Q_1J	Department of Education Advocacy/policy making		
				PA_10Q_1K	Department of Education Other		
				PA_10R_1A	Advocacy organizations- Dental sealants		
				PA_10R_1B	Advocacy organizations- Infrastructure building		
				PA_10R_1C	Advocacy organizations- Surveillance		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10R_1D	Advocacy organizations- Fluoride varnish		
				PA_10R_1E	Advocacy organizations- Cleaning/restorative		
				PA_10R_1F	Advocacy organizations- Screening/oral exams		
				PA_10R_1G	Advocacy organizations Dental education		
				PA_10R_1H	Advocacy organizations- Social marketing campaign		
				PA_10R_1I	Advocacy organizations- Develop training modules		
				PA_10R_1J	Advocacy organizations- Advocacy/policy making		
				PA_10R_1K	Advocacy organizations- Other		
				PA_10S_1A	Oral health associations- Dental sealants		
				PA_10S_1B	Oral health associations Infrastructure building		
				PA_10S_1C	Oral health associations Surveillance		
				PA_10S_1D	Oral health associations Fluoride varnish		
				PA_10S_1E	Oral health associations Cleaning/restorative		
				PA_10S_1F	Oral health associations Screening/oral exams		
				PA_10S_1G	Oral health associations Dental education		
				PA_10S_1H	Oral health associations Social marketing campaign		
				PA_10S_1I	Oral health associations Develop training modules		
				PA_10S_1J	Oral health associations Advocacy/policy making		
				PA_10S_1K	Oral health associations Other		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10T_1A	Medical associations- Dental sealants		
				PA_10T_1B	Medical associations Infrastructure building		
				PA_10T_1C	Medical associations Surveillance		
				PA_10T_1D	Medical associations Fluoride varnish		
				PA_10T_1E	Medical associations Cleaning/restorative		
				PA_10T_1F	Medical associations Screening/oral exams		
				PA_10T_1G	Medical associations Dental education		
				PA_10T_1H	Medical associations Social marketing campaign		
				PA_10T_1I	Medical associations Develop training modules		
				PA_10T_1J	Medical associations Advocacy/policy making		
				PA_10T_1K	Medical associations Other		
				PA_10U_1A	SCHIP/Medicaid- Dental sealants		
				PA_10U_1B	SCHIP/Medicaid- Infrastructure building		
				PA_10U_1C	SCHIP/Medicaid- Surveillance		
				PA_10U_1D	SCHIP/Medicaid- Fluoride varnish		
				PA_10U_1E	SCHIP/Medicaid- Cleaning/restorative		
				PA_10U_1F	SCHIP/Medicaid- Screening/oral exams		
				PA_10U_1G	SCHIP/Medicaid- Dental education		
				PA_10U_1H	SCHIP/Medicaid- Social marketing campaign		
				PA_10U_1I	SCHIP/Medicaid- Develop training modules		

Appendix D. Codebook for Qualitative Data

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_10U_1J	SCHIP/Medicaid-Advocacy/policy making		
				PA_10U_1K	SCHIP/Medicaid Other		
				PA_10V_1A	Coalition members-Dental sealants		
				PA_10V_1B	Coalition members-Infrastructure building		
				PA_10V_1C	Coalition members Surveillance		
				PA_10V_1D	Coalition members Fluoride varnish		
				PA_10V_1E	Coaltion members Cleaning/restorative		
				PA_10V_1F	Coalition members Screening/oral exams		
				PA_10V_1G	Coalition members Dental education		
				PA_10V_1H	Coalition members Social marketing campaign		
				PA_10V_1I	Coalition members Develop training modules		
				PA_10V_1J	Coalition members Advocacy/policy making		
				PA_10V_1K	Coalition members-Other		
				PA_10W_1A	Other- Dental sealants	(community stakeholders)	
				PA_10W_1B	Other Infrastructure building		
				PA_10W_1C	Other Surveillance		
				PA_10W_1D	Other Fluoride varnish		
				PA_10W_1E	Other Cleaning/restorative		
				PA_10W_1F	Other Screening/oral exams		
				PA_10W_1G	Other Dental education		
				PA_10W_1H	Other Social marketing campaign		
				PA_10W_1I	Other Develop training modules		
				PA_10W_1J	Other Advocacy/policy making		
				PA_1097	Don't know	(location)	
				PA_1099	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
10_1		PA	Identification of target audience	PA_10_1A	Needs assessment		
				PA_10_1B	Small grant applications		
				PA_10_1C	Individuals who conduct screenings		
				PA_10_1D	Other		
				PA_10_197	Don't know		
				PA_10_198	Legitimate skip		
				PA_10_199	Missing		
11	4	PA	Cultural appropriateness	PA_11A	Not considered		
				PA_11B	No resources to address appropriateness		
				PA_11C	Professional org provided input	(Multicultural center)	
				PA_11D	Staff had previous training		
				PA_11E	Bi-lingual staff		
				PA_11F	Internal review		
				PA_11G	Other		
				PA_1197	Don't know		
				PA_1198	Legitimate skip		
				PA_1199	Missing		
11_1		PA	Impact of cultural differences	PA_11_1A	Materials were developed in other languages	with SOHCS grant funding	
				PA_11_1B	Other	includes the development of materials with non-SOHCS funds and the use of existing materials	
				PA_11_198	Legitimate skip		
				PA_11_199	Missing		
12	5	PA	Staffing	PA_12A_1A	State Dental Director- coordinates activities		
				PA_12A_1B	State Dental Director-manages the budget		
				PA_12A_1C	State Dental Director-provides direct services		
				PA_12A_1D	State Dental Director-provides TA/training		
				PA_12A_1E	State Dental Director- delivers core activities		
				PA_12A_1F	State Dental Director- other		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_12A_197	State Dental Director-don't know		
				PA_12B_1A	Administrator/manager- coordinates activities		
				PA_12B_1B	Administrator/manager-manages the budget		
				PA_12B_1C	Administrator/manager-provides direct services		
				PA_12B_1D	Administrator/manager-provides TA/training		
				PA_12B_1E	Administrator/manager-delivers core activities		
				PA_12B_1F	Administrator/manager-other		
				PA_12B_197	Administrator/manager- don't know		
				PA_12C_1A	Social worker/case manager - coordinates activities		
				PA_12C_1B	Social worker/case manager - manages the budget		
				PA_12C_1C	Social worker/case manager -provides direct services		
				PA_12C_1D	Social worker/case manager -provides TA/training		
				PA_12C_1E	Social worker/case manager -delivers core activities		
				PA_12C_1F	Social worker/case manager -other		
				PA_12C_197	Social worker/case manager -don't know		
				PA_12D_1A	Nurse/PA -coordinates activities		
				PA_12D_1B	Nurse/PA -manages the budget		
				PA_12D_1C	Nurse/PA -provides direct services		
				PA_12D_1D	Nurse/PA -provides TA/training		
				PA_12D_1E	Nurse/PA -delivers core activities		
				PA_12D_1F	Nurse/PA -other		
				PA_12D_197	Nurse/PA -don't know		
				PA_12E_1A	Dentists -coordinates activities		
				PA_12E_1B	Dentists -manages the budget		
				PA_12E_1C	Dentists -provides direct services		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_12E_1D	Dentists -provides TA/training		
				PA_12E_1E	Dentists -delivers core activities		
				PA_12E_1F	Dentists - other		
				PA_12E_197	Dentists - don't know		
				PA_12F_1A	hygienists -coordinates activities		
				PA_12F_1B	hygienists -manages the budget		
				PA_12F_1C	hygienists -provides direct services		
				PA_12F_1D	hygienists -provides TA/training		
				PA_12F_1E	hygienists -delivers core activities		
				PA_12F_1F	hygienists - other		
				PA_12F_197	hygienists - don't know		
				PA_12G_1A	Oral health contractor/consultant - coordinates activities		
				PA_12G_1B	Oral health contractor/consultant - manages the budget		
				PA_12G_1C	Oral health contractor/consultant - provides direct services		
				PA_12G_1D	Oral health contractor/consultant - provides TA/training		
				PA_12G_1E	Oral health contractor/consultant - delivers core activities		
				PA_12G_1F	Oral health contractor/consultant - other		
				PA_12G_197	Oral health contractor/consultant - don't know		
				PA_12H_1A	Non-oral health consultant- coordinates activities		
				PA_12H_1B	Non-oral health consultant -manages the budget		
				PA_12H_1C	Non-oral health consultant-provides direct services		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
				PA_12H_1D	Non-oral health consultant-provides TA/training		
				PA_12H_1E	Non-oral health consultant-delivers core activities		
				PA_12H_1F	Non-oral health consultant- other		
				PA_12H_197	Non-oral health consultant- don't know		
				PA_12I_1A	Coalition members -coordinates activities		
				PA_12I_1B	Coalition members -manages the budget		
				PA_12I_1C	Coalition members -provides direct services		
				PA_12I_1D	Coalition members -provides TA/training		
				PA_12I_1E	Coalition members -delivers core activities		
				PA_12I_1F	Coalition members - other		
				PA_12I_197	Coalition members -don't know		
				PA_12J	Other		
				PA_1297	Don't know		
				PA_1299	Missing		
12_2		PA	Change over time	PA_12_2A	No		
				PA_12_2B	Yes		
				PA_12_297	Don't know		
				PA_12_299	Missing		
12a		PA	Non-dental professionals work on grant activities	PA_12aA	No		
				PA_12aB	Yes		
				PA_12a97	Don't know		
				PA_12a98	Legitimate skip		
				PA_12a99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
12b		PA	Factors that influenced this decision	PA_12bA	Need to partner with non-dental professionals for oral health promotion		
				PA_12bB	Work within existing health delivery system		
				PA_12bC	Other		
				PA_12b97	Don't know		
				PA_12b98	Legitimate skip		
				PA_12b99	Missing		
12c		PA	Impact of State regulations on program	PA_12cA	No impact		
				PA_12cB	Yes/other		
				PA_12cC	Delayed implementation		
				PA_12c97	Don't know		
				PA_12c98	Legitimate skip		
				PA_12c99	Missing		
12d		PA	Opposition	PA_12dA	None		
				PA_12dEX	Yes, examples provided		
				PA_12d97	Don't know		
				PA_12d98	Legitimate skip		
				PA_12d99	Missing		
12e		PA	Steps taken to address this opposition	PA_12eA	None		
				PA_12eEX	Yes, examples provided		
				PA_12e97	Don't know		
				PA_12e98	Legitimate skip		
				PA_12e99	Missing		
13	6	PA	Additional partners/agencies involved	PA_13A	No		
				PA_13B	Yes		
				PA_1397	Don't know		
				PA_1398	Legitimate skip		
				PA_1399	Missing		
13a		PA	Scholol partners	PA_13aA	No		
				PA_13aB	Yes		
				PA_13aWN	Reason why not		
				PA_13a97	Don't know		
				PA_13a98	Legitimate skip		
				PA_13a99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
13b		PA	State Dental Association partners	PA_13bA	No		
				PA_13bB	Yes		
				PA_13bWN	Reason why not		
				PA_13b97	Don't know		
				PA_13b98	Legitimate skip		
				PA_13b99	Missing		
13c		PA	Partner with pediatricians	PA_13cA	No		
				PA_13cB	Yes		
				PA_13cWN	Reason why not		
				PA_13c97	Don't know		
				PA_13c98	Legitimate skip		
				PA_13c99	Missing		
13d		PA	Private dentists	PA_13dA	No		
				PA_13dB	Yes		
				PA_13dWN	Reason why not		
				PA_13d97	Don't know		
				PA_13d98	Legitimate skip		
				PA_13d99	Missing		
13d_1			Engagement of private dentists	PA_13d_1EX	Examples provided		
				PA_13d_197	Don't know		
				PA_13d_198	Legitimate skip		
				PA_13d_199	Missing		
14	7	PA	State MCH/Title V agency	PA_14A	No relationship		
				PA_14B	Yes, relationship		
				PA_14EX	Examples provided	(nature of relationship)	
				PA_1497	Don't know		
				PA_1498	Legitimate skip		
				PA_1499	Missing		
14a		PA	Oral health as a priority need	PA_14aA	No		
				PA_14aB	Yes		
				PA_14a97	Don't know		
				PA_14a99	Missing		
14b		PA	Oral health as a performance measure	PA_14bA	No, no oral health performance measure		
				PA_14bB	Yes		
				PA_14bC	Don't know		
				PA_14b99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
14c		PA	Title V Needs Assessment	PA_14cA	No		
				PA_14cB	Yes		
				PA_14c97	Don't know		
				PA_14c99	Missing		
14c_1		PA	Why/Why Not	PA_14c_1A	Oral health has a big role in State Title V program		
				PA_14c_1B	Housed in same division		
				PA_14c_1C	Other		
				PA_14c_197	Don't know		
				PA_14c_199	Missing		
15	8	PA	SOHCS activities integrated into other Oral Health Activities	PA_15A	No		
				PA_15B	Yes		
				PA_1597	Don't know		
				PA_1598	Legitimate skip		
				PA_1599	Missing		
15_1		PA	How	PA_15_1A	Collaboration with other programs on oral health	(EHS, EPSDT)	
				PA_15_1B	Reporting SOHCS activites at statewide meetings		
				PA_15_1C	Data is used for program justification	(information sharing)	
				PA_15_1D	Form partnerships		
				PA_15_1E	Other		
				PA_14_197	Don't know		
				PA_15_198	Legitimate skip		
				PA_15_199	Missing		
16	1	AC	Key achievements/accomplishments	AC_16A	Statewide data		
				AC_16B	Successful partnering		
				AC_16C	Oral health plan developed		
				AC_16D	Leverage additional funding		
				AC_16E	Oral health awareness	(publicity/raising awareness)	
				AC_16F	Improved access		
				AC_16G	Program development		
				AC_16H	Additional staffing	(paid for through non-SOHCS funds)	
				AC_16I	Establishing relationships	(creation of new relationships)	
				AC_16J	Other		
				AC_1697	Don't know		
				AC_1699	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
17	2	AC	Important to successful implementation	AC_17A	Key partners		
				AC_17B	Infrastructure		
				AC_17C	Planning		
				AC_17D	Support		
				AC_17E	Resources	(including having the right people)	
				AC_17F	Carryover		
				AC_17G	Timing		
				AC_17H	Other		
				AC_1797	Don't know		
				AC_1799	Missing		
18	3	AC	Resources	AC_18A	Information		
				AC_18B	Support		
				AC_18C	Personnel		
				AC_18D	Supplies		
				AC_18E	Financial	(ability to bill 3rd party payers, etc)	
				AC_18F	Other		
				AC_1897	Don't know		
				AC_1899	Missing		
18a		AC	SOHCS Project Officer or MCHB personnel	AC_18aA	No		
				AC_18aB	Yes		
				AC_18a97	Don't know		
				AC_18a99	Missing		
18b		AC	State MCH/Title V personnel	AC_18bA	No		
				AC_18bB	Yes		
				AC_18b97	Don't know		
				AC_18b99	Missing		
18c		AC	Technical assistance	AC_18cA	No		
				AC_18cB	Yes	(if not specific)	
				AC_18cC	Yes, from SOHCS		
				AC_18cD	Yes, from CDC		
				AC_18cE	Yes, from ASTDD		
				AC_18c97	Don't know		
				AC_18c99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
18d		AC	Training	AC_18dA	No		
				AC_18dB	Yes		
				AC_18d97	Don't know		
				AC_18d99	Missing		
18e		AC	Networking	AC_18eA	No		
				AC_18eB	Yes		
				AC_18e97	Don't know		
				AC_18e99	Missing		
18f		AC	Listservs	AC_18fA	No		
				AC_18fB	Yes		
				AC_18f97	Don't know		
				AC_18f99	Missing		
19	4	AC	Barriers/challenges to implementation	AC_19A	Cultural differences		
				AC_19B	Mobilizing/working with partners		
				AC_19C	Staffing issues		
				AC_19D	Availability of materials/resources		
				AC_19E	Delay in funding		
				AC_19F	State restrictions		
				AC_19G	Billing systems		
				AC_19H	Calendar year differences		
				AC_19I	Oral health not a priority		
				AC_19J	None		
				AC_19K	Other		
				AC_1997	Don't know		
				AC_1998	Legitimate skip		
				AC_1999	Missing		
19a		AC	Cultural differences	AC_19aA	No		
				AC_19aB	Yes		
				AC_19a99	Missing		
19b		AC	Working with or mobilizing partners	AC_19bA	No		
				AC_19bB	Yes		
				AC_19b99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
19c		AC	Work force or staffing issues	AC_19cA	No		
				AC_19cB	Yes		
				AC_19c99	Missing		
19d		AC	Materials availability	AC_19dA	No		
				AC_19dB	Yes		
				AC_19d99	Missing		
19e		AC	Delay in funding	AC_19eA	No		
				AC_19eB	Yes		
				AC_192EX	Examples provided		
				AC_19e99	Missing		
19e_1		AC	Strategies used to address them	AC_19e_1EX	Examples provided		
				AC_19e_197	Don't know		
				AC_19e_199	Missing		
20	5	AC	Reason for carryover request	AC_20A	Delay, created by contracts with external agencies		
				AC_20B	Delay, due to other contractual delays		
				AC_20C	Delay, due to difficulty hiring appropriate personnel		
				AC_20D	Delay, due to staff turnover		
				AC_20E	Delay, due to bureaucratic issues		
				AC_20F	Delay, due to calendar mismatch	(Federal vs state)	
				AC_20G	Policy changes		
				AC_20H	Other		
				AC_2097	Don't know		
				AC_2098	Legitimate skip		
				AC_2099	Missing		
21	6	AC	Improve implementation	AC_21A	Additional networking opportunities		
				AC_21B	Knowledge of MCHB Oral Health Resource Center listserv		
				AC_21C	Continuity of staffing		
				AC_21D	No suggestions		
				AC_21E	Other		
				AC_2197	Don't know		
				AC_2199	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
21_1		AC	MCHB improve success	AC_21_1A	Require outcome measures		
				AC_21_1B	Increased communcation	(includes TA)	
				AC_21_1C	Other		
				AC_21_1D	No suggestions		
				AC_21_197	Don't know		
				AC_21_199	Missing		
22	1	Poms	Effectiveness	Poms_22A	Not very effective		
				Poms_22B	Little effective		
				Poms_22C	Very effective		
				Poms_2297	Don't know		
				Poms_2299	Missing		
23	2	Poms	Progress measured	Poms_23A	Number of downloads/hits on a site		
				Poms_23B	Monitoring	(surveys, deliverables)	
				Poms_23C	Number of clients reached		
				Poms_23D	Anecdotal evidence		
				Poms_23E	No		
				Poms_23F	Other		
				Poms_2397	Don't know		
				Poms_2399	Missing		
24	3	Poms	Unintended impacts	Poms_24A	No		
				Poms_24B	Yes, positive		
				Poms_24C	Yes, negative		
				Poms_2497	Don't know		
				Poms_2499	Missing		
25	4	Poms	Strengthen infrastructure	Poms_25A	No		
				Poms_25B	Yes		
				Poms_25EX	Examples provided		
				Poms_2597	Don't know		
				Poms_2599	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
26	5	Poms	Progress monitoring	Poms_26A	Reports	(Annual, monthly, etc)	
				Poms_26B	Site visits to local programs		
				Poms_26C	No regular monitoring		
				Poms_26D	Other		
				Poms_2697	Don't know		
				Poms_2699	Missing		
27	6	Poms	Reporting requirements	Poms_27A	Positive		
				Poms_27B	Neutral		
				Poms_27C	Negative		
				Poms_27D	No experience at time of interview		
				Poms_27E	Other		
				Poms_2797	Don't know		
				Poms_2798	Legitimate skip		
				Poms_2799	Missing		
28	7	Poms	Sustainability plan	Poms_28A	Integrate oral health into other programs		
				Poms_28B	Use of state money		
				Poms_28C	Secure additional funds		
				Poms_28D	Cut backs		
				Poms_28E	Other		
				Poms_28F	No need to sustain	(will have completed all activities)	
				Poms_2897	Don't know		
				Poms_2898	Legitimate skip		
				Poms_2899	Missing		
28a		Poms	No carryover allowed	Poms_28aA	Discontinue projects		
				Poms_28aB	Unable to honor contracts		
				Poms_28aC	Other		
				Poms_28a97	Don't know		
				Poms_28a98	Legitimate skip		
				Poms_28a99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
28b		Poms	Anticipate no-cost extension	Poms_28bA	No		
				Poms_28bB	Yes		
				Poms_28bC	Maybe		
				Poms_28b97	Don't know		
				Poms_28b98	Legitimate skip		
				Poms_28b99	Missing		
28c		Poms	Consequences	Poms_28cA	Termination of program		
				Poms_28cB	Other		
				Poms_28c98	Legitimate skip		
				Poms_28c99	Missing		
29	8	Poms	MCHB support sustainability	Poms_29A	Require outcome objectives		
				Poms_29B	Make oral health a priority in all MCH programs		
				Poms_29C	Offer additional grants addressing oral health		
				Poms_29D	Facilitate communication between grantees		
				Poms_29E	Coordination		
				Poms_29F	Other		
				Poms_2997	Don't know		
				Poms_2998	Legitimate skip		
				Poms_2999	Missing		
29_1		Poms	Other agencies support of sustainability	Poms_29_1A	Offer additional grants addressing oral health		
				Poms_29_1B	Other		
				Poms_29_197	Don't know		
				Poms_29_198	Legitimate skip		
				Poms_29_199	Missing		
30a	1	Rec	Guidance	Rec_30aA	No recommendation		
				Rec_30aB	Increase/facilitate communication		
				Rec_30aC	Other		
				Rec_30a97	Don't know		
				Rec_30a99	Missing		
30b		Rec	Program reporting requirements	Rec_30bA	No recommendation		
				Rec_30bB	Yes/Other		
				Rec_30b97	Don't know		
				Rec_30b99	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
31	2	Rec	Need for technical assistance	Rec_31A	No		
				Rec_31B	Yes, present		
				Rec_31C	Yes, past		
				Rec_3197	Don't know		
				Rec_3199	Missing		
31_1		Rec	What topics	Rec_31_1A	Evaluation		
				Rec_31_1B	Surveillance		
				Rec_31_1C	Monitoring		
				Rec_31_1D	Cultural competency		
				Rec_31_1E	Data collection	(general)	
				Rec_31_1F	Strategic planning		
				Rec_31_1G	Coalition development		
				Rec_31_1H	Other		
				Rec_31_197	Don't know		
				Rec_31_198	Legitimate skip		
				Rec_31_199	Missing		
32	3	Rec	On what topics could your program provide TA to other grantees	Rec_32A	Dental homes		
				Rec_32B	Organizing coalitions		
				Rec_32C	School-based programs		
				Rec_32D	Case management		
				Rec_32E	Social marketing		
				Rec_32F	Other		
				Rec_32G	None		
				Rec_3297	Don't know		
				Rec_3298	Legitimate skip		
				Rec_3299	Missing		
32_1		Rec	Have you provided TA on these topics	Rec_32_1A	No		
				Rec_32_1B	Yes		
				Rec_32_197	Don't know		
				Rec_32_198	Legitimate skip		
				Rec_32_199	Missing		
32_2		Rec	Outcome	Rec_32_2A	Program initiation		
				Rec_32_2B	Other		
				Rec_32_297	Don't know		
				Rec_32_298	Legitimate skip		
				Rec_32_299	Missing		

Question number	Original question number	Structural Code	Description	Code	Response options	Example	Notes
33	4	Rec	SOHCS comments	Rec_33A	Advance warning if MCHB decides to prematurely discontinue SOHCS grant funding		
				Rec_33B	Expedite carryover requests		
				Rec_33C	Emphasis on sharing best practices		
				Rec_33D	Other		
				Rec_33E	No comments		
				Rec_3399	Missing		
34	5	Rec	MCHB oral health initiatives comments	Rec_34A	Continue offering flexible grants		
				Rec_34B	Increased funding		
				Rec_34C	Support training on special needs populations	(Provider trainings)	
				Rec_34D	Offer additional grants addressing oral health		
				Rec_34E	Strengthen link between oral health and chronic disease		
				Rec_34F	Make initiatives more outcome-oriented		
				Rec_34G	Other		
				Rec_34H	No comments		
				Rec_3499	Missing		

Appendix E: References

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Appendix E. References

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