Healthy People 2010

Oral Health Toolkit

National Institute of Dental & Craniofacial Research
National Institutes of Health
Department of Health and Human Services

Foreword

Message from the Chief Dental Officer

Oral health has been a focus area in the Healthy People initiative since its inception in 1979 and, over time, the objectives have grown to cover a range of diseases and conditions, preventive services and programs, and public health infrastructure needs. We have learned about the value of data-derived and data-driven objectives that allow us to measure our progress from where we have been to where we need to be. While as a nation we have made substantial progress in improving oral health over the past two decades, many Americans still suffer unnecessary oral disease that could have been prevented.

The Healthy People 2010 oral health objectives provide us with a wide range of public health challenges and opportunities designed to increase the public's oral health and quality of life and to decrease oral health disparities. These objectives serve to keep us focused and on track as we implement the *National Oral Health Call to Action to Promote Oral Health*, which emanated from *Oral Health in America: A Report of the Surgeon General*.

Achieving the oral health objectives is a great challenge. Multiple approaches are needed, ranging from providing care in a clinical setting, to implementing community-based programs, to conducting research. The Tool Kit is an excellent resource that gives practical advice, methods, resources and examples to help you in planning, implementing and evaluating the oral health objectives in your state, territory, tribe or community.

We look forward to learning about your efforts for achieving the Oral Health objectives in Healthy People 2010 and implementing the *National Oral Health Call to Action to Promote Oral Health*.

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Acknowlegdements

The Oral Health Toolkit was developed by Beverly Isman, RDH, MPH, ELS, through a purchase order with the National Institute of Dental and Craniofacial Research, National Institutes of Health, U. S. Department of Health and Human Services.

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This publication is based on the *Healthy People 2010 Toolkit: A Field Guide to Health Planning* and expanded especially for achieving the Healthy People 2010 oral health objectives and implementing the *Call to Action to Promote Oral Health.*

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We especially appreciate the numerous individuals who provided valuable reviews of this document and many additional persons who provided a variety of examples from local, state and national perspectives.

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Chapter 1

Overview of the Oral Health Toolkit and History of Healthy People Initiatives and HP 2010

"If the only tool you have is a hammer, all of your problems will look like nails."
—Mark Twain

Welcome to the Healthy People 2010 Oral Health Toolkit! The purpose of the Toolkit is to provide guidance, technical tools, and resources to help states, territories, tribes and communities develop and implement successful oral health components of Healthy People 2010 plans as well as other oral health plans.[1] These plans are useful for 1) promoting, implementing and tracking oral health objectives, 2) educating the public and policymakers about oral health needs and disparities, and 3) leveraging resources for oral health-related programs and activities.

This chapter will cover:

1. **An overview of the oral health toolkit chapters and format**
2. **History of the HP 2010 Initiative, Consortium and Oral Health Steering Committee**
3. **Focus areas and leading health indicators**
4. **National oral health objectives and baseline data for 2010 with a comparison to objectives for 1990 and 2000**
5. **A framework for the "National Oral Health Call to Action to Promote Oral Health".**

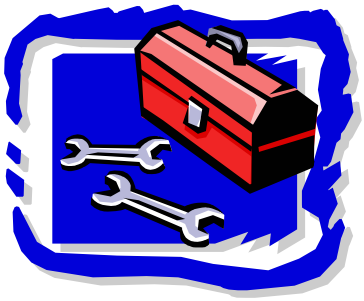
This chapter provides an overview of Healthy People initiatives since 1979 and provides details on the Oral Health Objectives. The other five chapters are organized around major "action areas," which were derived from national and state Healthy People initiatives and are common elements of most health planning and improvement efforts. The other chapters are:

Chapter 2. *Building the Foundation: Leadership and Structure*
Chapter 3. *Setting Health Priorities, Establishing Oral Health Objectives and Obtaining Baseline Data*
Chapter 4. *Identifying and Leveraging Resources*
Chapter 5. *Communicating Oral Health Goals and Objectives*
Chapter 6. *Implementing Strategies, Managing and Sustaining the Process, and Measuring Progress*

Each chapter includes:

- ✓ background information
- ✓ checklists and/or worksheets
- ✓ tips for success
- ✓ national, state/territorial, tribal or community examples
- ✓ resources and references for further information.

Using the Toolkit



The suggested processes, tools, and resources in the chapters can help you build on past successes and refine approaches to planning and achieving HP 2010 objectives. An effective planning initiative should reflect your area's unique needs, resources, and buy-in from a broad constituency. The Resources section at the end of each chapter contains lists of information, references, examples from states, territories, tribes and communities, and Web sites[2] that will help you choose appropriate strategies and contact others for advice.

Each person who uses the Toolkit will have a different background and level of knowledge about the HP 2010 initiative and about oral health issues and programs. The Toolkit is written for a broad audience, including health advocates, health planners and managers, dental public health professionals, clinical dental and medical practitioners, public health workers, and educators, to name a few examples. Some people may be in the initial stages of planning HP 2010 objectives, while others may be participants in ongoing coalitions that are in the process of implementing activities to reach the oral health objectives. How much and what portions of the Toolkit to read and use will depend on individual needs.

The Table of Contents is detailed to allow readers to gain a quick overview of the topics in all of the chapters, including the contents of each Resources section. The first page of each chapter is designed to include an overview of the chapter and some general tips related to the content. The divider page for the Resources section also serves as a reminder by including the table of contents of the resources.

Some ways that people plan to use the Oral Health Toolkit are highlighted below:

Public Health Nurse

" Our community has decided to convene a coalition to address the oral health needs of our citizens. I am a public health nurse and have developed HP 2010 objectives for nutrition and maternal and child health. I feel I need more knowledge about oral health issues and resources so I can help the coalition use HP 2010 as a framework. The oral health infrastructure section of Chapter 2 will be most useful, as well as the examples of oral health objectives and data resources in Chapter 3."

State Dental Director

"I have been the director of a state oral health program for two years and continually fight to have oral health issues included in broad health initiatives. We have been successful in collecting statewide oral health data, but now we need to use the data to highlight oral health issues with our public health colleagues and the public. We need to make sure that oral health objectives are included in the new state health plan that is based on HP 2010 objectives, and we need to identify resources to help implement the plan. I intend to primarily use Chapters 3-6 to guide me in this process. The Web site links and examples from other states will be very helpful."

Territorial Health Director

"Our health department has not had anyone on staff with dental or dental public health expertise for the past year. Although we have a few ongoing community oral health programs and files of oral health information, I don't have the expertise or the time to decide what our oral health priorities should be or how to fund them. I plan to briefly review the Oral Health Toolkit and then convene a small planning group of people with dental and non-dental backgrounds who can read and use the entire manual as a framework for action. We will ask for technical assistance from our HRSA Regional Dental Consultant, as well as from ASTDD, to help us 1) understand and build on existing information, 2) identify and prioritize our needs, and 3) suggest strategies and resources for addressing the needs."

Dental Hygienist in a Tribal Dental Clinic

"I have been asked to participate on the health committee that is developing our HP 2010 health objectives for our tribe. Although I have kept current on clinical dental hygiene practices and community health concepts and programs by attending the IHS Prevention courses and Dental Hygiene Updates, I am not as familiar with the HP 2010 initiative or where to identify resources. I plan to review Chapters 1, 3, 4, and 6, especially the Resources sections, and ask for assistance from the Area Dental Office. I know I can also get feedback or ideas using the dental public health listserv."

The HP 2010 Oral Health Toolkit builds upon and uses material from *Healthy People Toolkit 2010: A Field Guide for Health Planning* developed by the Public Health Foundation (PHF) in 1999 with funding from the Office of Disease Prevention and Health Promotion of the USDHHS. More information about the PHF toolkit and related materials is included available on the Healthy People Web site at **www.healthypeople.gov/state/toolkit/default.htm**.

Because the Oral Health Toolkit is in the public domain, we encourage you to copy it to share with others in your state, territory, community or tribe. This toolkit also is available on the NIDCR Web site at **www.nidcr.nih.gov/health/oralhealthtoolkit/index.asp**.

The Oral Health Co-Leads would like to hear about your HP 2010 initiative, how you are using the Toolkit, and what additional resources or examples would be helpful to you. For requests or comments, contact:

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[1] The term "plan" will be used throughout the Toolkit to indicate "state-, territory-, tribal- or community-specific Healthy People 2010 plan."

[2] Every reasonable effort to confirm the accuracy of all Web site addresses, resource listings, and contact information as of October 2002. We apologize for any inconvenience caused by inaccurate or changed listings.

History Behind the Healthy People 2010 Initiative

The Healthy People Initiative is in part 1) a statistical description of the health of the United States, 2) a textbook on current public health priorities, and 3) a national strategic plan for improving health. Healthy People 2010 builds on initiatives pursued over the past two decades. In 1979, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* provided national goals for reducing premature deaths and preserving independence for older adults. In 1980, another report, *Promoting Health/Preventing Disease: Objectives for the Nation*, set forth 226 targeted health objectives for the nation to achieve over the next 10 years.

Healthy People 2010 is grounded in science, built through public consensus, and designed to measure progress.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives, released in 1990, identified health improvement goals and objectives to be reached by the year 2000. The Healthy People 2010 initiative continues in this tradition as an instrument to improve health for the first decade of the 21st century. Documents related to Healthy People 2010 can be accessed at the Healthy People Web site at **www.healthypeople.gov/Publications/**.

Healthy People 2010 is designed to achieve two overarching goals:

Goal 1:	Help individuals of all ages increase life expectancy and improve their quality of life.
Goal 2:	Eliminate health disparities among different segments of the population.

How Was Healthy People 2010 Developed?

Twenty-eight focus areas of Healthy People 2010, which include 467 specific objectives, have been developed and coordinated by lead federal agencies with the most relevant scientific expertise. The development process was informed by the Healthy People Consortium—an alliance of more than 400 national membership organizations—and 250 state health, mental health, substance abuse, and environmental agencies. Additionally, through a series of regional and national meetings and an interactive Web site, more than 11,000 public comments on the draft objectives were received. The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 also provided leadership and advice in the development of national health objectives. Each of the chapters for the 28 focus areas also contains a concise goal statement. This statement frames the overall purpose of the focus area.

How Does Oral Health Fit into the Focus Areas?

Oral Health GOAL statement:
Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.

Oral health is one of the 28 focus areas. The entire list includes:

Healthy People 2010
Focus Areas

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-Based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. HIV
14. Immunization and Infectious Disease
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. **Oral Health**
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Disease
25. Sexually Transmitted Diseases
26. Substance Abuse
27. Tobacco Use
28. Vision and Hearing

Most oral health objectives are prefaced by the number 21, which references the Oral Health chapter in *Healthy People 2010: Objectives for Improving Oral Health.* Three other oral health objectives are included in other chapters.

How Will the Objectives Be Used?

Healthy People 2010 can be used as: a data resource; a vehicle to involve the public, media and elected officials; a basis to form coalitions and partnerships; the basis of agreements and interactions with government. Individuals, groups, institutions and organizations are encouraged to integrate Healthy People 2010 into current programs, special events, publications, and meetings. Businesses can use the objectives, for example, to guide worksite health promotion activities as well as community-based initiatives. Schools, colleges, and civic and faith-based organizations can undertake activities to further the health of all members of their community. Health care providers can encourage their patients to pursue healthier lifestyles and to participate in community-based programs. By selecting from among the national objectives, individuals and organizations can build an agenda for community health improvement and can monitor results over time. See page 1 of the Resources section of this chapter for more information on Web sites and materials that discuss the Healthy People Objectives and how they are being used.

Healthy People objectives have been specified by Congress as the measure for assessing the progress of the Indian Health Care Improvement Act, the Maternal and Child Health Block Grant, and the Preventive Health and Health Services Block Grant. Healthy People 2010 objectives also have been used in performance measurement activities. For example, the National Committee on Quality Assurance incorporated many Healthy People targets into its Health Plan Employer Data and Information Set (HEDIS) 3.0, a set of standardized measures for health care purchasers and consumers to use in assessing performance of managed care organizations in the areas of clinical preventive services.

What is the Healthy People Consortium?

The Healthy People Consortium is an alliance of organizations committed to making Americans healthier by supporting the goals of Healthy People 2010. It includes over 400 state and territorial public health, mental health, substance abuse, and environmental agencies, and national membership organizations representing professional, voluntary, and business sectors. There also are Focus Area committees. The following national dental organizations are represented on the consortium. These organizations also participated in the oral health work group to develop the HP2010 oral health objectives:

Academy of General Dentistry
American Academy of Pediatric Dentistry
American Dental Association
American Dental Hygienists' Association
American Public Health Association, Oral Health Section
American Association for Dental Research
American Dental Education Association
American Association of Public Health Dentistry
American Association of Community Dental Programs
Association of State and Territorial Dental Directors
Hispanic Dental Association
National Dental Association
Oral Health America

Healthy People 2010 Oral Health Steering Committee

Shortly after the launch of Healthy People 2010, the co-lead agencies formed an Oral Health Steering Committee as an oversight group. The purpose of the steering committee is to provide guidance and insight to the co-leads on identifying strategies to achieve Healthy People 2010 oral health objectives. The group consists of 12-15 members who rotate off the committee after a few years. The majority of members have oral health backgrounds. However, several members have complementary expertise including a county medical director, a member of a local board of public health, an executive director of a foundation and an executive officer of a health center.

What are the Oral Health Objectives?

Table 1.1 is a summary of the age targets and baseline data for the 17 objectives included in the Oral Health chapter. The Oral Health chapter is available at the Healthy People Web site at **www.healthypeople.gov/Document/HTML/volume2/21Oral.htm**.

Table 1.1. Summary: Healthy People 2010 Objectives -- Oral Health

Objective	Age(s)	2010 Baseline	2010 Objective
21.1 Reduce dental caries experience in children	2-4 6-8 15	18% 52% 61%	11% 42% 51%
21.2 Reduce untreated dental decay in children and adults	2-4 6-8 15 35-44	16% 29% 20% 27%	9% 21% 15% 15%
21.3 Increase % of adults with teeth who have never lost a tooth	35-44	31%	42%
21.4 Reduce % of adults who have lost all their teeth	65-74	26%	20%
21.5a Reduce gingivitis among adults	35-44	48%	41%
21.5b Reduce periodontal disease among adults	35-44	22%	14%
21.6 Increase detection of Stage I oral cancer lesions	all	35%	50%
21.7 Increase number of oral cancer examinations	40+	13%	20%
21.8 Increase sealants in 8 year old first molars and in 14 year old first and second molars	8 14	23% (1st) 15% (1st & 2nd)	50% 50%
21.9 Increase persons on public water receiving fluoridated water	all	62%	75%
21.10 Increase utilization of oral health system	2+	44%	56%
21.11 Increase utilization of dental service for those in long-term facilities, e.g., nursing homes	all	19%	25%
21.12 Increase preventive dental services for poor children	0-18	20%	57%
21.13 Increase number of school-based health centers with oral health component	K-12	developmental-unknown	
21.14 Increase number of Community Health Centers and local health departments with oral health component	all	34%	75%
21.15 Increase states with system for recording and referring orofacial clefts	all	23	51
21.16 Increase the number of states with state-based surveillance system	all	0	51
21.17 Increase the number of state & local dental programs with a public health trained director	all	developmental-unknown	

The three 2010 oral health objectives included in other focus areas are:

- **Access:** (1-8) Increase racial and ethnic representation in health professions
- **Cancer:** (3-6) Reduce oropharyngeal cancer deaths
- **Diabetes:** (5-15) Increase percentage of those with annual dental examinations

Clarifying terminology for the objectives is included in the Resources section.

Table 1.2 compares the focus of the national oral health objectives for three decades.

Table 1.2. Oral Health Objectives for Healthy People: Years 1990, 2000, 2010

Focus of Objective	1990	2000	2010
Community water fluoridation	x	x	x
Dental caries, children	x	x	x
Oral injury prevention, e.g., mouthguards	x	x	(x)
Gingivitis, adults	x	x	
Destructive periodontitis, adults	x	x	
Preventive dental services for children	x		x
Oral health status, services surveillance system	x		x
Untreated dental decay, children		x	x
Dental sealants		x	x
No tooth loss, adults		x	x
Total tooth loss, adults		x	x
Oral cancer mortality		x	(x)
Long-term care, oral exam and services		x	x
Utilization of oral health care system		x	x
States with ID/referral system for orofacial clefts		x	x
Smokeless tobacco use among males		x	(x)
Knowledge of risk factors for oral disease	x		
Gingivitis in children	x		
Reducing cariogenic food in vending machine	x		
Knowledge of adults, oral health, professional care	x		
Increasing school water fluoridation	x		
Topical/systemic fluoride in nonfluoridated areas		x	
Infant feeding practices for baby bottle tooth decay		x	
First school experience, oral health screening		x	
Untreated dental decay, adults			x
Oral cancer exam			x
Early stage detection of oral cancer lesions			x
Increase school-based health centers w/ oral health component			x
Increase Community Health Centers w/ oral health component			x
Increase # public health trained state & local health department directors			x

(x) means a related objective

Some objectives have been included every decade, while others were tracked for only one or two decades. Some were not continued because of changes in recommended interventions, e.g., school water fluoridation, whereas others were discontinued because of insufficient progress or inability to obtain data: (13-10) non-fluoridated areas receiving fluoride benefits; (13-11) infant feeding practices for baby bottle tooth decay; (13-13) oral health care required at institutional facilities; (13-16) institutions sponsoring sporting and recreational events requiring protective equipment. Progress reviews that occur throughout each decade help prioritize and refine objectives and data collection methods for subsequent years. The 1995 and 1999 *Progress Reports on Oral Health* are

included in the Resources section of the chapter (pages 8-11) and are available online at **www.cdc.gov/nchs/hphome.htm**. More than half of the 17 Healthy People 2000 oral health objectives showed progress, and one was met. One objective moved away from the target, and two showed mixed results.

In addition to age targets, objectives also are analyzed by ethnicity, gender, education level (head of household), disability status, or other subgroups as a way to track elimination of disparities. Table 1.3 provides an example of this for Objective 21-1--dental caries experience.

Table 1.3. Objective 21.1 Baseline Data by Demographic Factors

Children and Adolescents, Selected Ages, 1988–94 (unless noted)	Percent Dental Caries Experience		
	21-1a. Aged 2 to 4 Years	21-1b. Aged 6 to 8 Years	21-1c. Aged 15 Years
TOTAL	18	52	61
Race and ethnicity			
American Indian or Alaska Native	76* (1999)	91* (1999)	87* (1999)
Asian or Pacific Islander	DSU	DSU	DSU
Asian	34† (1993–94)	90† (1993–94)	DSU† (1993–94)
Native Hawaiian and other Pacific Islander	DNC	79‡ (1999)	DNC
Black or African American	24	50	70
White	15	51	60
Hispanic or Latino	DSU	DSU	DSU
Mexican American	27	68	57
Not Hispanic or Latino	17	49	62
Black or African American	24	49	69
White	13	49	61
Gender			
Female	19	54	63
Male	18	50	60
Education level (head of household)			
Less than high school	29	65	59
High school graduate	18	52	63
At least some college	12	43	61
Disability status			
Persons with disabilities	DNC	DNC	DNC
Persons without disabilities	DNC	DNC	DNC
Select populations			
3rd grade students	NA	60	NA

**DSU=data are statistically unreliable; DNC=data are not collected; NA=not applicable, *Data are for IHS service areas; †Data are for California; ‡Data are for Hawaii.

What are Related Objectives?

One of the themes noted in the Surgeon General's Report, *Oral Health in America,* (**www.surgeongeneral.gov/library/oralhealth/**) is integration of oral health with other aspects of health. Healthy People fosters this concept by including a list of related objectives from other focus areas at the end of each chapter. The objectives from other focus areas that are related to oral health are listed in on pages 5-7 of the Resources section for this chapter.

What are Leading Health Indicators?

In addition to the HP 2010 objectives, ten leading health indicators were identified to reflect major public health concerns in the United States. They were chosen based on:

- their ability to motivate action
- the availability of data to measure their progress
- their relevance as broad public health issues.

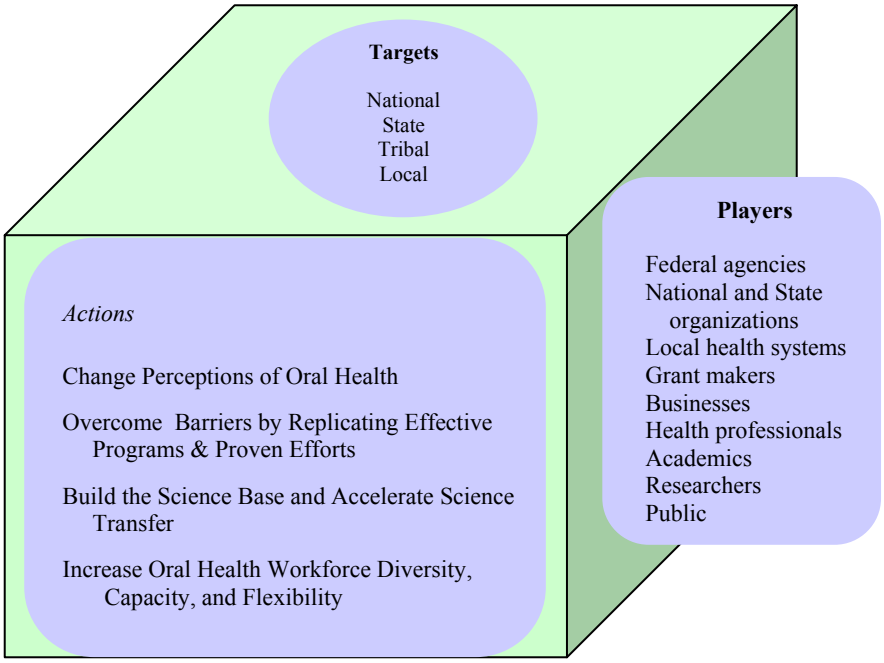
HP 2010 objectives specific to these ten leading health indicators will be used to track progress of the health of the nation. Although oral health *per se* is not included in this list as a separate priority, aspects of oral health fall under a number of the health indicators. For example, tobacco use is a risk factor for oral cancer and periodontal disease. Access to dental care is a major problem for a significant proportion of the population.

Leading Health Indicators

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization
- Access to healthy care

What is the National Oral Health Call to Action to Promote Oral Health?

The National Oral Health Call to Action to Promote Oral Health can provide a structure for coordination of activities across organizations, enabling achievement of the HP 2010 Oral Health Objectives. Such action, as articulated in the Surgeon General's Report on Oral Health, consists of four broad activities. These activities, along with potential targets and key players, are represented in the following diagram.



Details of a national oral health call to action have been developed with input from all the key players. The Call To Action to Promote Oral Health is available online at: **www.nidcr.nih.gov/sgr/nationalcalltoaction.htm**.

The success of a national oral health action plan, however, depends on how well the public understands and is involved in all aspects of the process, including community education, dental professions education, infrastructure development, oral health assessment, and research. The following chapter will provide information and tips on how to create networks and coalitions so that every member of the community can play a role in helping to achieve a healthy nation of people with optimal levels of oral health.

Resources

Chapter 1

- Useful Web Sites and References for Healthy People 2010
- Oral Health Terminology
- Related Objectives from Other Focus Areas
- 1995 Progress Report for Oral Health (www.healthypeople.gov/Data/PROGRVW/PDFs/PRGORAL.PDF)
- December 1999 Progress Review, Oral Health (odphp.osophs.dhhs.gov/pubs/HP2000/pdf/prog_rvw/proral.pdf)

Useful Web Sites and References for Healthy People 2010

Most materials related to Healthy People Initiatives can be accessed through the Office of Disease Prevention and Health Promotion (ODPHP) at 1-800-367-4725 and found online at **www.health.gov/healthypeople/**. *Adobe Acrobat Reader 4.0 or above is usually necessary to view and print most of the materials. If you don't have this software, it can be downloaded from the Adobe Web site at: **www.adobe.com/products/acrobat/readstep.html**. There is an extensive site map and numerous links. Some of the resources available include:

- *HP Toolkit 2010. A Field Guide to Health Planning*. The HP 2010 Oral Health Toolkit uses many materials from this general toolkit.
- A *State Healthy People 2010 Tool Library* includes numerous samples under the Toolkit categories from state plans and meetings. Examples include surveys, interview guides, reports, slides, technical assistance documents, marketing materials, etc.
- Links to state Healthy People or state health plan Web sites
- A list of state and territorial Healthy People contacts.
- A slide show and fact sheets that provide an overview of HP 2010.
- *Healthy People in Healthy Communities*. *A Community Planning Guide Using Healthy People 2010* is a guide for building community coalitions, creating a vision, measuring results, and creating partnerships dedicated to improving the health of a community. It includes "Strategies for Success" to help in starting community activities.

Partnerships for a Healthy Workforce, funded by the Robert Wood Johnson Foundation, is a group that seeks strengthened corporate involvement in Healthy People 2010. It provides tools that businesses can use to create a healthier workplace; offers a forum for business leaders, national organizations, and state and federal agencies to share best practices; and recognizes those companies that have shown leadership in its commitment to creating a healthy workplace. Information about this group can also be accessed via **www.prevent.org**.

Healthy Campus 2010: Making it Happen, by the American College Health Association, is a workbook to help campus health professionals develop health priorities for American campuses. The 110-page document includes 3 worksheets that help users assess which national health objectives are relevant, achievable and a priority for them. It uses data from the National College Health Assessment and CDC's National College Health Risk Behavior Survey (NCHRBS). See the ACHA Web site at **www.acha.org**.

Community-Campus Partnerships for Health is a non-profit organization that fosters partnerships between communities and educational institutions that improve health professions education, civic responsibility and the overall health of communities. Look for a new resource, *Advancing the Healthy People 2010 Objectives Through Community-Based Education: A Curriculum Planning Guide,* for faculty in health professions schools and their community partners for service-learning opportunities. Information included in the guide will be relevant for courses and service-learning programs for dental and dental hygiene students, as well as other health

professions students. See information about their program at **http://futurehealth.ucsf.edu/ccph.html**.

USDHHS. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: USDHHS, NIDCR, NIH. 2000. (**www.surgeongeneral.gov**) This is a comprehensive elaboration of the meaning of oral health and why it is essential to general health and well-being. It also covers how oral health is promoted, prevented, and maintained. The last section covers future needs and opportunities to enhance oral health.

USDHHS. *A National Call To Action To Promote Oral Health*. Rockville, MD: USDHHS, NIDCR, NIH. 2003. (**www.nidcr.nih.gov/sgr/nationalcalltoaction.htm**. The Call to Action is a follow up to *Oral Health in America: A Report of the Surgeon General* (**www.surgeongeneral.gov**) and is addressed to professional organizations and individuals concerned with oral health. The Call To Action is the product of a partnership of public and private organizations who have specified a vision, goals, and a series of actions to achieve the goals in order to accelerate the movement to enhance the oral and general health and well-being of all Americans.

Oral Health Terminology

Candidiasis (oral): Yeast or fungal infection that occurs in the oral cavity or pharynx or both.

Cleft lip or palate: A congenital opening or fissure occurring in the lip or palate.

Congenital anomaly: An unusual condition existing at, and usually before, birth.

Craniofacial: Pertaining to the head and face.

Dental caries (dental decay or cavities): An infectious disease that results in de-mineralization and ultimately cavitation of the tooth surface if not controlled or remineralized. Dental decay may be either treated (filled) or untreated (unfilled).

Caries experience: The sum of filled and unfilled cavities, along with any missing teeth resulting from decay.

Early childhood caries (ECC): Dental decay of the primary teeth of infants and young children (aged 1 to 5 years) often characterized by rapid destruction.

Root caries: Dental decay that occurs on the root portion of a tooth. (In younger persons, root surfaces are usually covered by gum [gingival] tissue.)

Dentate: A condition characterized by having one or more natural teeth.

Edentulism/edentulous: A condition characterized by not having any natural teeth.

Endocarditis: Inflammation of the lining of the heart.

Fluoride: A compound of the element fluorine. Fluorine, the 13th most abundant element in nature, is used in a variety of ways to reduce dental decay.

Gingivitis: An inflammatory condition of the gum tissue, which can appear reddened and swollen and frequently bleeds easily.

Oral cavity: Mouth.

Oral health literacy: Based on the definition of health literacy, the degree to which individuals have the capacity to obtain, process, and understand basic oral and craniofacial health information and services needed to make appropriate health decisions.

Periodontal disease: A cluster of diseases caused by bacterial infections and resulting in inflammatory responses and chronic destruction of the soft tissues and bone that support the teeth. Periodontal disease is a broad term encompassing several diseases of the gums and tissues supporting the teeth.

Pharynx: Throat.

Sealants: Plastic coatings applied to the surfaces of teeth with developmental pits and grooves (primarily chewing surfaces) to protect the tooth surfaces from collecting food, debris, and bacteria that promote the development of dental decay.

Soft tissue lesion: An abnormality of the soft tissues of the oral cavity or pharynx.

Squamous cell carcinoma: A type of cancer that occurs in tissues that line major organs.

Xerostomia: A condition in which the mouth is dry because of a lack of saliva.

Related Objectives from Other Focus Areas

1. **Access to Quality Health Services**
   - 1-1. Persons with health insurance
   - 1-2. Health insurance coverage for clinical preventive services
   - 1-3. Counseling about health behaviors
   - 1-4. Source of ongoing care
   - 1-7. Core competencies in health provider training
   - **1-8. Racial and ethnic representation in health professions**
   - 1-15. Long-term care services
2. **Arthritis, Osteopororsis, and Chronic Back Conditions**
   - 2-2. Activity limitations due to arthritis
   - 2-3. Personal care limitations
   - 2-7. Seeing a health care provider
   - 2-8. Arthritis education
3. **Cancer**
   - 3-1. Overall cancer deaths
   - **3-6. Oropharyngeal cancer deaths**
   - 3-9. Sun exposure and skin cancer
   - 3-10. Provider counseling about cancer prevention
   - 3-14. Statewide cancer registries
   - 3-15. Cancer survival
5. **Diabetes**
   - 5-1. Diabetes education
   - 5-2. New cases of diabetes
   - 5-3. Overall cases of diagnosed diabetes
   - 5-4. Diagnosis of diabetes
   - **5-15. Annual dental examinations**
6. **Disability and Secondary Conditions**
   - 6-13. Surveillance and health promotion programs
7. **Educational and Community-Based Programs**
   - 7-1. High school completion
   - 7-2. School health education
   - 7-3. Health-risk behavior information for college and university students
   - 7-4. School nurse-to-student ratio
   - 7-5. Worksite health promotion programs
   - 7-6. Participation in employer-sponsored health promotion activities
   - 7-7. Patient and family education
   - 7-11. Culturally appropriate and linguistically competent community health promotion programs
   - 7-12. Older adult participation in community health promotion activities
8. **Environmental Health**
   - 8-5. Safe drinking water
11. **Health Communication**
   - 11-1. Households with Internet access
   - 11-2. Health literacy
   - 11-3. Research and evaluation of communication programs
   - 11-4. Quality of Internet health information sources
   - 11-6. Satisfaction with health care providers' communication skills

12. Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths

14. Immunization and Infectious Diseases

14-3. Hepatitis B in adults and high-risk groups
14-9. Hepatitis C
14-10. Identification of persons with chronic hepatitis C
14-28. Hepatitis B vaccination among high-risk groups

15. Injury and Violence Prevention

15-1. Nonfatal head injuries
15-17. Nonfatal motor vehicle injuries
15-19. Safety belts
15-20. Child restraints
15-21. Motorcycle helmet use
15-23. Bicycle helmet use
15-24. Bicycle helmet laws
15-31. Injury protection in school sports

16. Maternal, Infant, and Child Health

16-6. Prenatal care
16-8. Very low birth weight infants born at level III hospitals
16-10. Low birth weight and very low birth weight
16-11. Preterm births
16-16. Optimum folic acid levels
16-19. Breastfeeding
16-23. Service systems for children with special health care needs

17. Medical Product Safety

17-3. Provider review of medications taken by patients
17-4. Receipt of useful information about prescriptions from pharmacies
17-5. Receipt of oral counseling about medications from prescribers and dispensers

18. Mental Health and Mental Disorders

18-5. Eating disorder relapses

19. Nutrition and Overweight

19-1. Healthy weight in adults
19-2. Obesity in adults
19-3. Overweight or obesity in children and adolescents
19-5. Fruit intake
19-6. Vegetable intake
19-11. Calcium intake
19-15. Meals and snacks at school
19-16. Worksite promotion of nutrition education and weight management

20. Occupational Safety and Health

20-2. Work-related injuries
20-3. Overexertion or repetitive motion
20-10. Needlestick injuries

22. Physical Activity and Fitness

22-4. Muscular strength and endurance
22-5. Flexibility

23. Public Health Infrastructure

23-1. Public health employee access to the Internet
23-2. Public access to information and surveillance data
23-3. Use of geocoding in health data systems
23-4. Data for all population groups
23-6. National tracking of Healthy People 2010 objectives
23-7. Timely release of data on objectives
23-8. Competencies for public health workers
23-9. Training in essential public health services
23-10. Continuing education and training by public health agencies
23-11. Performance standards for essential public health services
23-12. Health improvement plans
23.13. Access to public health laboratory services
23-14. Access to epidemiology services
23-16. Data on public health expenditures
23-17. Population-based prevention research

25. Sexually Transmitted Diseases

25-5. Human papillomavirus infection

26. Substance Abuse

26-12. Average annual alcohol consumption

27. Tobacco Use

27-1. Adult tobacco use
27-2. Adolescent tobacco use
27-3. Initiation of tobacco use
27-4. Age at first tobacco use
27-5. Smoking cessation by adults
27-7. Smoking cessation by adolescents
27-8. Insurance coverage of cessation treatment
27-11. Smoke-free and tobacco-free schools
27-12. Worksite smoking policies
27-14. Enforcement of illegal tobacco sales to minors laws
27-15. Retail license suspension for sales to minors
27-18. Tobacco control programs
27-19. Preemptive tobacco control laws
27-20. Tobacco product regulation
27-21. Tobacco tax

From *USDHHS. Healthy People 2010. Vol II. Chapter 21. Oral Health. 2nd ed. Washington DC: US Govt. Printing Office. 2000.*

- **1995 Progress Report for Oral Health**
  www.healthypeople.gov/Data/PROGRVW/PDFs/PRGORAL.PDF
- **December 1999 Progress Review, Oral Health**
  odphp.osophs.dhhs.gov/pubs/HP2000/pdf/prog_rvw/proral.pdf

PROGRESS REPORT FOR: Oral Health

ON JULY 28, 1995, the U.S. Public Health Service (PHS) conducted a review of progress on HEALTHY PEOPLE 2000 objectives for Oral Health. The Director of the National Institute of Dental Research (NIDR), National Institutes of Health (NIH) and the Director of the Division of Oral Health, National Center for Preventive Services of the Centers for Disease Control and Prevention (CDC) reviewed strategies and barriers toward achievement of the year 2000 targets. They were joined for the review by invited guests from both the public and private sectors.

Dr. Slavkin, the new NIDR director, began the review by commenting that comprehensive care should include oral health. He suggested that new coalitions be built to align education, social services, and health services with oral health care. Dr. Marianos of CDC addressed initiatives to fluoridate community water supplies, prevent early childhood caries, and ensure the safety of both patients and dental workers through adherence to recommended infection control practices in the delivery system. Dr. Gift of NIH reviewed the state of oral health in the Nation and focused on the socioeconomic risk factors that pose challenges for achieving the year 2000 targets.

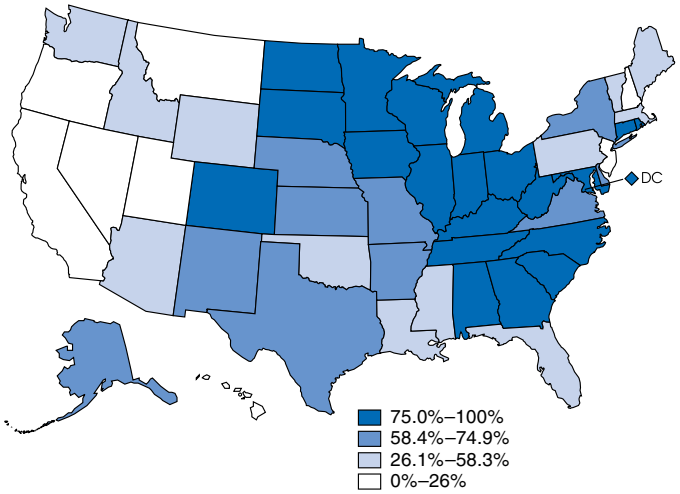
Objective 13.1 seeks to reduce dental caries. Between the 1986–87 baseline and the 1988–91 update, there has been modest change in the prevalence rates (54–52 percent) of dental caries in children. Among adolescents aged 15, dental caries has decreased over this same time period from 78 percent to 65 percent.

Objective 13.2 seeks to reduce untreated dental caries. Between the 1986–87 baseline and the 1988–91 update, there has been an apparent increase from 28 percent to 31 percent of children aged 6–8 with untreated dental caries. Special population groups—children whose parents have less than a high school education, American Indian/Alaska Native and Hispanic children—had higher rates of untreated dental caries, and that percentage increased over the past 3 years since the baseline. The percentage of adolescents aged 15 with untreated dental decay has remained at 24 percent.

Possibly the most effective strategy known to prevent dental caries is fluoridation. In this 50th year of water fluoridation, 62 percent of the people served by community water systems have optimally fluoridated water. Although new water systems have initiated fluoridation, the proportion of people receiving optimally fluoridated water remains virtually unchanged from the 1989 baseline of 61 percent. Low levels of fluoridation are found in the western States, New Jersey, and New Hampshire.

Another strategy to prevent dental caries, particularly on permanent molars, is dental sealants. Among children aged 8, the proportion having one or more dental sealants increased from 11 percent to 21 percent between 1986–87 and 1988–91. Among adolescents aged 14, the use of sealants increased from 8 to 28 percent over the same period. To reach the year 2000 target of 50 percent of children and adolescents having dental sealants requires continued efforts. One participant commented that oral health services, particularly fluorides and sealants, need to be considered as core population-based prevention services that address infectious and communicable diseases—"oral health immunizations."

Increase to 75 percent the proportion of people on public water systems served by fluoridation



Source: CDC/DOH Fluoridation Census Update, 1993

Since the publication of *Healthy People 2000*, increased attention has been given to the prevention of early childhood caries, also known as baby bottle tooth decay. One risk factor for this condition is bottle-feeding behavior. Baseline data from 1991 show that 55 percent of parents and caregivers of children aged 6–23 months reported using appropriate feeding practices—namely not giving a bottle at bedtime or giving the baby only water in a bottle at bedtime.

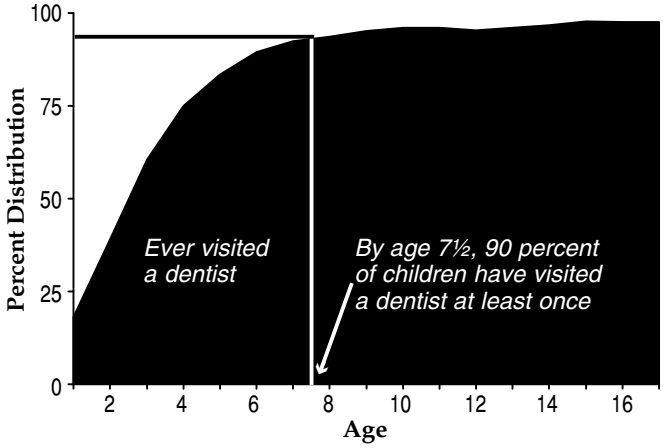
Objective 13.12 seeks to increase to at least 90 percent the proportion of children entering school who have received an oral health screening. In 1986, 66 percent of children aged 5 had visited the dentist in the past year, compared with 63 percent in 1991. This movement away from the year 2000 target is cause for concern about whether children have sufficient access to preventive dental services. When lifetime prevalence of dental visits is examined, it is not until the age of 7 that 90 percent of children have ever visited the dentist. For black children, it is not until the age of 10; for uninsured children, age 11; and for Hispanic children not until age 16 that 90 percent have ever had a dental visit.

Objective 13.3 seeks to increase the proportion of people aged 35–44 who have never lost a permanent tooth because of dental caries or periodontal disease. The 1985–86 baseline was 31 percent compared with the 1988–91 update of 32 percent. For objective

13.4, the proportion of people aged 65 and older who have lost all of their natural teeth declined from 36 percent in 1986 to 30 percent in 1993.

The discussion turned to the need to maintain focus on oral health and be diligent in encouraging and enhancing prevention at the individual, professional, and community levels. While many of the indicators of oral health demonstrate progress, lack of access to dental services, particularly for Medicaid-eligible children, is of concern. One study showed that, on average, children were enrolled in Medicaid for 3 years but had only one dental visit. A soon-to-be-released Office of the Inspector General report on the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program found that only one in five children were seen for dental screening services despite a program requirement that children be screened annually and followed up for dental services. Inadequate reimbursement, reluctance to treat Medicaid eligibles or young children, and cancelled appointments were cited in the study as problems. In Washington State, the ABCD Project, a partnership between the Spokane Dental Society, Spokane Health District, Medicaid program, and the University of Washington, is training some 90 dentists to see young children under age 3 and is training families on practicing good oral hygiene, keeping appointments, and behaving appropriately in the dental office.

Lifetime Prevalence of Any Use of Dental Services by Children and Adolescents Aged 2–17



Source: CDC/NCHS, National Health Interview Survey, 1989

The Assistant Secretary for Health raised a concern about the poor oral health status of American Indians. The Indian Health Service (IHS) staff responded that while there has been an increase in fluoridation in Indian communities, the biggest challenge is maintenance of systems—only 60 percent are functioning at an optimal level. While there has been progress over the past 15 years, particularly in the proportion of school-aged American Indian children who have dental sealants, there is still a gap with the total population that needs to be closed. IHS is responding with a public health focus and family-oriented services.

Participants noted major concerns about the public health infrastructure for oral health throughout the Nation. These include the lack of focus on oral health in school health education and school health services; the distribution of resources to train oral health care providers and to address oral health problems; and the lack of incentives for employment in public health settings.

The discussion turned to the risks of spit (smokeless) tobacco. A representative from Kaiser Permanente talked about a program to ensure that both medical and dental practitioners deliver the same message to their young patients. A number of professional and public education programs were mentioned. Other initiatives suggested included increasing the tax on spit tobacco and restricting accessibility to the product by minors. One participant compared the tax rates—2½ cents on a can compared with 25 cents on a pack of cigarettes—and estimated a half billion dollars in lost tax revenue a year. Higher prices as a result of taxation have been shown to be a deterrent to tobacco use by children and youth.

The discussion turned to the unmet needs of adults, including homebound and institutionalized. Root caries among older adults is becoming more common as individuals retain their teeth. More services could be provided by dental hygienists and expanded duty dental assistants if State practice acts were altered.

The progress review concluded with a summary of action items for achieving HEALTHY PEOPLE 2000 objectives. These include more effective outreach to minority and low-income people—particularly through the Medicaid program. As managed care increases in the Medicaid program, it will be important to ensure coverage of dental services, sustain enrollment, and encourage the appropriate utilization of services. PHS agencies should work with the Health Care Financing Administration to address oral health care issues in the Medicaid program. Stronger links in preschool and school health programs for oral health education and services should be created and maintained. Within PHS, the emphasis on oral health should be sustained by strengthening the professional base, by increasing training opportunities in public health dentistry, enhancing appropriate skills among a variety of health care providers in prevention of oral diseases, and providing policy guidelines, technical assistance, and resources for States and communities to pursue population-based preventive services. Prevention programs and tax policies on spit tobacco should be examined. Communication among States, communities, and the private sector on successful models of preventive activities should be enhanced. PHS should pursue national surveillance initiatives to ensure adequate information about the oral health status of Americans and support State surveillance activities. Linkages with the private sector must be sustained to ensure that the oral health status of Americans continues to improve.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

HEALTHY PEOPLE 2000 Coordinator

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738G Humphrey Building
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PROGRESS REVIEW

Oral Health

DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ December 15, 1999

In the concluding session of the decade-long series of Healthy People 2000 progress reviews, the Assistant Secretary for Health and Surgeon General chaired the third review of progress in achieving objectives for Oral Health. The review was organized by the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA), the co-lead agencies for this Healthy People priority area. The proceedings were telecast by satellite to viewers at remote sites, who were able to submit questions by telephone and fax. Of the 17 objectives in this priority area, one (oral cancer deaths) met its target and nine are moving in the right direction. One (gingivitis) is moving away from the target and two others showed mixed results or no change. Data are not available to assess progress for four objectives. Discussion focused on the following objectives in priority area 13 of Healthy People 2000:

13.1 The proportion of children aged 6-8 years who had experienced tooth decay (caries) in primary or secondary teeth decreased from 54% in 1986-87 to 52% in 1988-94 (2000 target, 35%). For black children aged 6-8, the decrease was from 56% to 50% (target, 40%). Among 15 year-old adolescents, the proportion who had ever had caries decreased from 78% in 1986-87 to 61% in 1988-94, nearly meeting the target of 60%.

13.2 Untreated dental caries, ages 6-8—see chart. Among adolescents 15 years of age, data from 1988-94 show that the prevalence of untreated dental caries was 20% in 1988-94 (target, 15%). Of those with parents with less than a high school education, 29% had untreated caries (target, 25%), as did 29% of Blacks (target, 20%) and 36% of Mexican Americans (target, 25%). Sixty-one percent of 15 year-old American Indians/Alaska Natives had untreated caries in 1991, a decrease from 84% in 1983-84 (target, 40%).

13.3 Data from 1988-94 show that 31% of people aged 35-44 years had experienced no loss of teeth, a proportion unchanged from the mid-1980's (target, 45%).

13.4 The proportion of people aged 65 and over who had lost all their teeth decreased from 36% in 1986 to 30% in 1997. (target, 20%). In 1986, complete tooth loss had been experienced by 46% of people whose annual family income was less than $15,000; this decreased to 44% in 1997 (target, 25%).

13.6 In 1985-86, 25% of people aged 35-44 had periodontal disease which decreased to 22% in 1994 (target, 15%).

DEVELOPMENTS

- A Surgeon General's report on oral health is scheduled for release in 2000. Disparities in oral health status is a central focus, as is the fact that oral health is an integral component of overall health.
- The Oral Health Initiative of HRSA and the Health Care Financing Administration expands services and bolsters oral health infrastructure at the State and community level. It seeks to increase access to dental care for children eligible for assistance from Medicaid and the Children's Health Insurance Program.
- Beginning in 2001, HRSA, CDC and NIH plan to fund several Centers for Research to Reduce Oral Health Disparities. The centers will focus on children and their care-givers and span the spectrum from basic to community-based research and health promotion.
- CDC and the Association of State Dental Directors are jointly developing a State-based national oral health surveillance system.
- Minority enrollments in dental schools need to increase three-fold to appropriately raise, by 2025, the proportion of minorities represented among providers of dental care (a Healthy People 2010 objective).
- People with low income or a low level of educational attainment are three times as likely to have tooth decay and only half as likely to have visited a dentist as the total population.

13.7 Oral cancer mortality—see chart.

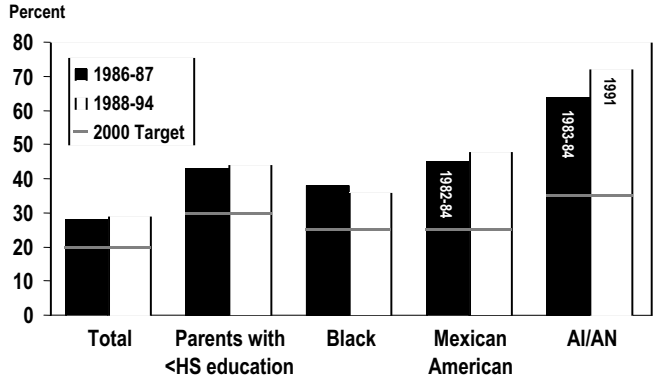
13.8 Protective dental sealants for 8-year-old children increased between 1986-87 and 1994, as follows: for all, from 11% to 23%; for Blacks, from 4% to 11%; for Mexican Americans from 9% to 7%. For 14-year-olds: for all, from 8% to 24%; for Blacks from 3% to 5%, and for Mexican Americans, from 6% to 7% (target, 50% for all groups).

13.9 The proportion of people served by community water systems whose drinking water was adequately fluoridated increased only slightly, from 61% to 62%, between 1985 and 1992 (target, 75%).

13.14 Between 1986 and 1997, the proportion of people aged 35 and over who had visited a dentist in the previous year increased from 54% to 63% (target, 70%). Over the same time period, the proportion of edentulous people aged 35 and over regularly visiting a dentist increased from 11% to 20% (target, 50%) and the proportion of people aged 65 and over doing so increased from 42% to 55% (target, 60%). Between 1991 and 1997, the proportion of other select population groups in the age group 35 and over who had regular dental visits increased as follows: for Blacks, from 43% to 53%; for Mexican Americans, from 38% to 47%; and for Puerto Ricans, from 51% to 54% (target, 60% for each).

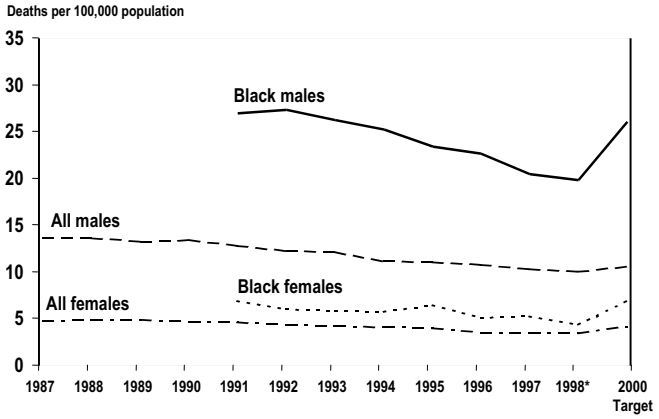
13.17 Use of smokeless tobacco by males aged 12-17 years decreased from 6.6% of this population in 1988 to 3.7% in 1997, surpassing the target of 4%. Use by males aged 18-24 declined from 8.9% in 1988 to 6.9% in 1994.

13.2 - Children aged 6 to 8 years with untreated tooth decay in permanent or primary teeth



Source: National Survey of Dental Caries in U.S. School Children, NIH, NIDR; National Health and Nutrition Examination Survey, CDC, NCHS; NC Oral Health School Study, UNC School of Public Health; Survey of Oral Health, IHS; Oral Health Status and Treatment Needs Survey of American Indians/Alaska Natives, IHS.

13.7 - Deaths due to cancer of the oral cavity and pharynx in people aged 45 to 74 years



*Data are preliminary.
Source: National Vital Statistics System, CDC, NCHS.

DEVELOPMENTS (Cont'd.)

- In California, one of the western States where fluoridation levels have historically been lowest, a law now requires communities with a population greater than 10,000 to fluoridate their drinking water. Los Angeles began fluoridating its water supply in August 1998 and Sacramento has recently begun to do so.
- Only nine percent of U.S. adults in 1998 reported that they had been screened for oral cancer in the past year. On average, people who develop oral cancer have made over ten visits to a physician in the year preceding diagnosis of the disease.
- Twenty-five percent of all children 5-17 years of age account for 80 percent of all dental caries.
- Fluoridation is an effective means to prevent tooth decay and has greatest benefits for those most in need of dental care. Twenty States and the District of Columbia have met the Healthy People 2000 target for fluoridation.
- Periodontal disease can affect diabetes control and be associated with low birth weight and premature babies, cardiovascular disease, stroke and pulmonary disease.

FOLLOW-UP

- Concentrate and coordinate resources needed to close the gap in access to preventive and restorative dental health services, especially for racial and ethnic minorities and those with low levels of education.
- Step up efforts to recruit racial/ethnic minorities into the public and private sectors of the dental profession and allied health professions.
- Continue to build and expand public/private partnerships to improve oral health, incorporating community multi-cultural coalitions.
- Extend the reach of activities to inform the public that most oral diseases are preventable and that dental sealants and fluorides (in water, toothpaste, mouthrinses and professional applications) have proven preventive health benefits. Ensure that these public messages are culturally and ethnically sensitive.
- Stem the increase in dental caries in younger children, with a special focus on minority and low-income segments of the population.

PARTICIPANTS

- Administration on Aging
- Academy of General Dentistry
- American Academy of Pediatric Dentistry
- American Dental Association
- American Dental Hygienists' Association
- American Association of Dental Schools
- American Association of Public Health Dentistry
- American and International Associations for Dental Research
- American Public Health Association
- Association of Community Dental Programs
- Association of State and Territorial Dental Directors
- Boston Department of Health
- Center for Policy Alternatives
- Centers for Disease Control and Prevention
- Children's Dental Health Project
- Cincinnati Health Department
- Connecticut Department of Public Health
- District of Columbia Commission of Public Health
- Federal Bureau of Prisons
- Food and Drug Administration
- Health Care Financing Administration
- Health Resources and Services Administration
- Hispanic Dental Association
- Indian Health Service
- Los Angeles County Department of Health
- Maryland Department of Health and Mental Hygiene
- Minority Oral Health Research Center
- National Dental Association
- National Institutes of Health
- Nebraska Department of Health and Human Services
- New York University
- Office of Disease Prevention and Health Promotion
- Office of Public Health and Science
- Ohio Department of Health
- Oral Health America
- Pan American Health Organization
- Special Olympics, Inc.
- University of California/ San Francisco
- University of Maryland
- Voices of Detroit Initiative

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Surgeon General

Chapter 2

Building the Foundation: Leadership and Structure

This chapter will cover:

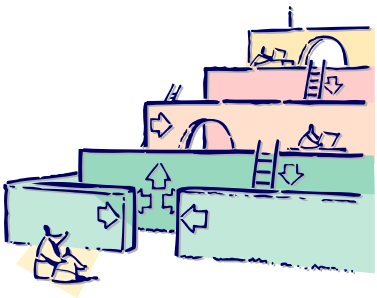
1. **An overview of oral health program infrastructure at the national, regional, state tribal and community level**
2. **Examples of HP2010 planning models**
3. **Roles and responsibilities for HP2010 teams**
4. **How to recruit members for the team**
5. **Tools for successful teams and meetings**

Involvement of and support from leaders, officials, health officers, dental directors, health educators, political leaders, key policy makers and others at the state, territorial, tribal and local levels significantly improves and strengthens any HP 2010 oral health planning process. Effective leadership is necessary to inspire a shared vision and enlist appropriate partners and staff in the development process.

The suggestions and tools in this chapter can help you build a strong foundation for planning Healthy People 2010 activities and for forming oral health coalitions or workgroups. Implementation of plans and activities will depend on the unique characteristics of each state, territory, tribe or community.

Use the Oral Health Infrastructure Checklist and the HP 2010 Oral Health Self-Assessment in the Resources section to determine how much you already know about the oral health infrastructure in your state, territory, tribe or community, and what Healthy People coalitions and oral health coalitions already exist.

Oral Health Infrastructure



Resources for implementing HP2010 oral health objectives go beyond dental professionals and oral health programs. Chances for success are increased, however, when implementation and tracking activities are coordinated by committed dental public health professionals. This section of the chapter provides an overview of the oral health infrastructure at the national, regional, state/territory, tribal, county and community levels. Web sites for the various agencies and organizations are included in the text and also on page 4 of the Resources section for this chapter.

Federal Government

Federal agencies serve dental public health needs in a variety of ways. Oral health professionals and programs are primarily concentrated in the U. S. Department of Health and Human Services. An organizational chart depicting the major agencies and administrators can be viewed online at **www.hhs.gov/about/orgchart.html**.

Secretary of DHHS advises the President, while the Assistant Secretary for Health is the senior advisor on public health and science issues to the Secretary. Offices significant to oral health that fall under the Assistant Secretary's leadership and the Office of Public Health Science are:

- **Office of the Surgeon General:** Dr. C. Everett Koop was a great supporter of oral health, and Dr. David Satcher released the first-ever Surgeon General's Report on Oral Health in 2000 (**www.surgeongeneral.gov/library/oralhealth/**). Dr. Richard Carmona, our current Surgeon General officially, released the *National Oral Health Call to Action to Promote Oral Health* to serve as a framework for generating oral health plans and activities at all levels (**www.nidcr.nih.gov/sgr/nationalcalltoaction.htm**).

- **Office of Disease Prevention and Health Promotion:** works to strengthen the disease prevention and health promotion priorities of DHHS within the collaborative framework of the HHS agencies and serves as the lead office for the HP 2010 initiatives.

- **Other offices relate indirectly to promotion or tracking of oral health objectives:**
  - Office of HIV/AIDS Policy
  - Office of International and Refugee Health
  - Office of Military Liaison and Veterans Affairs
  - Office of Minority Health
  - Office on Women's Health.

The following agencies are key to federal policies and programs related to oral health. Those with an asterisk (*) serve in coordination roles for HP 2010 oral health objectives. Their Web sites are listed on page 4 of the Resources section, and some are described further in this chapter and in other chapters.

- **Administration for Children and Families (ACF)**: over 60 programs provide services and assistance to needy children and families; most important to oral health are some direct care funds, foster care programs and Head Start.

- **Administration on Aging (AOA)**: supports a nationwide aging network that helps seniors to remain independent, and provides policy leadership on incorporating oral care programs into community-based initiatives through Area Agencies on Aging.

- **Agency for Healthcare Research and Quality (AHRQ)**: supports cross-cutting research on health care systems, quality and cost issues, and effectiveness of medical treatments. Research on oral health services, especially performance indicators and

measures of quality, help inform policy-makers and program planners on how to improve oral health and dental care services.

- ***Centers for Disease Control and Prevention (CDC)**: has the primary responsibility for supporting state and community-based programs to prevent oral diseases, for promoting oral health, and for fostering applied research. The Division of Oral Health is crucial to encouraging and tracking effective use of fluorides, dental sealants, and developing ways to collect, analyze and disseminate oral health data.

- **Centers for Medicare & Medicaid Services (CMS)**: previously known as the Health Care Financing Administration (HCFA), CMS administers the Medicare, Medicaid and State Children's Health Insurance Program, which provide financing for medical and dental care serving primarily aged and indigent populations--about one in four Americans.

- **Food and Drug Administration (FDA)**: assures the safety of food and cosmetics, and the safety and efficacy of pharmaceuticals, biological products and medical devices.

- ***Health Resources and Services Administration (HRSA)**: helps provide health resources for medically underserved populations and supports a nationwide network of more than 650 community and migrant health centers, and over 140 primary care programs for the homeless and residents of public housing. HRSA also works to strengthen the health care workforce and maintains the National Health Service Corps. It serves other special populations through the Ryan White CARE Act programs and MCH Title V block grants to states, and cooperative agreements for national projects and centers.

- ***Indian Health Service (IHS)**: supports a network of 37 hospitals, 60 health centers, 3 school health centers, 46 health stations and 34 urban Indian health centers to provide services to nearly 1.5 million American Indians and Alaska Natives of 557 federally recognized tribes in 35 states. It employs over 400 dentists as well as allied dental health staff. Through PL 93-638 self-determination contracts, tribal health programs also administer 12 hospitals, 116 health centers, 3 school health centers, 56 health stations and 167 Alaska village clinics.

- ***National Institutes of Health (NIH)**: with 17 separate institutes, NIH is a premier research organization, supporting some 35,000 research projects nationwide. The National Institute of Dental and Craniofacial Research (NIDCR) provides national leadership in conducting and supporting dental and craniofacial research and training, and promoting science transfer and dissemination of information. In addition to basic research and clinical trials, NIDCR also supports state models for oral cancer prevention and early detection as well as centers for reducing oral health disparities.

A summary of the scope of essential public health services supported by agencies of the USDHHS is presented in Table 2.1. The US Departments of Defense, Transportation and Veterans Affairs, and the US Department of Justice's Bureau of Prisons also provide dental care services, while the US Department of Agriculture administers the Women, Infants and Children (WIC) program that is increasingly serving as a link for prevention, early detection and referral of early childhood tooth decay in high risk children.

Table 2.1 Scope of Essential Public Health Services Supported by Agencies of the U.S. Department of Health and Human Services, and Level of Support								
Essential Public Health Services	**AHRQ**	**CDC**	**FDA**	**HRSA**	**IHS**	**NIH**	**CMS**	**ACF**
Monitor health status to identify and solve community health problems	x	x			x	x		
Diagnose and investigate community health problems		x		x	x			
Educate and empower people about health issues	x	x	x	x	x	x	x	x
Develop policies and plans that support individual and community efforts		x		x	x			x
Enforce laws and regulations that protect health and ensure safety			x				x	
Link people to personal health services; ensure provision of care when otherwise unavailable				x	x		x	x
Ensure a competent public health and personal health care workforce	x	x		x	x	x		
Evaluate effectiveness, accessibility, and quality of personal and population-based services	x	x		x	x		x	x
Conduct research for new insights and innovative solutions to health problems	x	x	x	x		x		
Oral health component (FY 2000) ($ millions)	<1	<10	<3	<150	<80	<250	2000	<10
Total agency budget (FY 2000) ($ billions)	>0.2	3.1	1.4	4.2	2.8	16	343	38
Oral health as proportion of agency budget	<0.5%	0.3%	0.2%	0.3%	3%	1.5%	<0.2%	<0.1%

Sources: Data from PHS Oral Health Coordinating Committee, personal communication, 2000, Public Health Functions Steering Committee 2000. Published in USDHHS, *Oral Health in America: A Report of the Surgeon General,* Rockville, MD, USDHHS, NIDCR, NIH, 2000.

National Associations and Organizations

A number of national organizations, some with state or regional affiliates, were formed to advocate for oral health issues or to represent dental health professionals or programs. Only a few, however, are devoted primarily to oral health in a *public health* framework. The American Public Health Association's (APHA) Oral Health Section, American Association of Public Health Dentistry (AAPHD), and Special Care Dentistry (comprised of the American Society for Geriatric Dentistry, Academy of Dentistry for Persons with Disabilities, and American Association of Hospital Dentists) represent broad constituencies, while the Association of State and Territorial Dental Directors (ASTDD), American Association of Community Dental Programs (AACDP), and National Network for Oral Health Access (NNOHA) represent more specific constituencies.

Associations such as the American Dental Association (ADA), American Dental Hygienists' Association (ADHA), American Dental Education Association (ADEA) and American Association for Dental Research (AADR) have sections or councils devoted to public health issues. ADEA also houses the Children's Dental Health Project, a WK Kellogg Foundation

project to assist policymakers, advocates and parents in improving children's oral health and increase their access to dental care. The National Dental Association represents over 10,000 African American dentists, dental hygienists, dental students, dental technologists, and others through 48 state and local chapters in the US and the Caribbean. Likewise, the Hispanic Dental Association seeks to advocate for oral health care for Hispanic populations, maintaining 23 regional affiliates in 10 states and the District of Columbia. The Academy of General Dentistry represents 37,000 general dentists. Other specialty dental groups like the American Academy of Pediatric Dentistry serve important advocacy roles for children's oral health. A number of national organizations such as Oral Health America and Special Olympics foster public/private partnerships for oral health projects. Numerous other national groups, e.g., Association for Maternal and Child Health Programs, National Association of County and City Health Officials, National Association of Local Boards of Health, National Head Start Association, and National Indian Health Board, interface with the dental public health groups to address common oral health concerns and develop collaborative strategies to address problems.

The American Dental Trade Association (ADTA) is the oldest and largest trade association representing the dental industry in the United States. Its membership consists of over 125 dental distributors, laboratories, and manufacturers of supplies and equipment used by the dental team. The ADTA undertakes projects and provides services that few dental companies could undertake individually. In addition, the ADTA maintains working relations and liaisons with a variety of other national dental organizations. The ADTA and Oral Health America have maintained a partnership for over 40 years and recently are working together to improve the oral health of the nation through HP 2010 initiatives.

Each of these groups addresses Healthy People 2010 initiatives in different ways. For example:

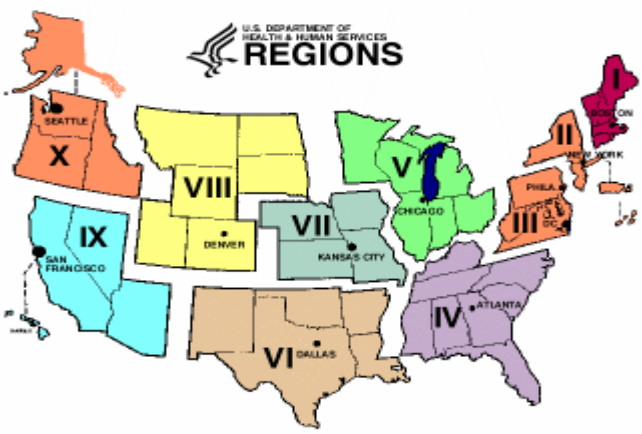
- DHHS signed a memorandum of understanding (MOU) in June 2002 with the Academy of General Dentistry (AGD) to promote access to preventive oral health services and to eliminate oral health disparities. The partnership commits four agencies within DHHS to work with AGD over the next three years to improve access to oral health care, train the dental workforce, and provide public education. Their main focus is to increase oral health literacy.

- DHHS signed a MOU, in May 2003, with AADR to 1) disseminate information and communicate with researchers about HP 2010; 2) contribute to a national action plan; 3) encourage AADR sections to work locally; 4) educate policymakers; and 5) promote HP 2010 via meetings and publications. In addition, in May 2001, the AADR Board of Directors adopted three HP 2010 objectives (dental caries, gingivitis/periodontal disease, and detecting oral cancer) as a means to focus on outcomes and address disparities.

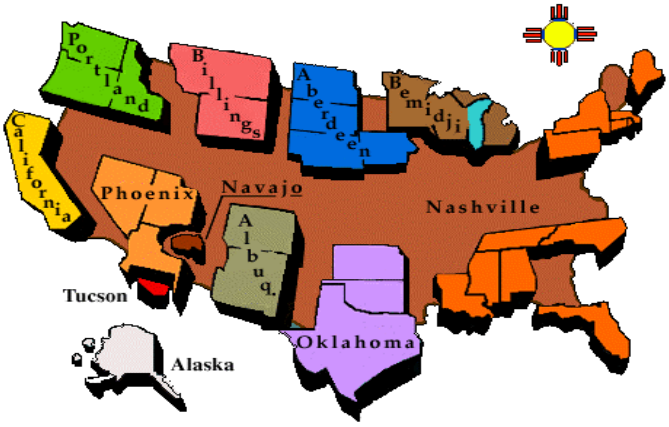
- DHHS is working on MOUs with other organizations.

Regional Offices

The Department of Health and Human Services maintains offices and staff in 10 different regions of the country. Dental consultants on staff are used to monitor contracts and interface with state agencies to provide technical assistance and support. Information about each regional office can be found online at **www.hhs.gov/about/regions**.



Indian Health Service Areas

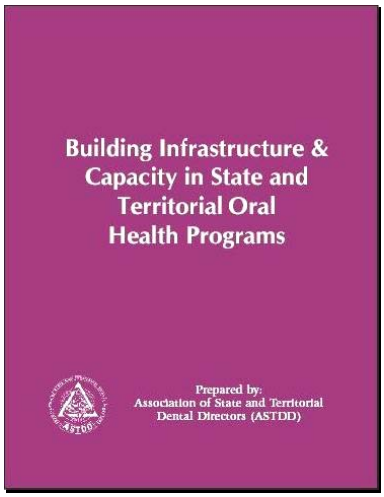


The Indian Health Service also maintains a regional focus through 12 Area Offices, although these regions do not conform to the HHS regions. The list of Indian Health Service Area Offices is on the agency Web site at **www.ihs.gov**. The role of the Area Dental Officer is to interface with tribes to assure that they have the funding, personnel, equipment and other resources necessary to deliver comprehensive, quality oral health services to their members. The Area Offices provide technical assistance, training, data management, program evaluation services, recruitment, and budget oversight to tribal and direct programs as well as work with other members of the Area Office team.

State Government

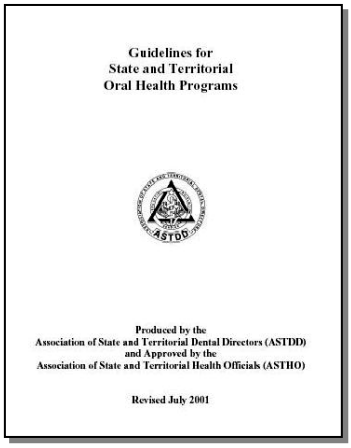
State Health Agencies may conduct a range of important oral health activities, many under the direction of an Oral Health Program or Office. Current lists of state oral health programs and their Web sites are maintained on the ASTDD Web site (**www.astdd.org**). Some oral health activities may be supported by Divisions of Maternal and Child Health, Aging Services, Primary Care, or Rural Health. Other Departments such as Education, Corrections or Developmental Disabilities/Rehabilitation may also provide or fund oral health programs or dental care services. A 1999 survey conducted by the ASTDD looked at existing infrastructure for state oral health programs and what is needed to maintain fully effective programs.

The report, *Building Infrastructure and Capacity in State and Territorial Oral Health Programs,* is available on the ASTDD Web site. Although the data change due to agency reorganizations or personnel changes, in 1999:



- 31 states and 5 territories had full-time dental directors
- 20 states had part-time or vacant positions
- About half of the states, with populations totaling 92 million people, had state oral health programs supported by budgets of $500,000 or less.

The report identifies characteristics of successful programs and 10 essential elements that would build infrastructure and capacity for oral health programs. These elements reflect the public health functions of assessment, policy development and assurance. Note that one of the HP 2010 objectives (21.17) seeks to increase the number of state and local dental programs with directors who have formal public health training, not just credentials in dentistry or dental hygiene. Monies to fund these programs generally are from the federal MCH Title V Block Grant, the Preventive Health and Health Services Block Grant, or from state general funds. Since July 2001, CDC has established cooperative agreements with a number of states and territories to strengthen their oral health programs and reduce inequalities in the oral health of their residents.



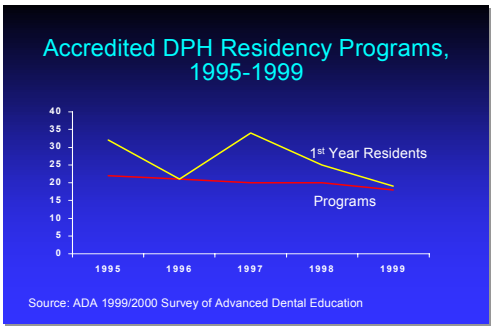
A companion document, *Guidelines for State and Territorial Oral Health Programs*, also developed in 1985 and revised in 1997 and 2001 by ASTDD (available on the ASTDD Web site), provides guidance for government officials and public health program administrators on essential public health services to promote oral health in the U.S. These guidelines are used by ASTDD to mentor new state dental directors and evaluate state and territorial oral health programs through a self-assessment process and on-site reviews by a team of consultants. The guidelines can be adapted for use by local and tribal oral health programs.

State Medicaid and State Children's Health Insurance Programs may or may not be located in the same agency as the State Oral Health Program. There usually are Medicaid dental consultants who interface with practitioners and dental plans around reimbursement and policy issues. Over 40 million people (about 50% are children) had Medicaid coverage in 1999. Each state's Medicaid program is unique, but the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires Medicaid coverage for treatment of any dental problem identified through an EPSDT medical or dental screening. Unfortunately private practitioner participation as Medicaid providers was only 28% nationally in 1999, ranging from 0%-100% participation in each state. Some State Children's Health Insurance Programs (SCHIP) provide funding for dental personnel and equipment outside traditional private office settings. In some cases, these organizations even provide funding or staff for school-based dental services. Many Medicaid and SCHIP agencies contract with dental insurance, managed care, and dental managed care organizations to provide dental services to Medicaid and SCHIP enrollees. A HRSA 25-page report, *Opportunities to Use Medicaid in Supporting Oral Health Services,* is available online at **www.ask.hrsa.gov/OralHealth.cfm**.

State regulatory boards for dental professionals set rules and regulations that govern the standards of practice. The board's authority is limited to that granted by the state legislature and typically includes: 1) establishment of qualifications for licensure, 2) issuance of licenses to qualified individuals, 3) establishment of standards of practice and conduct, 4) taking disciplinary action against those who engage in misconduct, and 5) promulgation of rules to enable the board to perform its duties. Practice acts and licensure requirements for dental professionals vary by state, a situation that can impede professional mobility and distribution of the workforce to areas most in need. Some states allow licensure by credentials to individuals who already are practicing in another state where the licensure standards are similar, while others allow reciprocity to licensees from states with which they have formal reciprocal agreements. Visit the American Dental Association's Web site **www.ada.org** for more information about state dental statutes and regulations. The American Association of Dental Examiners (**www.aadexam.org**) publishes *Composite,* a document that includes information about state boards' structure and operation, licensee population, board disciplinary actions, and licensing requirements.

Dental Health Professions Schools

There are 55 dental schools (36 public, 14 private, 5 private-state related) and 254 dental hygiene programs throughout the nation. A variety of dental assisting and dental lab technician programs are available, primarily through community or technical colleges in local communities. A listing of US and Canadian dental schools, allied health programs, federal dental service programs, and hospital programs not affiliated with dental schools are listed on the ADEA Web site at **www.adea.org**. These programs provide significant influence on the oral health workforce in terms of numbers and types of professionals, translation of research findings, and provision of continuing education courses. Schools of dentistry and dental hygiene often collaborate with community-based oral health programs to provide dental care to underserved groups, especially where there is a high demand for services and an insufficient number or variety of providers.



Dental residencies and graduate programs in a variety of specialty areas are administered through universities, hospitals, or public health agencies. Each year there are approximately 30-40 dentists enrolled in dental public health residency programs, but the program directors are having difficulty filling positions, as indicated in the following graph. Only 4% of public health schools include a department or program in Dental Public Health.

Dental Insurance, Managed Care, and Dental Managed Care Organizations

Some dental insurance, managed care, and dental managed care organizations are involved in efforts to improve access to dental care. For example, Delta Dental Plan of California, which administers the fee-for-service Medicaid dental program in California, has an outreach unit that actively solicits provider participation and provides grants to community clinics for dental equipment and staff.

Dental insurance organizations and prepaid dental plans typically are regulated by state Departments of Insurance or Corporations. Many dental managed care plans belong to a national organization, the National Association of Dental Plans (**www.nadp.org**). When these companies also are nonprofit organizations (e.g., Delta Dental), they may be required by their charters or by state or federal law to donate a portion of their revenues to charitable or public service types of projects. The Washington Dental Service Foundation (**www.deltadentalwa.com/oral_health/foundation.htm**) is an example of how one Delta Dental plan has used its revenue to support a variety of dental public health activities, including dental clinics, a state oral health coalition (**http://childrensalliance.org/teeth/washingt.htm**),
and most recently, a major initiative called "Watch Your Mouth" (**www.kidsoralhealth.org**/) intended to raise public awareness of the importance of improving children's oral health.

Local Programs

The majority of dental care provided to the US population is through private practice dental offices. Most of these are small general practices of less than 3 providers (dentists and dental hygienists), rather than group practices or specialty practices. Nationally the supply of dentists per population is decreasing, partly due to a decline in the number of dental school graduates and aging of the dental workforce.

Dental safety net programs expand services to populations who do not or cannot obtain care n the private sector. Many of these programs are community clinics administered by local or county health departments, tribal programs or the Indian Health Service; those receiving other federal funds as federally qualified health centers (FQHC) or “look-alikes”; independent non-profit dental clinics; school-based or school-linked health centers; hospital-based services; dental school satellite clinics; mobile or portable dental programs; programs administered by non-profit community organizations such as Volunteers in Health Care, religious organizations (e.g., United Health Ministries); or worksite programs. While many community programs provide restorative dental care, others may provide only preventive services, screening and referral, dental health education, or case management. Workforce shortages from recruitment and retention problems are occurring in many of these programs, thus hampering efforts to meet local and national objectives. For example, the vacancy rate for dental providers in American Indian/Alaska Native programs is 22% in 2002. Some rural clinics have been trying to recruit dental providers and staff for over three years.

The National Association of County and City Health Officials (NACCHO) estimates there are about 2900 local health departments (LHD) nationwide. Local health departments vary considerably in organization, type and number of staff, specific services provided, etc. Often the number of LHDs in a state has no direct relationship to geographic or population size. For example, California is one of the largest states for both parameters, yet only has about 60 county or city health departments, while Massachusetts, one of the smaller states, has over 325 LHDs. Most LHDs are entities of county government that derive authority from both state and local statutes. Eighty-one percent of LHDs report to local boards of health. The local boards of health belong to a national organization, the National Association of Local Boards of Health (**www.nalboh.org**). These boards establish general public health policies or provide advice on such policies. They provide vital roles as 1) links to the community; 2) advocates for developing programs within the LHD; and 3) liaison to the state legislature. They can advocate in ways the LHD employees cannot. (Much of this information was gleaned from an excellent reference, *Local Public Health Practice* by Mays, Miller and Halverson, that is cited in the reference list). Table 2.2 provides a summary from the same reference of the percentage of LHDs providing various types of services (these statistics are derived from various surveys so they may be from different years.)

Table 2.2. Percent of LHDs Offering Various Services	
Dental services	44%
Community outreach and education	88%
Tobacco use prevention	67%
Well child care	79%
WIC providers	75%
Injury control	49%
School-based clinics	33%
School health programs	65%
Community assessment	76%
Epidemiology and surveillance	83%

A variety of local funds are used for oral health programs, including community block grant funds, local assistance funds, or grants from local philanthropic organizations or businesses. In a study by NACCHO in the early 1990s, LHDs nationwide received 34% of their funds from local government, 40% from state government (includes federal funds), 7% from Medicaid services, 3% from Medicare services, and 16% from other sources such as private foundations. Communities also can apply for other state funding such as the tobacco master settlement agreement or earnings from tobacco taxes.

Numerous advocacy groups and local coalitions have emerged to address disparities in health and oral health care. They provide much needed lobbying efforts and leveraging of resources, as well as outreach and education to underserved populations. Some have a limited focus such as young children, the homeless, elders or people with developmental disabilities, while others represent more broad-based coalitions for a geographic region, e.g., Rural Health Councils. In the past few years, a number of dental summits have been convened to address dental access issues (see partial list on Page 10 of the Resources section for this chapter—reports from some available are online at **www.mchoralhealth.org**). Many of these summits resulted in ongoing oral health coalitions. The next section discusses the roles of coalitions and partnerships in relation to HP 2010 initiatives and other oral health activities.

Creating Coalitions and Partnerships for HP 2010 Initiatives

Models for Planning

The success of the Healthy People Initiative has been the fostering of flexibility and innovation within a general framework. Each state and community has different political realities, infrastructures, population groups, health needs, and ways of getting things done. A number of planning structures have been used to guide the process for creating HP 2010 plans and oral health plans. Some plans have been led by a governor's initiative or state legislation, some by health department leadership, and others by community coalitions. For example:

- Louisiana passed a bill to create the Louisiana Healthy People 2010 Planning Council in the Department of Health and Hospitals, with funding for a paid staff person to assist the Council.

- In Ohio, the Department of Public Health initiated a strategic planning process to strengthen Ohio's public health system. This evolved into the Work Group on Healthy People Ohio.

- A Florida statute requires the Department of Health to "biennially publish, and annually update, a state health plan that assesses current health programs, systems, and costs; make projections of future problems and opportunities; and recommend changes needed in the health care system to improve public health."

- Diagrams of Maryland's process and timelines are included in the Resources section.

- In North Dakota a Healthy People 2010 oral health coalition evolved as part of the Chronic Disease Working Group for Healthy People 2000.

- The Oral Cancer Consortium in New York-New Jersey consists of 22 dental institutions/organizations that are addressing the oral cancer objectives through community outreach and early detection.

- The Arkansas Oral Health Program in the Department of Health recently received an Infrastructure Development grant from CDC. Some of the monies are being used to develop oral health coalitions and to hold a dental summit that will begin the process for oral health planning.

- The Kentucky Dental Health Coalition began in 1990 as a collaborative effort between the University of Louisville School of Dentistry and the University of Kentucky School of Dentistry, and then incorporated as a non-profit organization in 1993. The membership and the board of directors have expanded over the years to include many other groups interested in promoting oral health. They have held a successful dental summit, conducted a statewide needs assessment and participated in the NGA Policy Academy.
- The Maine Dental Access Coalition was convened in June 1997 as a collaboration between Maine's Oral Health Program and the Maine Children's Alliance. This ad-hoc

group has grown to over 115 individuals representing themselves, dental and other health professional associations, community and state agencies, foundations, and other groups from around the state. The Coalition has served as a sounding board and advocate for ideas and strategies to improve access and for new legislation, sponsored a conference for community oral health coalitions, produced public education materials and convened a task force to coordinate early childhood caries prevention and intervention efforts. Support from the Office of Health Planning's HRSA-funded Maine Oral Health Partnership Project provides paid staff support.

Four common planning models for HP 2010 initiatives are diagramed in the Resources section of this chapter. These represent state models but they can be easily adapted for territorial, tribal or community models. Community models are discussed in *Healthy People in Healthy Communities,* a booklet available on the Healthy People Web site (**www.health.gov/healthypeople**). The booklet outlines the MAP-IT approach, (shown below) that mirrors the national Healthy People approach.

Mobilize individuals and organizations that care about the health of your community into a coalition.

Assess the areas of greatest need in your community, as well as the resources and other strengths that you can tap into to address those areas.

Plan your approach: start with a vision of where you want to be as a community; then add strategies and action steps to help you achieve that vision.

Implement your plan using concrete action steps that can be monitored and will make a difference.

Track your progress over time.

A similar approach called MAPP (Mobilizing for Action through Planning and Partnerships), promoted by the National Association of County and City Health Officials, is available online at **www.naccho.org**. The following nine communities are implementing the MAPP process to show how it can be used in a variety of settings:

- Amherst, MA
- Hartford, CT
- Columbus, OH
- Lee County, FL
- Mendocino, CA
- Nashville/Davidson County, TN
- Northern Kentucky District, KY
- San Antonio, TX
- Taney County, MO

A number of excellent references and resources are available for forming community groups, particularly coalitions and collaboratives. General references are listed in the Resources section. Two references specific to oral health include:

- *Community Roots for Oral Health. Guidelines for Successful Coalitions* was developed by the Washington State Department of Health in March 2000 and has been used extensively in Washington and other states to create oral health coalitions. A few sample worksheets from this workbook are included in the Resources section of this and other chapters. (Workbook available online at **www.cdc.gov/oralhealth/library**).

- *Connecticut Community Oral Health Systems Development Project Guidelines* is a manual that offers guidance in building collaborations, performing a community oral health needs assessment, and developing plans and proposals. (1-860-509-7809).

Examples of Other Oral Health Coalitions and Collaboratives

As of October 2002, more than 20 states have held dental summits, and more are planned to address dental access issues. Most states used a multidisciplinary planning group and then invited other stakeholders to a 1-2 day conference to discuss the issues and create task forces or workgroups to develop action plans. These summits have resulted in a number of positive outcomes that directly or indirectly address the HP 2010 objectives. Information about the summits can be obtained from the National Maternal and Child Oral Health Resource Center (**www.mchoralhealth.org**). In 2002 ASTDD, with support from HRSA and ACF, funded similar state/territorial oral health forums focused on Head Start/early childhood issues. A list of forums and primary contacts is on the ASTDD Web site (**www.astdd.org/projects**).

Another initiative that is built on collaborative planning is the National Governors Association Oral Health Policy Academies. Three rounds of academies involving 21 states have been conducted since 2000, with each state receiving technical assistance and funding to create a State Action Plan to further oral health policies that address oral health concerns. A list of the participating states is included in the Resources Section, and additional information can be accessed via the NGA Web site at **www.nga.org**.

Oral Health America sponsors National Spit Tobacco Education Program (NSTEP) coalitions in about 20 states to provide oral exams, cessation counseling, public awareness activities and educational events with Minor League and Major League baseball teams. Information on this program is available online at **www.nstep.org** and would be useful in addressing the tobacco and oral cancer-related HP 2010 objectives.

Special Olympics Special Smiles is a dental screening, education and referral program that operates under the auspices of the Special Olympics Healthy Athletes Initiative. Athletes also receive free mouthguards for contact or high-risk sports at most locations. Special Smiles events are scheduled all around the country, and coordinated and conducted by groups of local dental professionals and students. The program offers Academy of General Dentistry and ADA recognized continuing education credits in exchange for professional participation. Oral health data collection is an important part of this program. Information on the program can be found online at **www.specialolympics.org/healthy_athletes/smiles**.

The following examples highlight how four states have used coalitions to further an oral health agenda.

Pennsylvania

In July 2000, the Pennsylvania Department of Health began a formal strategic planning process to improve oral health in the state and reduce oral health disparities. From September 1998 through October 2000 the first school oral health needs assessment was conducted on children in grades 1, 3, 9 and 11 in six health districts. Using the results of this assessment and other oral health data (e.g., BRFSS, Head Start, etc.) the Oral Health Program prepared a strategic planning "menu" of options to use in developing programs, policies and procedures to address oral health needs. Issues were organized using the 6 categories of health action from the Pennsylvania State Health Improvement Plan. This menu was presented to the Oral Health Stakeholders group, some of which are NGA Policy Academy team members, for prioritizing recommendations and action steps.

Contact Neil Gardner at ***ngardner@state.pa.us***

Colorado

The Colorado Commission on Children's Dental Health, with support from the Governor and funding from the Anthem Blue Cross Blue Shield Foundation, began deliberations in May 2000 to study a set of key public policy issues for improving children's oral health. The expected outcome was to provide recommendations on ways to improve the current system of dental care. The Commission made 9 recommendations and published a written report that was widely distributed and available on the Oral Health Program's Web site. Three legislative and two budget initiatives passed in the 2001 legislative session that directly addressed 5 of the recommendations. With the addition of a dental benefit in SCHIP, a Dental Network Adequacy Workgroup was convened to address the legislative mandate, using some members of the Commission, some dental safety net providers, and the Colorado NGA Policy Academy team. Meetings began in October 2001 with the dental association, Medicaid program, School of Dentistry and NGA team to develop strategies for improving systems for serving low-income clients.

Contact Diane Brunson at ***diane.Brunson@state.co.us***

New Mexico

The New Mexico Oral Health Collaborative was formed in 1999 and is composed of a number of American Indian (AI) community-based organizations in the Albuquerque metro area. In addition to assuring that the primary AI clinic remains open to provide vital dental care services, the Collaborative discussed other expansions and partnerships such as:

- Recruitment and retention of AI dental auxiliaries
- General Practice Residency and Advanced Education in General Dentistry programs
- Use of the operating room and anesthesiologist available through UNM for young children with complex dental needs
- Linking the UNM Dental Hygiene program with the AI dental clinic
- Sharing oral health promotion/disease prevention programs of the Albuquerque Area Dental Support Center with First Nations Healthsource
- Identifying and securing financing to support expanded services, particularly for diabetic patients.

The Collaborative is in the unique position of forming a program designed to promote an inclusive environment where communities and service providers participate in a cross-cultural learning process.

Contact Mary Altenberg at ***maltenberg@abq.ihs.gov***

Alaska

Since 1970 the Alaska Native Regional Health Corporations have gradually contracted for management of the Indian Health Service (IHS) hospitals and clinics in regional hubs. In 1998, under self-governance authority, the 21 regional health corporations created the Alaska Native Tribal Health Consortium (ANTHC) in order to manage statewide health services. Currently, the Alaska Area has 21 dental clinics, managed by 14 different tribal organizations all represented by ANTHC. As a result of geographic isolation, lack of a State oral health program, vacant dentist positions, and high yearly dentist turnover in rural dental clinics, the oral health of Alaska Natives is far worse than the U.S. all-races oral health status. This oral health disparity became a priority with the ANTHC members and in May of 2000 a task force was established to address the issues of insufficient dental care in rural Alaska. This initiative resulted in an IHS Clinical and Preventive Support Center (Support Center) grant. The ANTHC Support Center will achieve its objectives by utilizing the federal authority to train Community Health Aides in expanded dental functions, thus creating the Dental Health Aide (DHA) program. DHAs will provide new village-based capability in primary dental care, including community education, preventive intervention, individual assessments, early referral of dental problems, and help to address Healthy People 2010 and GPRA objectives.

Contact Ron Nagel at ***rnagel@anthc.org***

Roles and Responsibilities of HP 2010 Teams

This section is derived from Delaware's Healthy People 2010 initiative and offers an excellent framework for analyzing how teams can be formed to meet the needs and resources of your particular area. No matter what structure is selected, all team members should:

- Contribute personal and professional experience and expertise to the group
- Speak up for and faithfully represent community, professional, or constituency perspectives
- Identify work group decisions that may present a conflict of interest and abstain from committee votes on these matters.

Authority: Advisory vs. Steering Responsibilities

In any planning structure, participants should know:

- Who has an advisory role? Persons in an advisory role may provide informed input on topics such as the HP 2010 planning process, priority or focal areas, target populations, scope of objectives, marketing, and other aspects of the HP 2010 plan.
- Who has a steering role? Persons in a steering role navigate the course of the planning process, establish work groups, determine input processes, and make decisions about the content of the state plan.
- Who makes final decisions, weighing all input?
- Who will be held accountable for the plan and see the plan through?

Advisory Structure Options

- Single advisory group that meets throughout the process (multidisciplinary representation)
- Two or more advisory groups to ensure input from specific constituencies (e.g., geographic areas, racial and ethnic populations, age-related programs), periodically convened
- Consortium of various advisory groups, (e.g., maternal and child health, oral health)
- No formal advisory group, but planned events or activities to gain input from key constituencies (e.g., town hall meetings, focus groups)

Steering Structure Options

- Steering group with full authority to develop and adopt the HP 2010 plan
- Steering group with significant authority to develop the HP 2010 plan, subject to the final approval of the governor, state health officer, mayor, or others
- Steering group with specific authority over certain tasks (such as the development of objectives), with other tasks (such as marketing and publication of the plan) under the authority of the state health agency, governor's office, or another organization

Distributing the Work

The following options may apply to distributing the work of advisory groups or steering groups, according to the planning structure you have chosen.

Delegation Options

- All the work is done during steering group meetings
- Members are divided into work groups or subcommittees
- Work groups are established and chaired by a steering group member, with membership open to non-steering group members who have expertise or have expressed an interest
- The steering group charges the state health agency or another official group with forming work groups as needed

Work Group Options

Number

- Limited number of work groups built around specific focus areas or objectives
- Unlimited number of work groups that expand as the need arises

Organization

- By focal areas (e.g., access, oral health, infrastructure), so that work groups are responsible for all aspects of developing the plan for their areas of expertise
- By functions (e.g., objectives, strategies, marketing, public input), so that work groups oversee one aspect of the process for all focal areas
- By populations (e.g., grouped by life stage, gender, race/ethnicity, people with disabilities)
- By target audience (e.g., business, government, community organizations)
- Combination of work group types

Communication

- Work groups operate independently, reporting only to the steering group
- All work groups are periodically convened with steering and advisory groups, sharing progress and discussing priorities of common concern
- Certain related work groups periodically meet together
- Staff interactions, minutes and other materials, Web sites, listservs or electronic newsletters facilitate communication among groups

Staffing Options

- Members or their respective staffs do all the work
- Agencies and organizations jointly support the process

- Umbrella agency or organization shares technical support (e.g., data, program expertise, or references) and administrative support responsibilities with members
- Umbrella agency hires contractual staff for administrative or technical support

Public Input and Involvement

Options

- Public meetings with formal testimony
- Public meetings with informal discussion with steering committee members
- Public meetings with breakout rooms for structured input or activities
- Requests for specific input or comment via e-mail, Web site, fax, or mail
- Surveys
- Key informant interviews
- Focus groups
- Internet discussion groups

The following examples demonstrate some models that incorporate many of these options.

- The Governor's Task Force for Healthy Carolinians appointed five committees to develop the North Carolina 2010 Health Objectives: Maternal and Young Child, Child and Adolescent, Adult, Older Adult, and Community Health. Each committee set its own agenda and determined subject areas for study and discussion. Experts were invited to present detailed information about 1) the issues, problems, and determinants/risk factors; 2) data that demonstrated problems and identified the disparities; and 3) solutions—resources that exist, resources and policies that are needed. Governmental and other agency representatives, university faculty and research center staff, advocacy groups, and healthcare practitioners provided much guidance in developing the health objectives. Oral health objectives emerged from three of the committees.

- The District of Columbia Department of Health oversaw the planning process for their Healthy People 2010 initiative, which was coordinated by the State Center for Health Statistics. A planning group with work groups and program liaisons was established. Citizen participation was solicited via committees and advisory groups and in three public hearings. The final plan was submitted to the Director of the Department of Health and to the Mayor. Pediatric Dental Health was included as one of 21 focus areas.

- Alaska posted their healthy Alaskans 2010 chapter reviews on its Web site to solicit feedback before being finalized. Oral health emerged as one of the health goals and is written as a chapter. Alaska has also created a listserv for continuing discussion.

- Approximately 550 Iowans representing more than 200 separate organizations, working in 23 chapter teams, developed the HP 2010 objectives.

- West Virginia used 30 workgroups and over 300 people to develop their HP 2010 objectives

- Oral Health 2000 was established as a committee of the Connecticut State Dental Association in 1993. Ultimately this group evolved into Oral Health 2010 and became an independent advocacy group with 501c3 status. Partnerships have been established with the Connecticut Department of Health to develop a train-the-trainer curriculum on oral health, and with the Hartford Health Department to collaborate on local action.

Who Should Be On the Team?

Partnerships for the HP2010 initiative are necessary because no one agency or organization has all of the necessary resources, experience, expertise, credibility, or relationships to initiate and sustain such a broad-based effort. An article by Green, Daniel and Novick in *Public Health Reports*, (see Reference list) suggests that partnering:

- Prevents tunnel vision
- Enables participation without overburdening one individual or agency
- Creates critical mass for empowerment and action
- Minimizes duplication of effort and resources—acts as a strategy to mobilize and leverage resources
- Allows intervention at multiple levels to initiate change.

How many partners are enough? How many are too many? The number and type of people on the team will in part be determined by the planning structure and the number and type of resources contributed by organizations or government agencies. As the group becomes larger there is a trade-off in terms of the effort required to manage the increased numbers and complexity.

A multidisciplinary group that represents different viewpoints and types of expertise is crucial to developing scientifically sound, realistic and culturally acceptable objectives and action plans.

As the team moves forward in its task, workgroups or other smaller divisions are more appropriate for detailed planning and implementation. Workgroups that focus on oral health objectives should not just include dental professionals; other health professionals, consumers and advocates may have different concerns and viewpoints. Involving people with diverse viewpoints at the outset will help to disclose these early in the discussions and will foster ownership of the process by the entire group. A number of community networks such as local interagency councils exist to address cross-cutting issues; these may be helpful for identifying partners.

On a national level, tribal leaders are proposing a collaboration among AI/AN tribes, states, Indian Health Service, HRSA, USDHHS, NIDCR, CDC, and the private sector to reduce oral disparities throughout Indian Country. This would include recommendations for increasing involvement and partnerships at the tribal and community level.

On a state level, lists of North Dakota HP 2010 Oral Health partners and members of the Missouri Oral Health Coalition are included in the Resources section as examples from states that have active and successful coalitions.

The Dental Directors/Chiefs for the nine US affiliated Pacific territories (jurisdictions) have formed the Pacific Basin Dental Association as a starting point to pull in other partners such as Head Start grantees. They recently received funding to convene a Head Start oral health forum for the Republic of Palau, Pohnpei and American Samoa to address oral health issues such as early childhood caries.

Resources to Identify and Invite Partners

Two worksheets to help identify potential team members are included in the Resource section. *Recruiting Coalition Members* and *Oral Health Coalition Contact List* are taken from the previously referenced workbook, *Community Roots for Oral Health Guidelines for Successful Coalitions.*

Delaware used a number of unique methods for their Healthy People 2010 initiative. One example is a two-page marketing/recruitment tool called *Partnership Opportunities* (copy in the Resources Section). It is a checklist of the various activities where the planning team needs assistance, with a contact person listed. This outlines a broad array of activities and allows people to select the type and level of involvement they wish to have. It can easily be adapted for an oral health workgroup. Two other tools in the Resources section, a *Chamber of Commerce Member Questionnaire* and a *Steering Committee Survey,* ask for valuable input to guide the entire HP 2010 process.

Partnerships for a Healthy Workforce has produced a publication, *Healthy Workforce 2010, An Essential Health Promotion Sourcebook for Employers*, to help solicit support from the business community. The document is online at **www.prevent.org/publications/Healthy_Workforce_2010.pdf**. Although oral health is only briefly mentioned in the booklet, supplemental materials could be given to bring members of the business community into oral health coalitions.

What are Some Tools to Assure Successful Teams and Team Meetings?

Community partnerships imply a "coming together" for a common purpose. Collaboration occurs among people, however, not among institutions. Collaboration is a means to an end, not an end in itself.

Two tenets of community partnerships are:

1) Mutual trust is based on openness and equal opportunity for all members, and
2) Interdependency is based on reciprocity—everyone gives and gets something.

Common pitfalls and challenges, as outlined by Berkowitz and Wolff in *The Spirit of the Coalition* (see Reference list) are listed in the box below.

Common Pitfalls and Challenges of Coalitions

- Failing to engage, trust and involve members of the community (consumers)
- Lead agencies retaining too much control over the membership and process
- Everyone protecting their own "territory"
- Avoiding meaningful action—spend time just talking or complaining about lack of resources
- Weak leadership
- Becoming overwhelmed and losing "balance"
- Inability to maintain members' motivation and faith in the cause.

A handout, *Definition of a Team,* (see Resources section, Page 21) was used by Iowa during their Healthy People 2010 planning process at the first team meeting. Two resources adapted from Healthy Iowans are included in the Resources Section to help meeting facilitators or team leaders. *Ground Rules* covers a shared set of norms that can be used to guide a team's behavior. It is helpful to present ground rules at the beginning of the meeting, and if there are additions, get participants' buy-in, and check in during subsequent meetings to make sure the ground rules are still being followed. *Guidelines for Productive Meetings* discusses use of agendas, facilitators, minutes, evaluation and timing.

Tips for Getting Your Team Started

- ✓ **Someone needs to be in charge of meeting preparation, especially the logistics and how to create a successful environment where everyone will feel welcome and their opinion valued. Make sure assignments are made for timekeeping, taking and distribution of minutes, etc.**

- ✓ **Introducing members via ice breakers, biosketches or verbal introductions: sharing biosketches before the first meeting will reduce the time needed for introductions during the first meeting and will allow more time for team building activities.**

- ✓ **Set aside a time at the beginning for sharing expectations and clarifying which ones are not appropriate for the timeframe or purpose of the first meeting; check back at the end of the meeting to see which expectations have been met and which steps need to be taken.**

- ✓ **Determine a process for decision-making. Will decisions require a consensus or a majority vote? What group process techniques might be helpful (e.g., nominal group process technique)?**

- ✓ **Mission and vision: If a written mission and vision statement have not already been developed, then draft one so that the group feels ownership and everyone "is on the same page." Overall goals, objectives and strategies will then be developed from key data and information.**

- ✓ **Scope of the initiative: make sure everyone knows the scope of activities and any limitations, e.g., statewide? All ages?**

- ✓ **Potential roles, responsibilities and expectations for members: everyone will have different levels of involvement and roles; presenting the options at the beginning lets people decide what responsibilities they want and are able to assume.**

- ✓ **Timelines: discuss the entire timeframe for the HP 2010 initiative and then establish more short-term timelines as you go.**

- ✓ **Resources: review resources already available and ones that will be needed.**

- ✓ **Communication tools: brainstorm how communication among team members and with individuals and organizations outside the group will be handled and who will be responsible for overall communication.**

One important step for any team engaging in a planning process is identifying assets and resources that will guide the selection of priorities, formulation of objectives, and implementation of interventions for achieving goals. This process will increase the efficiency of planning efforts, help prevent duplicative efforts, and increase awareness of potential barriers and new resources. A useful tool for facilitating this process is the SWOT worksheet found in the Resources section of this chapter.

SWOT outlines potential:

- **Strengths**
- **Weaknesses**
- **Opportunities**
- **Threats.**

The Reference list in the Resources section includes other helpful books and articles on community coalitions and collaboratives. One additional comprehensive tool is the *Community Toolbox,* produced by the Workgroup on Health Promotion & Community Development at the University of Kansas, and available online at **http://ctb.lsi.ukans.edu**.

The next chapter will provide examples of specific strategies for setting health priorities, implementing national HP 2010 oral health objectives or developing state or community ones, and obtaining data for baselines and targets.

Resources

Chapter 2

- Oral Health Infrastructure Checklist
- HP 2010 Oral Health Planning Self-Assessment
- Web Sites and Contact Information for National Agencies and Organizations
- Sample 2010 Planning Structures
- Model for the Development of Maryland's Project 2010 (also downloadable from http://mdpublichealth.org/ohp/html/oral)
- NGA Oral Health Policy Academy Participating States
- Worksheet: Recruiting Coalition Members
- Worksheet: Oral Health Coalition Contact List
  - Sample Recruiting Tool: Partnership Opportunities (download from www.phf.org/HPtools/state/DEpartnr.pdf)
- Examples of Oral Health Coalitions and Member Groups in North Dakota and Missouri
- Healthy Delaware 2010 Chamber of Commerce Member Questionnaire (also downloadable from www.phf.org/HPtools/state/Ident-D.pdf)
- Healthy Delaware 2010 Steering Committee Survey (also downloadable from www.phf.org/HPtools/state/Survey.pdf)
- Handout: Definitions of a Team (also downloadable from www.phf.org/HPtools/state/teamdefn.pdf)
- Handout Example: Ground Rules (also downloadable from www.phf.org/HPtools/state/grndrule.pdf)
- Guidelines for Productive Team Meetings (also downloadable from www.phf.org/HPtools/state/grndrule.pdf)
- SWOT Worksheet
- References

Oral Health Infrastructure Checklist

How many resources are you aware of in your state/territory, tribe or community that you could contact for assistance with oral health programs or projects? The following list provides a few examples. Adapt this worksheet to list contact information for each resource.

Regional and Statewide Agencies or Programs

- ☐ DHHS Regional Office
- ☐ Indian Health Service Area Dental Officer
- ☐ State Dental/Oral Health Program Director
- ☐ State Medicaid/SCHIP Dental Consultant(s)
- ☐ State EPSDT Dental Consultant
- ☐ Other State Oral Health Staff (e.g., MCH, Developmental Disabilities, Migrant Health, Corrections)
- ☐ State Dental Board (members)
- ☐ State Dental Association
  - Dental Auxiliary (dental spouses)
- ☐ State Dental Hygienists' Association
- ☐ State Dental Assistants' Association
- ☐ Other Statewide Dental Professional Organizations
- ☐ Dental Schools
- ☐ Dental Hygiene Schools
- ☐ Dental Assisting Programs
- ☐ Dental Technician Programs
- ☐ Public Health Schools
- ☐ Area Health Education Centers
- ☐ Statewide Oral Health Coalitions, Task Forces, Advisory Groups
- ☐ Dental Residency Programs
- ☐ Research or Policy Centers/Institutes with Oral Health Staff
- ☐ Advocacy Organizations
- ☐ Dental Managed Care Plans
- ☐ Dental Insurance Organizations
- ☐ Dental Products/Equipment Companies
- ☐ Dental Laboratories
- ☐ Other (list here):

Local/ Community Programs

- ☐ Health Departments with Dental Director or other Oral Health Staff
- ☐ Community Health Centers with Dental Programs
- ☐ School-based Dental or Oral Health Programs
- ☐ Early Childhood Oral Health Programs
- ☐ Indian Health Service or Tribal Programs

- ☐ Migrant Health Programs or Health Centers
- ☐ Homeless Health Programs or Health Centers
- ☐ Other Health Department Dental Care Assistance Programs
- ☐ Non-Profit/Volunteer Dental or Oral Health Programs
- ☐ Clinics
    - Mobile vans or trailers
    - Portable equipment
    - Screening/referral
    - Preventive services
    - Other:
- ☐ Private General Dentists who accept Medicaid/SCHIP
- ☐ Private General Dentists who provide other Reduced Fee Services
- ☐ Pediatric Dentists who accept Medicaid/SCHIP
- ☐ Pediatric Dentists who provide other Reduced Fee Services
- ☐ Dental Specialists who participate in state-sponsored programs
- ☐ Donated Dental Services Program
- ☐ Local Hospital Programs
- ☐ Case Management Programs
- ☐ Transportation Assistance
- ☐ Other Insurance Programs
- ☐ Local Oral Health Coalitions
- ☐ Local Dental Societies
- ☐ Local Dental Hygiene Components
- ☐ Local Dental Assistants Societies
- ☐ Local Dental Auxiliaries (Dental Spouses)
- ☐ Local Advocacy Groups/Service Organizations
- ☐ Dental Supply Companies
- ☐ Dental Laboratories
- ☐ Other:

HP 2010 Oral Health Planning Self-Assessment

Assess your knowledge of what is occurring in your state/territory that can be used for the HP 2010 Initiative. If you don't know the answer, place an × in the DK "don't know" option, and then research the answer.

At what stage is your state in having a HP 2010 Plan?
____completed ____ in progress ____ not started ____ DK

Is there a Web site to access the information?
____yes ____no ____ DK

Are any oral health objectives included in the HP 2010 Plan?
____yes ____no ____ DK

If yes, is oral health a separate chapter or focus area? ___yes ___ no ____ DK

Are there any local or tribal HP 2010 plans? ___yes ___ no ____ DK

What sources of funding have been used to support HP 2010 planning efforts? ____ DK
Governmental: ____federal ____ state ____county/local
Private: ____national ____ state ____local
Other:

Is there a statewide oral health coalition? ___yes ___ no ____ DK

Are there any other oral health coalitions for specific communities or purposes?
____yes ____no ____ DK

Is there a written state oral health plan? ____yes ____no ____ DK

Has your state participated in a NGA Policy Academy? ____yes _____no ____ DK

Has your state had any Oral Health Summits or Forums? ____yes ____no ____ DK

Does your state have a State Oral Health Program/Dental Director?
____yes _____no ____ DK

If yes, is he/she ____full-time ____part-time? ____ DK
Does he/she have dental credentials? ____yes ____no ____ DK
Does he/she have public health credentials? ____yes ____no ____ DK

State_____ Title_____

Web Sites for Selected National Organizations & Agencies

Associations and Organizations

Academy of General Dentistry: **www.agd.org**
American Academy of Pediatric Dentistry: **www.aapd.org**
American Association for Dental Research: **www.aadr.org**
American Association of Dental Examiners: **www.aadexam.org**
American Association of Public Health Dentistry: **www.aaphd.org**
American Dental Association: **www.ada.org**
American Dental Education Association: **www.adea.org**
American Dental Hygienists' Association: **www.adha.org**
American Dental Trade Association: **www.adta.org**
American Public Health Association: **www.apha.org**
Association of Clinicians for the Underserved: **www.clinicians.org**
Association for Maternal and Child Health Programs: **www.amchp.org**
Association of State and Territorial Dental Directors: **http://www.astdd.org**
Hispanic Dental Association: **www.hdassoc.org**
National Association of County and City Health Officials: **www.naccho.org**
National Association of Dental Plans **http://nadp.org**
National Association of Local Boards of Health: **www.nalboh.org**
National Congress of American Indians: **www.ncai.org**
National Dental Association: **www.ndaonline.org**
National Governors Association Center for Best Practices: **www.nga.org/center**
National Indian Health Board: **www.nihb.org**
National Maternal and Child Oral Health Resource Center: **www.mchoralhealth.org**
Oral Health America: **www.oralhealthamerica.org**
Special Care Dentistry: **www.scdonline.org**
Special Olympics: **www.specialolympics.org**

Agencies

For most government programs, use the initials of the program followed by ".gov", e.g.,

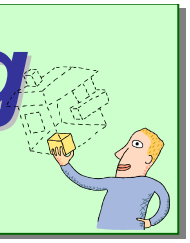
- Office of the Surgeon General: **www.surgeongeneral.gov**
- NIDCR: **www.nidcr.nih.gov**
- HRSA: **www.hrsa.gov**
- Head Start: **www.acf.dhhs.gov**
- CDC, Division of Oral Health: **http://cdc.ncdphp.doh.gov**

Contact Information for National Associations Who Do Not Have Web Sites

American Association of Community
Dental Programs
C/o Dr. Larry Hill
3101 Burnet Avenue
Cincinnati, Ohio 45229
larry.hill@rcc.org

National Network for Oral Health Access
C/o Dr John McFarland
Plan de Salud del Valle Dental Clinic
1115 E 2nd Street
Fort Lupton, CO 80621
Jmcfarland@saludclinic.org

Sample 2010 Planning Structures



1

State Agency Steering Group

- Makes final decisions
- Establishes and staffs state HP 2010 work groups
- Focal point for all input

Advisory Committee

- Makes recommendations on HP 2010 process & priorities
- Includes public and private members
- Non-state agency chair or co-chair

Work Group | **Work Group** | **Work Group** | **Work Group**

2

State Agency Support Team

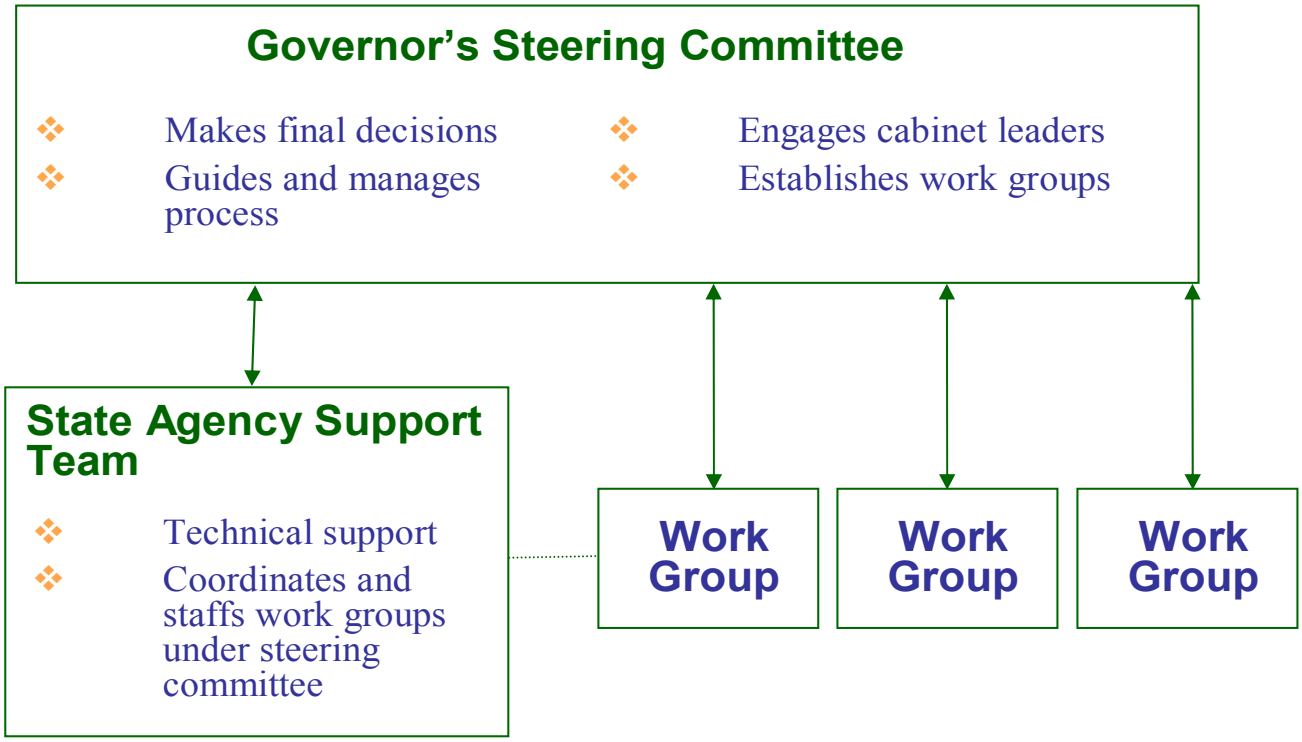
- Coordinates and staffs work groups
- Provides technical and administrative support to the steering group

Steering Group

- Makes final decisions
- Includes public and private members
- Establishes work groups
- Public or private; potentially honorary chair

Work Group | **Work Group** | **Work Group** | **Work Group**

3



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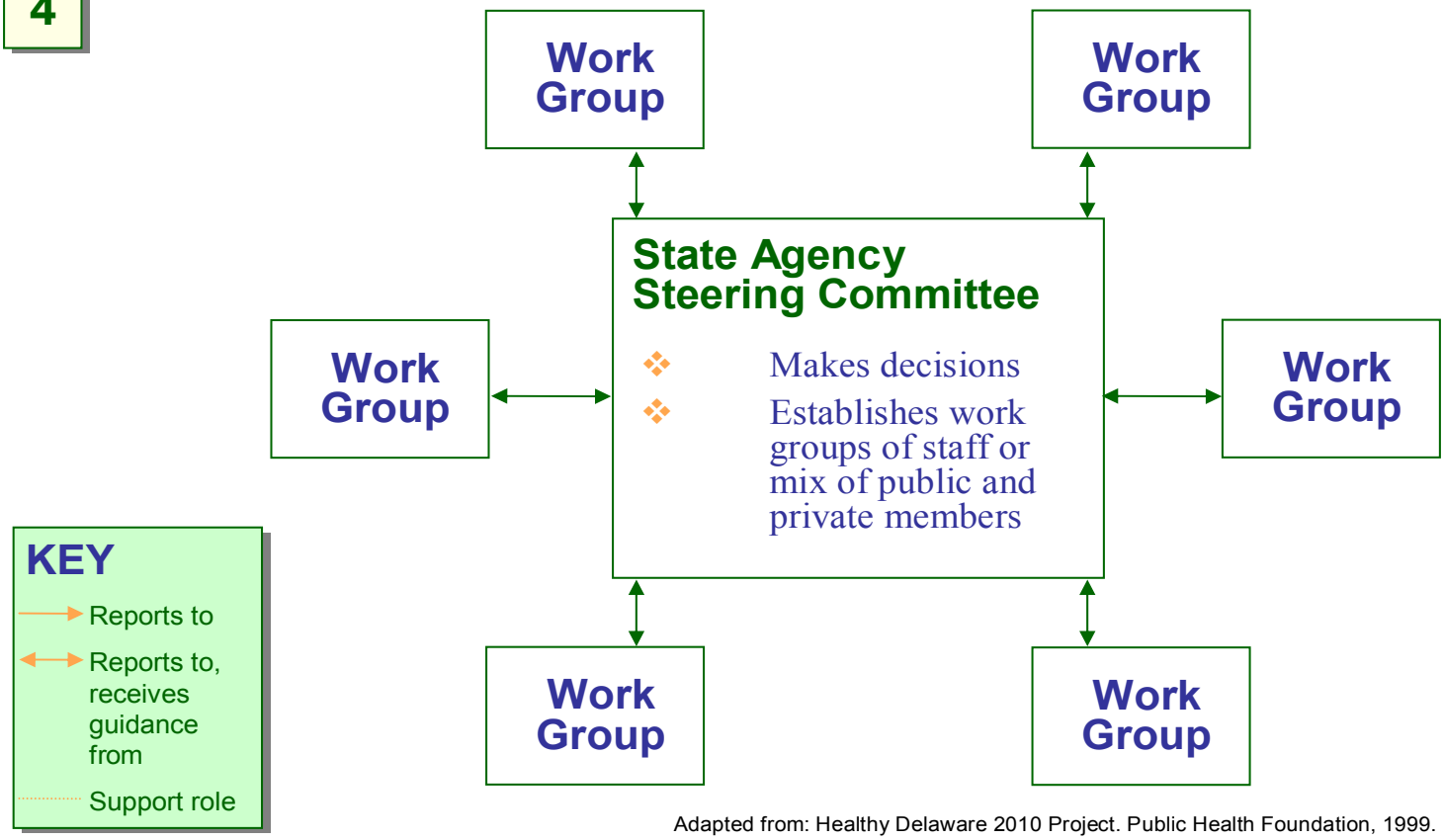
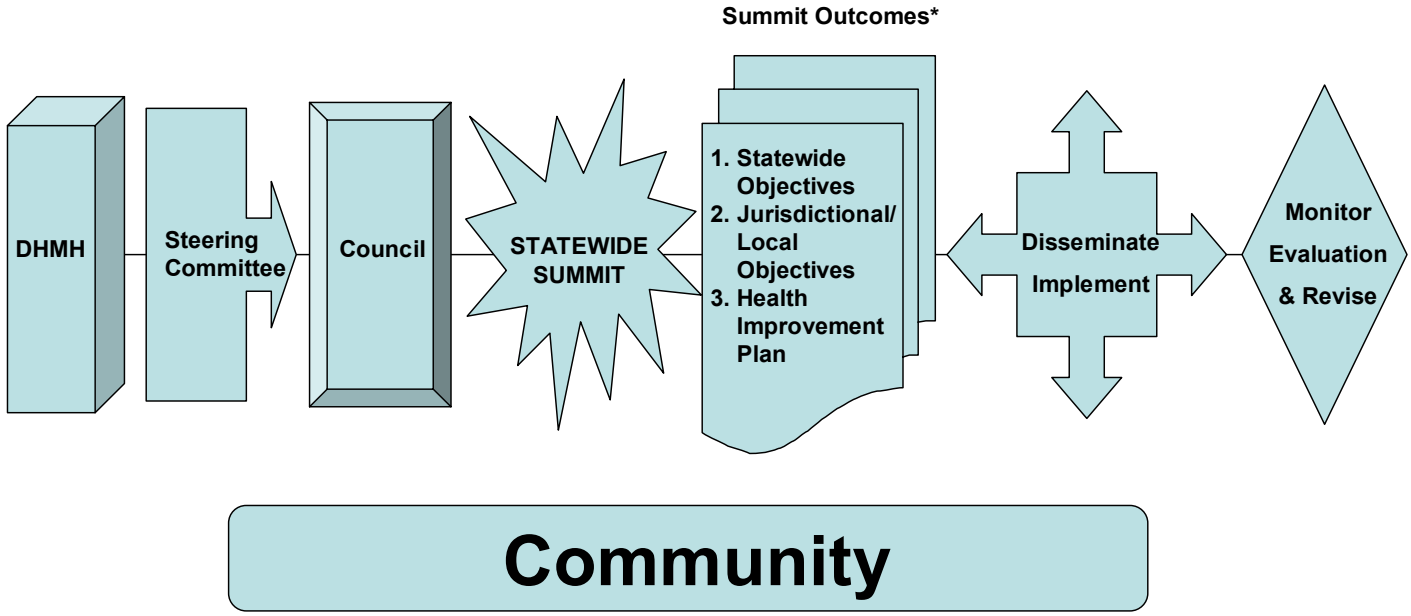


Adapted from: Healthy Delaware 2010 Project. Public Health Foundation, 1999.

Model for the Development of Maryland's Project 2010



Community

Public/Private, Local/State, Health Providers/Professions, Academia, Business, Non-Profit, Faith, Consumers

***Linked to Healthy People 2010 Framework**

NGA Oral Health Policy Academy
Participating States

Round 1: Dec 2000 in Charleston, SC. These states have submitted reports to NGA on outcomes achieved and strategies for implementing their action plans.

- Alabama
- Colorado
- Minnesota
- Ohio
- Oregon
- South Carolina
- Virginia

Round 2: May 2001 in Nashville, TN. These states are in the process of developing their action plans.

- Arkansas
- Delaware
- Georgia
- Kentucky
- Tennessee
- Utah
- West Virginia
- Wyoming

Round 3: Oct 2001 in Jackson, MS. These states just completed their first Academy meeting and teams are continuing to meet on their own.

- Florida
- Maine
- Massachusetts
- Mississippi
- Missouri
- Pennsylvania

Worksheet
Recruiting Coalition Members

1. Why do you want or need members?

2. How many members do you need?

3. What kind of members do you need? (i.e., individuals, members who speak for organizations, members with specific skills or expertise)

4. When do you want to have the first meeting? What tasks need to be accomplished to be ready for that meeting? (develop a timeline)

5. How should you approach potential members? What do you want to say? (How will they benefit from joining the coalition?)

6. What is the best method for contacting potential members? (in person, on the phone, by mail)

7. Who is going to contact potential members'? (divide the task)

Reprinted with permission from Washington State Department of Health. *Community Roots for Oral Health. Guidelines for Successful Coalitions.* March 2000.

Oral Health Coalition Contact List

Reprinted with permission from Washington State Department of Health. *Community Roots for Oral Health. Guidelines for Successful Coalitions.* March 2000

Worksheet

Agency/Group Represented	Contact Person	Address	Phone	E-mail Address
Local Health Dept.				
Dental Society				
Dental Hygiene Society				
Head Start				
Health and Human Service Providers				
School Nurses				
Service Clubs				
Parents				
Dental Consumers				
Health Clinics				
Hospitals				
Health Care Providers				
Media				
Policy Makers				
Key Businesses				
Multi-cultural Groups				
Prenatal Outreach Programs				
WIC				
Churches				
Community Foundations				
Provider Schools/Colleges				
Children's Advocates				

Partnership Opportunities

January 2000

Build the Initiative

To get Healthy Delaware 2010 off the ground, we need leadership and partnership from many organizations and individuals. Contribute your efforts, resources, or staff to the committees responsible for creating a successful initiative.

Development— oversees the development of action-oriented plans by work groups. This committee needs:

- ❑ Experts to help prepare and review briefing materials on important health issues for work groups (Jan – Feb 2000)
- ❑ Facilitators for monthly work group meetings (Apr – Sept 2000)
- ❑ Donated food, beverages, and appreciation items for work group participants (Apr – Sept 2000)
- ❑ Administrative assistance with copying and mailing materials to work group participants (Feb – Oct 2000)

Marketing— promotes the initiative and participation from all sectors. This committee needs:

- ❑ Professional marketers, good writers, and graphic artists to help put the marketing plan into action—volunteers or staff on "executive loan" to refine marketing strategies, write articles, prepare kits for speakers, plan events, and develop the "Healthy Delaware Heroes" awards program
- ❑ Web site assistance — professionals or students to help do design work, put documents on the site, and arrange links to and from the Healthy Delaware 2010 site
- ❑ Printing—print or underwrite the cost of printing the Healthy Delaware 2010 plan (April 2001)
- ❑ Sponsors for "companion publications" geared to the needs of specific groups (such as businesses or schools)
- ❑ Mailing/distribution—handle major quarterly mailings promoting the initiative or help distribute plans beginning April 2001
- ❑ Host sites and meeting planning assistance for public comment meetings in each county (Jan – Feb 2001); the Healthy Delaware 2010 launch event (April 2001); and post-launch promotional events in each county (summer- fall 2001).
- ❑ Donated food, beverages, and appreciation items for the Healthy Delaware 2010 launch event (April 2001)

Sustaining the Initiative — focuses on long-term success through strategic partnerships, resources, incorporation of Healthy Delaware into public/private initiatives, and ways to support efforts. This committee needs:

- ❑ Legal and staff assistance to help establish an independent, nonprofit Healthy Delaware 2010 organization or community foundation
- ❑ An interim fiscal agent
- ❑ Staff to develop and maintain a database of Healthy Delaware Prevention Partners and organizations' specific commitments
- ❑ Leaders to help attract, motivate, and coordinate participation among partners in their sectors.

Evaluation— ensures we can measure the achievements of Healthy Delaware. This committee needs:

- ❑ People with technical expertise in public and private sector data systems to help track Healthy Delaware progress
- ❑ Volunteers from all sectors to help design and implement evaluation plans for the initiative

Join a Work Group to Develop the Healthy Delaware 2010 plan

Work with others from your sector to help develop the community health guide for the decade.

- ❑ Volunteer for a work group. Participants must commit to attend 2-4 meetings, plus time to review background materials on Delaware issues, past efforts, and effective strategies.

Comment on the Draft Plan

- ❑ Review and comment on the draft Healthy Delaware 2010 plan, available at meetings, in print, or online at healthydelaware.com (Jan – Feb 2001).

Become a Healthy Delaware "Prevention Partner"

Pledge your support and gain recognition as a Healthy Delaware Prevention Partner.

- ❑ Request and complete a partnership agreement by February 2001.
- ❑ Mobilize your affiliates, association members, or others to become partners in the initiative.

Promote Healthy Delaware

Promote Healthy Delaware 2010 and your involvement.

- ❑ Put a link to healthydelaware.com on your web page.
- ❑ Include relevant Healthy Delaware goals and objectives in your materials.
- ❑ Include the Healthy Delaware 2010 logo on your publicity for activities and events that support Healthy Delaware 2010.
- ❑ Invite speakers to your organization or staff meeting to discuss the initiative and your partnership.
- ❑ Mail the draft plan or the final plan to your constituency with a cover letter highlighting areas of importance to them.
- ❑ Use the initiative's local marketing guide (available April 2001) to help promote the initiative.

Share Responsibility for Achievement

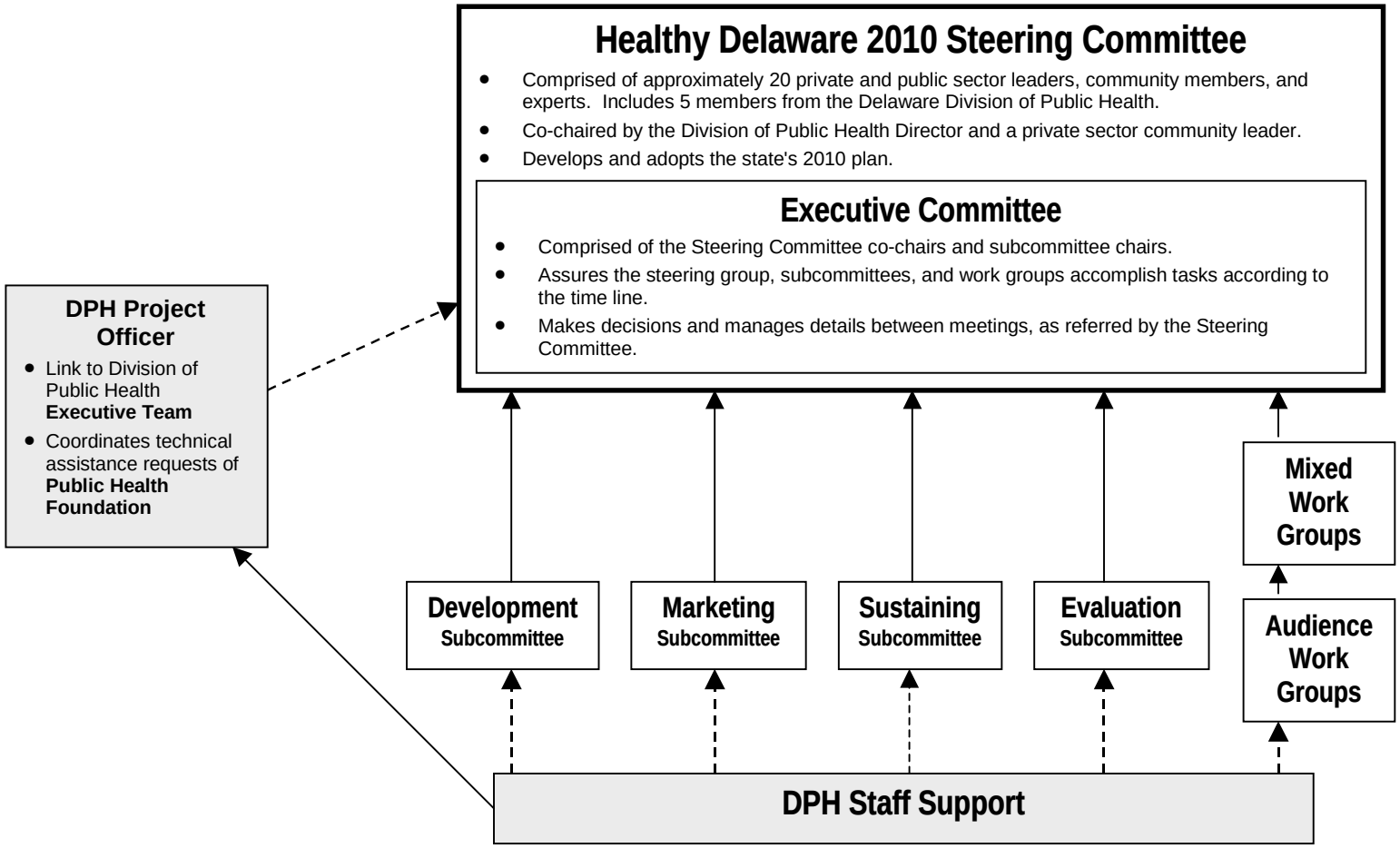
- ❑ Incorporate the recommendations for your sector into your strategic or community plans.
- ❑ Set annual performance agreements with managers specifying how their teams or programs will help achieve and track progress according to Healthy Delaware 2010 objectives.
- ❑ Use Healthy Delaware 2010 to choose a prevention focus for worksite, community, school, faith-based, or policy initiatives.
- ❑ Use Healthy Delaware 2010 or healthydelaware.com to find resources and information on best practices.
- ❑ Collaborate with others in your sector or make cross-sector partnerships to undertake Healthy Delaware 2010 strategies.
- ❑ Sponsor employee or student Healthy Delaware wellness events.
- ❑ Expand or modify current agency initiatives to focus on Healthy Delaware 2010 prevention goals.
- ❑ Volunteer to be listed in Healthy Delaware 2010 as an organization responsible for leading action in specific areas.
- ❑ Advocate for (or propose) policies to achieve the Healthy Delaware prevention agenda. Show your organization, school, or elected leaders how their policies can make a difference.
- ❑ Use Healthy Delaware 2010 for evaluation and tracking. Collect and share data to compare your community or program participants to the state objectives.

To get involved, contact:

Healthy Delaware 2010
Terrance Zimmerman, PhD, Coordinator

Delaware Division of Public Health
Jesse Cooper Building
P.O. Bo 637
Dover, DE 19903
Voice: 302-739-3034
Fax: 302-739-3008
TDD: 1.800.464.HELP
Email: tzimmerman@state.de.us

Healthy Delaware 2010 Planning Structure



Lines of support

Lines of accountability

Examples of Oral Health Coalitions & Member Groups

North Dakota HP 2010 Oral Health Coalition

- North Dakota Department of Health
- North Dakota Department of Human Services – Medicaid and Health Tracks
- North Dakota Department of Public Instruction
- Indian Health Service
- Head Start State Collaboration Office
- WIC
- Local health agencies
- North Dakota Board of Dental Examiners
- State Dental Association
- State Dental Hygiene Association
- State Dental Assistants Association
- Community Action Association
- Community Health Centers
- Primary Care Association
- Primary Care Organization
- Aging Services
- Patterson Dental Supply Company
- North Dakota Insurance Department
- North Dakota Blue Cross/Blue Shield (Noridian)
- Red River Region Dental Access Coalition
- Dakota Medical Foundation
- North Dakota Tobacco Control Program
- Tobacco Free North Dakota
- Municipal Facilities – Fluoridation Program
- Media representative – Public Radio, AP
- North Dakota State College of Science – Allied Dental Health Department
- University of North Dakota – Medical School
- Cancer Program/Registry

Missouri Coalition for Oral Health Care Access

- MO Primary Care Association
- MO Dental Association
- UMKC School of Dentistry
- MO Chapter, American Academy of Pediatrics
- MO Head Start Association
- MO Public Health Association
- MO Dental Hygienists Association
- MO Area Health Education Centers
- Boone County Council on Aging
- MO Association for Social Welfare
- MO Conference of the United Methodist Church
- Mineral Area Study Club
- MO Children's Trust Fund

Healthy Delaware 2010: Chamber of Commerce Member Questionnaire

The Delaware Division of Public Health has asked the Public Health Foundation to assist in developing a statewide plan to improve the health of Delawareans by the year 2010. The final product will be a state health plan, called Healthy Delaware 2010 which will contain objectives and strategies to improve the health of Delaware. The expected completion date is April 2000.

The purpose of this questionnaire is to collect information from stakeholders before planning begins. This information will help the steering committee focus its efforts, create a plan that people will use, and engage both the private and public sectors in important health efforts. As the plan is developed, there will be other opportunities for public input and involvement.

1. What health issues are of greatest concern to your business?

_____

_____

_____

2. How do you feel public health issues relate to what you do in your business?

_____

_____

_____

_____

_____

_____

3. **Does your business offer health-oriented programs? If so, please briefly explain what they are and how they were chosen (e.g., employee need, direction of company headquarters, labor agreement, staff idea.)**

   Type of Program: _____

   _____

   How Chosen: _____

   _____

4. **What types of plans, if any, do you use in your everyday work?**

   _____

   _____

   _____

5. **What would a publication need to look like in order for it to seem relevant to you? Are there specific publications you can give as examples?**

   _____

   _____

   _____

   _____

   _____

   _____

6. **What could be done to make the state health plan helpful & easy for businesses to use to guide their involvement in health issues or worksite programs?**

_____

_____

_____

_____

_____

_____

7. **What could motivate or interest other businesses in getting involved with a state health improvement initiative?**

_____

_____

_____

_____

_____

_____

8. In which of the following ways would you be interested in assisting with the state health plan or addressing issues covered in the plan? (*Check all that apply*)

- ☐ Join a work group
- ☐ Give input at a public meeting
- ☐ Motivate other leaders to be involved
- ☐ Publicly support the plan's priorities
- ☐ Publicly commit to addressing certain areas
- ☐ Propose new health policies
- ☐ Develop or expand programs or initiatives (employee, community, agency, school)
- ☐ Comment on draft plans
- ☐ Contribute resources (monetary donations, printing/copying, mailing/distribution, host promotion events, administrative staff, technical staff)
- ☐ Integrate state plan into current organization plans
- ☐ Evaluate or track progress in certain areas
- ☐ Other:_____
- ☐ _____

9. **All things considered, what is the most important message we should give to the people making the state health plan?**

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire! Your input is greatly appreciated.

Please return by August 25, 1999 via fax [(202) 898-5609] or mail to Dianna Conrad, Public Health Foundation, 1220 L St. N.W., Ste. 350, Washington, D.C. 20005.

Healthy Delaware 2010 Steering Committee Survey

The Healthy Delaware 2010 Subcommittee needs your input in order to recommend a framework and methods to develop our state health plan.

For multiple choice questions below, please mark the circle next to the response that best describes your opinion. It is not necessary to color in the circle; an "X" or check is okay. IMPORTANT: Pay attention to the number of responses allowed. Some questions allow more than one response. Thank you!

Framework

1. How would you most like to see the state health plan organized? (choose ONE)

   - ☐ Chapter for each health indicator (e.g., teen smoking), containing objectives and activities pertaining to each target audience
   - ☐ Chapter for each target audience, containing objectives and activities to address each health indicator
   - ☐ A book organized by health indicator on one side and—when flipped over—organized by target audience on the other side
   - ☐ Other (please specify):
   - ☐ Not sure
   - ☐ No preference

2. Please take a few minutes to review the attached handouts, "Using Health Indicators to Identify Priorities." Of the five sets of health indicators listed on pages 3 – 7, which do you favor most as a framework for Healthy Delaware 2010? (choose ONE)

   - ☐ Health Status Indicators of Healthy People 2000, Objective 22.1, Set
   - ☐ Community Health Status Indicators Project Set O Health Determinants and Health Outcomes Indicators Set
   - ☐ Life Course Determinants Set
   - ☐ Prevention-Oriented Set
   - ☐ Not sure
   - ☐ No preference

What indicators (if any) would you delete from your choice in question #2? (list up to TWO)

What indicators (if any) would you ADD to your choice in question #2? (list up to TWO)

Healthy Delaware 2010 Steering Committee Survey (Cont.)

Organizing Work Groups

3. Most of the work to develop Healthy Delaware 2010 will be done in work groups, open to people outside the Steering Committee. Regardless of how the work groups are organized, their recommendations can be "plugged into" the plan's printed format chosen by the Steering Committee (see question #1).

Think about how people work best together and the goals of Healthy Delaware 2010. What would be the best way to organize work groups? (Choose ONE)

- ☐ Convene audience groups* to set their objectives and strategies around indicators, independent of other audiences
- ☐ Convene mixed groups** around each indicator, enduring that each audience is represented when developing objectives
- ☐ Convene audience groups to discuss potential objectives, then send delegates to a mixed group around each indicator
- ☐ Convene mixed groups to develop common objectives for each indicator, then have audience groups develop strategies
- ☐ Other (please specify):
- ☐ Not sure
- ☐ No preference

* such as business, government, or community-based organizations
** including people from multiple audiences

Target Audiences

4. Which of the following target audiences should the Steering Committee use to organize Healthy Delaware 2010 work groups and sections of the plan? (choose AS MANY AS YOU LIKE)

- ☐ Government (e.g., government agencies, elected officials)
- ☐ Business (e.g., industry, chamber of commerce)
- ☐ Consumers (e.g., citizens, patients, persons at risk)
- ☐ Health systems and hospitals (e.g., managed care organizations, provider
- ☐ networks)
- ☐ Community health organizations (e.g., community health centers, American Heart Association, Planned Parenthood)
- ☐ Other community-based organizations (e.g., civic groups, faith communities,
- ☐ YMCA, Boys & Girls Clubs)
- ☐ Education (e.g., schools, teacher associations, parent-teacher groups, colleges)
- ☐ Other:
- ☐ Not sure
- ☐ No preference

Healthy Delaware 2010 Steering Committee Survey (Cont.)

Community Input

5. The Steering Committee could seek community input and ideas on several aspects of Healthy Delaware 2010. For which of the following is it most important to seek outside input? (choose up to TWO)

   - ☐ Framework and priority setting methods
   - ☐ Measurable objectives in the plan
   - ☐ Who can work on certain strategies
   - ☐ The health indicator set for Delaware
   - ☐ Strategies that will work to address health indicators
   - ☐ Other (please specify):
   - ☐ No preference

6. Considering Healthy Delaware 2010 goals, target audiences, and resources, what methods of gaining community input would be best? (choose up to TWO)

   - ☐ Public hearings with testimony
   - ☐ Telephone survey
   - ☐ Members gather input from their organizations
   - ☐ Other (please specify):
   - ☐ No preference
   - ☐ Use web to post drafts for comment
   - ☐ Focus groups on specific issues
   - ☐ Informal open meetings with discussion
   - ☐ Not sure

What other suggestions do you have for the Framework Subcommittee on how we should develop Healthy Delaware 2010?

Definition of a Team

team n. 1. Two or more draft animals harnessed to a vehicle or farm implement. 2. To harness or form together so as to form a team.

A group is not a team.

A **group** is defined as *two or more persons who are interacting with one another in such a manner that each person influences and is influenced by each other person*.

A **team** is defined as *a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable*.

(Jon Katzenbach & Doug Smith, *The Wisdom of Teams*, 1993. Harvard Business School Press, p 45)

A team has two important characteristics that differentiate it from a group:

- specific results for which the group is **collectively** responsible; and
- supra-consciousness of being a team, awareness that we need each other.

Source: Healthy Iowans 2010

Ground Rules

Definition: A shared set of norms which guide the team's behavior.

General Ground Rules	Team Meetings Ground Rules
Refreshed We each have the responsibility to stay physically refreshed so our heads stay in the game. ***Dialogue*** Be direct and caring; Everyone participates; Listen as an ally; Concede to wisdom, not position. ***Stretch*** Learning takes many forms -respect other's learning styles. ***Team Work*** None of us is as smart as all of us. ***Consequences*** Teams must decide what actions to take if members do not follow ground rules.	Attendance/Quorum. Promptness (define on time). Advanced scheduling. Prepare an agenda in advance. Establish consistent meeting site. Set length of meetings to meet the team's needs. Complete actions/assignments on time. Record minutes. Evaluate meetings. Define team rules.
Team Discussion	**Team Decisions**
Everyone participates. Open flow of ideas. Non-judgmental. Stay issue focused. Find common ground. Use consensus, when possible. Interruption - 100 mile rule. Confidentiality.	Determine process for decision making, i.e., consensus. Ensure common understanding of the issue(s). Gather relevant facts/data. Analyze the data. Make decision based on facts/data.

Source: Healthy Iowans 2010

Guidelines for Productive Team Meetings*

The initial team meetings are critical for setting the proper tone: there is serious work at hand, but everyone can have fun and contribute to the organization by working together. Ground rules need to be discussed and agreed upon at the outset. Some typical examples are attendance, promptness, equal opportunity to participate, interruptions, assignments, role assignments, decision-making methods, confidentiality, meeting evaluation method, chronic violations of ground rules.

The best way to have productive meetings is to follow guidelines from the start and at a time when team members expect to learn new ways of working together.

• Use agendas.

Each meeting must have an agenda, preferably one drafted at the previous meeting. It should be sent to participants in advance, if possible. (If an agenda has not been developed before a meeting, spend the first five or 10 minutes writing one on a flipchart.)

Agendas should include the following information:

Agenda topics (including, perhaps, a sentence or two that defines each item and why it is being discussed). The presenters (usually the person who originated the item or the person most responsible or knowledgeable about it). A time guideline (the estimated time in minutes needed to discuss each item). The item type, and whether the item requires discussion or decision, or is just an announcement.

Agendas usually list the following activities:

Warm-ups: short activities used to free people's minds from the outside world and get them focused on the meeting. A quick review of the agenda. Simply start each meeting by going over the agenda, adding or deleting items, and modifying time estimates. Breaks for long meetings. If the meeting last more than two hours, schedule at least one short break. Meeting evaluation. This is perhaps the most important item on the agenda.

Introduce these elements the first meeting and include them in all subsequent meetings. As team members become more comfortable with the group, they will feel less self-conscious about these activities.

• Have a facilitator.

Each meting should have a facilitator who is responsible for keeping the meeting focused and moving. Ordinarily, this role is appropriate for the team leader, but your team may rotate the responsibility among the members. The facilitator's chief responsibilities are to keep the discussion focused on the topic and moving along; intervene if the discussion fragments into multiple conversations; tactfully prevent anyone from dominating or being overlooked; bring discussions to a close.

The facilitator should also notify the group when the time allotted for an agenda item has expired or is about to expire. The team then decides whether to continue discussion at the expense of other agenda items or postpone further discussion until another meeting.

• Take minutes.

Each meeting should also have a scribe who records key subjects and main points raised, decisions made (including who has agreed to do what and by when) and items that the group has agreed to raise again later in this meeting or at a future meeting. Team members can refer to the minutes to reconstruct discussion, remind themselves of decisions made or actions that need to be taken, or to see what happened at a meeting they missed. Rotate this duty among the team members.

• Draft next agenda.

At the end of the meeting, draft an agenda for the next meeting.

• Evaluate the meeting.

Always review and evaluate each meeting, even if other agenda items go overtime. The evaluation should include decisions on what will be done to improve the meeting next time and helpful feedback to the facilitator.

• Adhere to the "100-mile rule."

Once a meeting begins, everyone is expected to give it full attention. No one should be called from the meeting unless it is so important that the disruption would occur even if the meeting were 100 miles away from the workplace. The "100-mile rule" will need to be communicated--perhaps repeatedly--to those who keep taking phone messages or would interrupt the team's work for other reasons.

*These guidelines have been excerpted from *The Team Handbook* by Peter R. Scholtes and *Running Effective Meetings* (Joiner Associates). Copies of a suggested form for streamlining meeting minutes, meeting evaluation, and meeting skills checklist are available from these publications.

SWOT Worksheet

SWOT is an examination of a group's internal strengths and weaknesses, as well as the environment's opportunities and threats. It should be used in the beginning stages of decision making and strategic planning.

Strengths: What are your state's particular strengths? Do you do something particularly unique? What could be an asset in developing objectives for your state plan?

Weaknesses: Where is your state lacking? What do others seem to accomplish that you cannot? What could limit your state planning efforts?

Potential Internal Strengths	Potential Internal Weaknesses
1.	1.
2.	2.
3.	3.
4.	4.

Opportunities: What is happening in your state that could provide opportunities?
Threats: What is happening that could pose threats to the process or your goals?

Potential External Opportunities	Potential External Threats
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Adapted from: Balamuralikrishna R., Dugger J.C. "SWOT Analysis: A Management Tool for Initiating New Programs in Vocational Schools." *Scholarly Communications Project, University Libraries, Virginia Tech.*
http://borg.lib.vt.edu/ejournals/JVTE/v12n1/Balamuralikrishna.html

References: Building the Foundation: *Leadership and Structure*

Infrastructure

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National Center for Health Workforce Information and Analysis. *The Key Ingredient of the National Prevention Agenda: Workforce Development.* Rockville MD: USDHHS, HRSA, BHP. 2001. (**www.hrsa.gov**)

Partnership for Prevention. *Healthy Workforce 2010. An Essential Health Promotion Sourcebook for Employers, Large and Small.* Washington DC: Partnership for Prevention. 2001. (**www.prevent.org**)

Public Health Infrastructure. Chapter 23. In *USDHHS. Healthy People 2010. Vol II. Chapter 21. Oral Health.* 2nd ed. Washington DC: US Govt. Printing Office. 2000. (**www.healthypeople.gov/document/HTML/Volume2/23PHI.htm**)

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USDHHS. *Oral Health in America: A Report of the Surgeon General.* Rockville MD: USDHHS, NIDCR, NIH. 2000. (**http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf and www.nidcr.nih.gov/sgr/execsumm.htm**)

Coalitions

AHEC/Community Partners. Amherst MA. **www.ahecpartners.org/resources/**. Numerous materials that can be downloaded free. Materials focus on community-building and coalitions, health care access, and Healthy Communities Massachusetts.

Berkowitz B and Wolff T. *The Spirit of the Coalition*. Washington DC: APHA. 2000. (**www.apha.com**)

Bruce TA and McKane SU. *Community-Based Public Health: A Partnership Model.* Washington DC: APHA. 2000. (**www.apha.com**)

Kretzmann JP and McKnight JA. *Building Healthy Communities from the Inside Out. A Path Toward Finding and Mobilizing a Community's Assets*. Evanston, IL: Institute for Policy Research, Northwestern University, 1993. (**www.northwestern.edu/ipr/publications/community/introd-building.html**)

Sierra Health Foundation. *We Did It Ourselves. Guidelines for Successful Community Collaboration*. Sacramento CA: Sierra Health Foundation. 2000. (**www.sierrahealth.org/library/special.html**)

Washington State Department of Health. *Community Roots for Oral Health. Guidelines for Successful Coalitions*. Olympia WA: Washington State Dept. of Health. 2000. (**www.doh.wa.gov/cfh/OralHealth/manuals/Roots/Roots.html**)

Wolff T and Kaye G. *From the Ground Up!* Washington DC: APHA. 1995. (**www.apha.com**)

Women's I Children's Health Policy Center. *Resource Guide to Concepts and Methods for Community-Based and Collaborative Problem-Solving.* **www.med.jhu.edu/wchpc/pub/**.

Chapter 3

Setting Health Priorities, Establishing Oral Health Objectives and Obtaining Baseline Information

This chapter will cover:

1. **Ways to prioritize oral health issues**
2. **Choosing target populations**
3. **Criteria for developing objectives**
4. **Examples of how states and communities developed objectives**
5. **Examples of state oral health objectives**
6. **Creating a needs assessment plan and obtaining baseline data**
7. **Tips for setting target levels for objectives**
8. **Considerations for evaluating data collection methods and data**
9. **Resources for data and assistance**

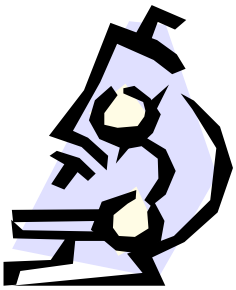
When people are motivated to do something to address health problems and disparities, they immediately want to engage in some form of action and see some results. This phase of planning may not be satisfying for all of your partners. Many well-intended partners do not want to sit and discuss objectives, look for baseline measures or create evaluation plans. The challenge that always confronts public health professionals when trying to promote HP 2010 is gaining commitment to use an organized planning approach based on setting priorities, developing measurable objectives, setting realistic targets, and measuring progress at regular intervals. Without this approach, interventions become fragmented, people lose sight of the desired outcome, the "doers" get tired, and progress is impossible to track. The challenge at this stage is to engage the "passionate doers" primarily when they can "do" something such as "vote" on options, "survey" people in their neighborhood about oral health knowledge and attitudes, or "examine" children to collect baseline data and refer them for the care they need.

Tips

- Make the best use of your partners' time and interests.
- Learn what community members and key partners see as important oral health issues and why they feel they are important.
- Be clear about the criteria for determining priorities and establishing objectives; gain ownership for the process.
- Align priorities, objectives, and strategies with your state's or community's strengths, assets, barriers, and opportunities.
- Before collecting new data, determine what data already exist and if they are adequate to serve as baseline data.
- Use the many on-line data sources that are available.
- Set challenging yet realistic targets for objectives.
- Decide what intervals to use to track progress on objectives. Intervals may not be the same for all objectives.

Using the National Objectives as a Framework

Healthy People 2010 provides a framework to assess health status, health behaviors and services, and to plan and evaluate health promotion programs. The national objectives serve as a "menu" for identifying priorities and selecting objectives that are most relevant to states, territories, tribes, communities, settings (schools, worksites, etc.), and health care delivery systems. By using the national objectives as a common point of departure, agencies and organizations can tailor programs for their customers, yet retain a common basis for evaluating performance in relation to the nation, other states, or other populations.



A new focus on "performance" and "accountability" is prompting health agencies to shift their emphasis on primarily providing services to include needs assessment and methods to assure that quality care is provided. This shift requires increased collection and analysis of data. Health care providers are being asked to collect information on patients, services, and outcomes in a standardized way. This emphasis on assessment and evaluation increases the need to address issues of data availability, validity/reliability, comparability, and utilization. Although the large number and diversity of health agency structures and resources make this a challenge, increased attention to these details will help when designing and tracking progress on the HP 2010 objectives. Health agencies also vary in their capacity to monitor the objectives they identify as most relevant to their missions.

Setting Priorities

Determining health priorities helps direct resources to the programs that matter most to communities--those that will have the greatest impact on the health status of the population. Probably the most difficult task in the Healthy People 2010 planning process is reaching consensus on health priorities and creating realistic objectives to address the priorities. A sound priority-setting process that is well publicized and documented helps achieve widespread support and endorsement for the plan.

Many health concerns compete for limited resources—not enough to meet all the needs and demands for preventive and treatment services. Although dental professionals believe that oral health should be one of the top health priorities, as dental diseases affect most of the population, oral health often ends up on the bottom of the list. Why? Until recently, oral health has not had a broad base of advocates on a national level clamoring that it is a major health concern. States and communities have been more successful, creating coalitions to increase the visibility of oral health disparities and planning innovative strategies to reduce the prevalence of dental disease.

Many priority-setting methods exist for creating HP 2010 objectives:

- Delaware used a method that asks questions and creates a formula for prioritization based on:
    - size of the health problem

- seriousness of the problem
- potential for interventions to impact the public's health.

They weighted the seriousness of the health problem as twice the importance of the size of the health problem. The most important criterion was the effectiveness of interventions according to a review of the scientific literature. The *State Healthy People 2010 Tool Library* includes examples of other useful frameworks and options that Delaware and other states used to set their Healthy People 2010 priorities (**www.phf.org/HPtools/state.htm**).

- Maryland used a ranking system (i.e., 1-5) to compare state-specific health indicators to national health indicators as "better than," "same as," or "worse than," and then to arrive at a consensus set of health indicators. Their 24 local jurisdictions also used the same process. Counties, communities or tribes can compare their health indicators to state, territorial or regional rates.

- Kansas is using input from committees and groups formed during HP 2000 implementation. They also are using objectives from their state Injury Plan, Tobacco Control Plan and Cancer Plan.

- Two American Indian tribes in Wisconsin formed committees consisting of tribal health clinic staff, teachers, tribal community leaders, and others. Each committee then identified priority issues and used the Healthy People 2000 and HP 2010 documents to formulate their objectives. Experts from the field also provided input.

Ways to Gather Input to Make Decisions on Health Priorities

- compile and evaluate existing health data
- seek expert opinion
- invite public comment
- conduct opinion surveys

- Another framework used by one of the counties in Maryland is the PEARL Framework, a socioeconomic, legality and political viability tool. The framework looks at:

  P = propriety; is an intervention suitable?
  E = economics; does it make economic sense to address this problem?
  A = acceptability; will this community accept an emphasis on this problem and will they accept the proposed intervention?
  R = resources; are funding and other resources available or potentially available?
  L = legality; do the current laws allow the intervention to be implemented, and if not, is it worthwhile to expend time, energy and resources working for legislative and regulatory change?

Source for Maryland example: HP 2010 Toolkit, http://www.health.gov/healthypeople/state/toolkit/priorities.htm#Priority Setting in Maryland

Source for the PEARL Framework: Vilnius, D., Dandoy, S. "A Priority Rating System for Public Health Programs." Public Health Reports, 105(5):463-470, 1990.

This approach seems to be especially relevant to oral health priorities and interventions that address access issues and reduction of oral health disparities.

Choosing Target Populations

Several types of target populations are used for national Healthy People 2010 objectives. This is important to know when developing state or other HP 2010 objectives whose outcomes you plan to compare to the national objectives. Note that populations in the US territories or protectorates are not included in these definitions.

Resident Population

The resident population includes all persons whose usual place of residence is in one of the 50 States or the District of Columbia, including Armed Forces personnel stationed in the United States. The resident population is usually the denominator when calculating birth and death rates and incidence of disease rates from a number of data sources. The resident population also is the denominator for selected population-based rates that use numerator data from the National Nursing Home Survey.

Civilian Population

The civilian population is the resident population, excluding members of the Armed Forces (although their family members are included). The civilian population is the denominator for other Healthy People 2010 data sources, such as the National Hospital Discharge Survey.

Civilian, Noninstitutionalized Population

The civilian, noninstitutionalized population is the civilian population not residing in institutions (e.g., correctional facilities, psychiatric hospitals, and nursing homes). This population is the denominator for rates from Healthy People data sources such as the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Care Survey. This population is also used in the weighting procedure to produce national estimates from health surveys such as National Health Interview Survey and National Health And Nutrition Examination Survey (see survey descriptions on pages 14-15).

Populations will differ for various oral health objectives; some objectives may be targeted to a very narrow age group or special population group. When drafting a HP2010 plan and objectives, state clearly which populations are targeted and why. Remember that a goal of the HP 2010 initiative is to reduce health disparities, so make sure to include groups that have the greatest health disparities.

Criteria for Developing Objectives

- The results to be achieved should be **important and understandable** to a broad audience and relate to the Healthy People 2010 goals, objectives and focus areas.
- Objectives should be **prevention-oriented** and should address health improvements that can be achieved through population-based and health-service interventions.
- Objectives should **drive action** and suggest a set of interim steps that will achieve the proposed targets within the specified timeframe.
- Objectives should be **useful and relevant**. States, localities, and the private sector should be able to use them to target efforts in schools, communities, worksites, health practices, and other settings.
- Objectives should be **measurable** and include a range of measures—health outcomes, behavioral and health service interventions, and community capacity—directed toward improving health outcomes and quality of life. They should count assets and achievements and look to the positive.
- **Continuity and comparability** are important. Whenever possible, objectives should build upon Healthy People 2000 and those goals and performance measures already adopted.
- There must be sound **scientific evidence** to support the objectives.

Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Developing Objectives for Healthy People 2010, 1997.

Nationally, increasing emphasis is being placed on evidence-based approaches to prevention and treatment of oral diseases. A number of citations in the References included in the Resources section provide some guidance about levels of effectiveness of certain community-based approaches to preventing oral diseases. In some cases, insufficient research has been conducted to be able to determine effectiveness. Check the scientific literature periodically for updates that might influence your decisions.

Selecting Oral Health Objectives

The manner in which states and communities have accepted the HP 2010 challenge varies considerably. Table 3.1 shows some of the variations in the number of overall objectives, focus areas and oral health objectives. This table does not include all states with oral health objectives. Links to state HP 2010 Web sites can be accessed on the Healthy People Web site (**www.health.gov/healthypeople/**). Sometimes it is difficult to locate the oral health objectives in state plans if there is not a separate focus area devoted to oral health.

Table 3.1. Number of HP 2010 Overall Objectives, Focus Areas, and Oral Health Objectives in Selected States		
State	**HP2010 Overall Objectives**	**Oral Health Objectives**
Alabama	47 objectives in 4 topic areas	2
Arizona	52 objectives in 12 health areas	5
Kentucky	350 objectives in 26 focus areas	14
Maine	75-100 objectives in 10 focus areas	5
Minnesota	200 objectives for 18 goals (areas)	7
New Hampshire	61 objectives in 11 focus areas	2
New Jersey	142 objectives in 19 areas	1
North Carolina	110 objectives in 12 focus areas	5
Vermont	82 objectives in 16 priority areas	6

In some instances, states adapted the national objectives to make them more relevant to their population's needs or to correspond to previously collected baseline data. For example:

- Kentucky added the age group of 12-year-olds to the oral health objectives for children and expanded the cleft palate objective to include children with other craniofacial anomalies.
- Iowa included a number of objectives for seniors over the age of 75.
- Minnesota and Iowa are tracking deaths from oral and pharyngeal cancer but not oral screening rates or stage at detection.

In other cases, states have developed objectives that differ from any of the national objectives. For example:

- Arizona and Minnesota are measuring the proportion of the population with comprehensive dental insurance.
- Iowa is assessing untreated root caries in seniors.
- Iowa has an objective for increasing oral health screening and preventive counseling for 1-year-old children by qualified health professionals.
- Kentucky has an objective specific to Family Resource Centers and Youth Service Centers providing screenings, referrals and follow-up.

Examples of specific oral health objectives used by some states are included in the Resources section. Also included is a worksheet for drafting oral health objectives. When drafting objectives, do not forget to review the related objectives from other focus areas, especially those for cultural competence, health communication, diabetes, public health infrastructure, access, injury and violence prevention.

Establishing a Needs Assessment Plan and Obtaining Baseline Data

HP 2010 can act as an impetus to enhance the availability of valid, coordinated, useful data that can then be used to track oral health outcomes. One important step in developing objectives is to determine what baseline data already are available. Use a variety of sources to determine this:

Community partnerships are important for identifying gaps in information, helping to gather information on hard-to-reach populations, and assuring that information is collected in a culturally sensitive and appropriate manner.

- Healthy People 2000 and 2010 documents and databases
- National, state, and local surveys, surveillance systems, and registries
- Community partners with their own databases (e.g., hospitals, community clinics, schools).

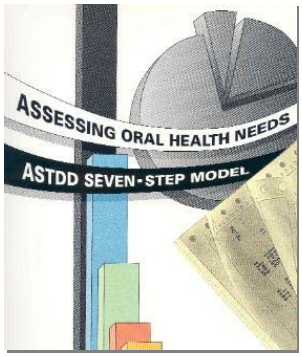
Use the section in this chapter on Resources for Data and Assistance to help locate data.

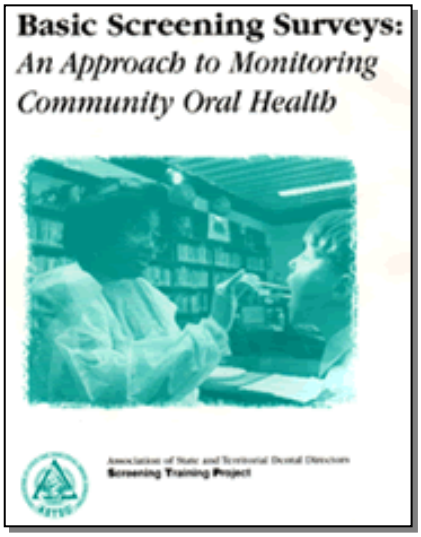
The following considerations can be used for judging if existing data are suitable for establishing baselines or using in a needs assessment process:

- Reliability: How accurate and complete are the data?
- Timeliness: What is the most recent year and for what other years are data available?
- Representativeness: Is there a reason to believe the data are no longer representative?
- Comparability: Can you compare these data with other data you plan to use (e.g., standard definitions, similar collection methods)?
- Linkage: Do these data contain identifiers that will permit linkage with other data (e.g., patient identifiers, census tracts)?
- Variability: Have any data elements changed (e.g., definitions, reporting requirements, collection methods)?
- Confidentiality: Do the data implicitly or explicitly identify individuals?
- Automation: To what extent are the data computerized and what hardware/software is required to transfer/translate data files?

Source: Association of State and Territorial Dental Directors. Assessing Oral Health Needs. ASTDD Seven-Step Model. Columbus, OH: ASTDD. 1995.

To assist states in performing oral health needs assessments, the ASTDD developed *Assessing Oral Health Needs. ASTDD Seven-Step Model*. This document provides an organized approach to planning and implementing an oral health needs assessment as well as analyzing and reporting data from the process. Although written primarily for states, communities and other groups will also find it useful. An updated version that includes a new section on prioritizing needs is available on the ASTDD Web site at **www.astdd.org/docs/ASTDDdocs/sevenstep/sevensteps.htm**. The Resources section of this chapter includes a helpful handout from the *ASTDD Seven-Step Model* that summarizes these methods in terms of purpose, cost, time involvement and advantages. A similar summary that includes a few other techniques is included in the textbook, *Community Oral Health Practice for the Dental Hygienist*, cited in the References list.





In 1999 ASTDD, in conjunction with the Ohio Department of Health, produced *Basic Screening Surveys: An Approach to Monitoring Community Oral Health*. The Basic Screening Survey (BSS) is a standardized set of surveys designed to collect information on the observed oral health of participants, self-report or observed information on age, gender, race and Hispanic ethnicity, and self-report information on access to care for preschool, school-age, and adult populations. The surveys are cross-sectional and descriptive. Observations of gross dental or oral lesions are made by dentists, dental hygienists, or other health care workers in accordance with state law. The examiner records presence of untreated cavities and urgency of need for treatment for all age groups. For preschool children, presence of early childhood caries, including white spot lesions, and caries experience are recorded. For school-age children, presence of sealants on permanent molars and caries experience are recorded. Edentulism (no natural teeth) is recorded for adults.

One or more of the surveys in the BSS can be used to obtain oral health status and dental care access data at a level consistent with monitoring Healthy People 2010 objectives. As of October 2002, about 30% of states have used or are in the process of using the BSS, and more are planning to use it. Training materials, including a video and manual are provided with the Basic Screening Surveys, available for purchase on the ASTDD Web site (www.astdd.org). Technical assistance on sampling and analysis is available on a limited basis through ASTDD to states and others undertaking these surveys using the standard protocol.

A number of states have conducted statewide oral health needs assessments and published reports of their methodology and findings, some of which include county-specific data. Many of these reports are available online at **www.mchoralhealth.org** or through Web sites of state oral health programs (access via direct links on ASTDD Web site). Some state examples include Washington, Oregon, Ohio, California, New Hampshire, North Carolina, Kentucky, Maine, Maryland, Iowa, Alabama, and Texas.

Most states have conducted some form of open-mouth survey with convenience samples or a carefully selected sampling framework. These may have been on a statewide basis, in counties or cities, or in specific school systems or other community-based programs. They may be done on a sporadic basis, on a regular cycle such as every five years, or as part of an oral health surveillance system.

Selecting samples is one of the most difficult decisions for states and communities wishing to conduct surveys, especially when funds are limited. It is wise to consult with a statistician or epidemiologist when making these decisions.

One important factor to plan for is the significant time involvement for planning, conducting and analyzing information from an oral health needs assessment—often more than a year. Discuss the entire process with others who have done surveys, and solicit technical assistance to assure that you have a well-developed plan and adequate resources.

Two examples show how states have used or adapted the *Seven-Step Model* or the *Basic Screening Survey*.

Arizona

The Arizona Department of Health Services Office of Oral Health has developed a state oral health surveillance system based on the Basic Screening survey. They have published a small booklet, Guidelines for Oral Health Screenings and a training guide for the BSS. They monitor the oral health status of school-age children in communities greater than 1,000 residents by surveying a stratified random sample of children attending grades K to 3 in public schools. Data elements include demographics (age, gender, grade, community/school, dental insurance, race/ethnicity, last dental visit, household yearly income, number of people in home) and oral health indicators (DMFS/dfs, untreated decay, decay experience, sealants present, sealants needed, treatment urgency, and fluorosis). Data are updated every three years.

*Contact: AZ Office of Oral Health, **www.hs.state.az.us/cfhs/ooh/index.html***
602-542-1866

Illinois

Illinois has used the ASTDD Seven-Step model and a supplemental guide that they developed to assist communities throughout the state to assess oral health status and needs and to develop comprehensive community-specific oral health plans. Since 1996, 48 grantees representing 59 communities and 7.4 million people have participated in this survey. Each community uses a planning group to look at existing data, collect primary data, and consider community perception of need. This approach has resulted in a ground swell of community-based oral health programs and activities around the state to address HP 2010 objectives.

Contact: Lew Lampiris at ***llampiri@idph.state.il.us***

Setting Target Levels for Objectives

One of the central issues many states struggle with when developing objectives is how to set achievable, realistic targets for outcome, performance, and process objectives. This task requires decisions based on a comparison of data available for your state, territory, tribe or community with regional or national data. A handout in the Resources section, adapted from information included in the *HP Toolkit 2010*, explains how the national objectives were set for population objectives, health outcomes and performance objectives, and process objectives. Another handout in the Resources Section provides an example of how target levels were set by the Indian Health Service for some of their objectives.

Once target objectives are set, it is important to track progress on these levels periodically to determine if they were realistic and if they need to be adjusted. Chapter 6 discusses this topic and provides examples.

Tip

Set challenging, yet realistic, targets for your objectives:

- Identify lessons learned from the year 2000 targets (e.g., how many were too ambitious or not ambitious enough, how many had to be reset or deleted and why).
- Use previously identified performance measurements.
- Use existing agency or program-specific benchmarks.
- Set targets to eliminate population health status disparities.
- Use applicable national Healthy People 2010 targets.
- Use other statistical methods covered in the handout in the Resources section.

Evaluating Data: Data Issues and Uses

Involving evaluation specialists and epidemiologists in your HP 2010 planning group is crucial to making sure that your plan for collecting, analyzing and reporting data is well thought out and technically accurate. Unfortunately, many health professionals find issues related to data and evaluation daunting, and either ignore them or postpone making decisions. Poor planning in this regard can sabotage the outcomes of your entire HP 2010 plan.

These are some general data issues that you may want to address:

- **Data Quality** – When using new data collection systems, be sure to check for standardization of data collection and recording, data management and analysis, and structure and content of questions.
- **Limitations of Self-Reported Data** – When relying on self-reported data such as income level, use of fluorides, or health screening behaviors, be aware of self-reporting bias. Measures will vary based on the type of data collection (written survey, telephone interview, direct observation, etc.).
- **Data Validity and Reliability** – Revision of survey questions and the development of new data collection systems will require careful validity and reliability testing. In monitoring efforts, the validity of responses over time may also become an issue.
- **Periodicity of Data Availability** – Data collection efforts are not always performed on a regular basis. Take this into consideration when planning your dissemination and communication efforts.
- **Timeliness of Data Availability** – As previously stated, this is not always possible, but still important. It helps to be able to regularly identify progress and areas that may need additional efforts.
- **Representativeness of Data** – Special considerations need to be made when collecting data for specific population groups or local communities. Do responses collected represent those individuals of interest?
- **Small-Area Analysis** – This takes into account the limitations of applying national data to the state, local and community levels. This pertains to using small numbers in one's statistics. Poisson distribution, non-parametric statistics, and standardized mortality rates/ratios (SMRs) may be appropriate methodologies.

Source: Committee on Leading Health Indicators for Healthy People 2010. Leading Health Indicators for Healthy People 2010: Final Report. Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.

Evaluate your existing data collection methods using these guidelines:

- Simplicity
- Flexibility
- Data quality
- Acceptability
- Sensitivity
- Predictive value positive
- Representativeness
- Timeliness
- Stability

Source: Guidelines Working Group. Updated guidelines for evaluating public health surveillance systems. MMWR. 50(RR13):1-35, July 27, 2001.

A table is included in the Resources section that outlines technical and strategic characteristics of data that are important for policy making.

Summary checklist for setting priorities, establishing objectives, obtaining baseline measures, and setting targets

- Solicit and evaluate input from community partners and experts
- Establish criteria and a process for final determination of priorities
- Set criteria for evaluating existing public and private data sources for baseline measures, and inventory these sources
- Review progress in achieving Healthy People 2000 objectives
- Conduct assessments of health needs, if necessary, to establish baselines
- Develop draft objectives
- Develop targets with appropriate baselines and measures

Resources for Data and Assistance

This section includes descriptions of a long list of organizations, agencies, Web sites and specific surveys that you can refer to when establishing baselines and targets, and when wording your objectives. Although the information may appear overwhelming, readers are encouraged to read the entire section, as this information is not generally available in one resource document.

Many partners can help you locate, and process and/or analyze data. These include:

- National agencies and organizations such as NIDCR, CDC, ASTDD, ADA, ADEA, Council of State and Territorial Epidemiologists
- State centers for health statistics
- State cancer registries
- Health department statisticians, epidemiologists, and program directors
- Health data analysts at local, state, and national levels
- Other local and state government agencies
- Academic partners, e.g., schools of public health, dental schools
- Dental managed care and dental insurance companies

Publications that include an overview of oral health problems, such as the HP 2010 Oral Health chapter and the Surgeon General's Report on Oral Health, cite numerous data sources. A guide to federal health information centers and clearinghouses that focus on specific topics and provide minority health data is available through the USDHHS Office of Minority Health (**www.omhrc.gov**). Information on children and populations with special health care needs is available online through the National Oral Health Information Clearinghouse (NOHIC) at **www.nohic.nidcr.nih.gov** and the National Maternal and Child Oral Health Resource Center at **www.mchoralhealth.org**. The Pan American Health Organization has published a monograph that includes annotated bibliographic entries of articles in 25 oral health categories (citation on page 12 of this chapter's Resources section.)

If specific articles are needed for background information or data, the US National Library of Medicine (NLM) provides free access to *Medline* and additional life sciences journals. NLM *Gateway* provides a single online access point for the multiple information resources of the NLM at **www.gateway.nlm.nih.gov**. *Locatorplus* is an on-line catalog of the library's holdings of monographs, journals and audiovisuals (**www.locatorplus.gov**). DOCLINE is the automated interlibrary loan request, routing and referral system that individuals can use, usually for a fee.

The following section provides an overview of some other national resources for oral health data

Centers for Disease Control and Prevention (CDC)

A good overview of information available through CDC is in the Spring/Summer 2001 issue of *Chronic Disease Notes and Reports* on the CDC Web site at **www.cdc.gov/nccdphp**.
In 1991, the Health Promotion Statistics Division was established at CDC/National Center for Health Statistics (NCHS) to monitor Healthy People 2000. Staff in this unit coordinate with the HHS lead agencies in collecting and reporting on the national Healthy People objectives.

DATA2010 is an interactive database system that contains the most recent monitoring data for Healthy People 2010. It now contains national data for all the objectives and subgroups, but state data may be available for selected objectives in the future. Users can search by objectives within a focus area, objectives by data source, specific population groups, and key words. The database is updated quarterly and is hosted on CDC's Wonder data system. You can access the system from the Healthy People Web site via the DATA 2010 link. At the CDC Wonder login screen, enter your Wonder user ID or select Anonymous User. This forwards you to the database.

NHANES: Oral health data were collected in the National Health and Nutrition Examination Survey (NHANES I, NHANES III, and NHANES IV)(***www.cdc.gov/nchs/express.htm***).

- NHANES I was conducted between 1971 and 1975. This survey was based on a national sample of about 28,000 persons between the ages of 1 and 74. Extensive data on health and nutrition were collected by interview, physical examination, and laboratory analyses. The sampling design of NHANES I did not include persons of Hispanic/Latin origin.

- NHANES III, conducted between 1988 and 1994, included about 40,000 people selected from households in 81 counties across the United States. To obtain reliable estimates, infants and young children (aged 1 to 5 years), older persons (aged 60 years and older), Black Americans and Mexican Americans were sampled at a higher rate. NHANES III also placed an additional emphasis on the effects of the environment on health.

- NHANES IV began in April 1999 and will be a continuous survey visiting 15 U.S. locations per year. Approximately 5,000 people will be surveyed annually.

- Hispanic Health and Nutrition Examination Survey (HHANES) was a national survey from 1982 through 1984 of approximately 16,000 Hispanic persons in three subgroups, 6 months to 74 years of age. Hispanics were included in past health and nutrition examinations, but neither in sufficient numbers to produce estimates of the health of Hispanics in general, nor specific data for Puerto Ricans, Mexican Americans, or Cuban Americans. HHANES was conducted in selected areas of the United States rather than as a national probability sample.

Data from the HHANES are generally organized by the data collection method (e.g., Child Sample Person Questionnaire or Dental Examination). The data files comprising the HHANES include a number of demographic and socioeconomic variables on each tape, including age, gender, ethnicity, income, education, and marital status. Data are available on the NCHS Web site as public use data files (**www.cdc.gov/nchs/**).

National Health Care Survey, is an integrated survey of health care providers formed from the merger of four existing surveys: the National Hospital Discharge Survey, the National Ambulatory Medical Care Survey, the National Nursing Home Survey and the National Health Provider Inventory. New surveys added to the database include: the National Survey of Ambulatory Surgery, National Hospital Ambulatory Medical Care Survey, National Home and Hospice Care Survey, and National Employer Health Insurance Survey. All surveys are described on the NCHS Web site (**www.cdc.gov/nchs/**).

The National Health Interview Survey (NHIS) is a cross-sectional household interview survey on the health of the civilian noninstitutionalized population of the United States. The sampling plan follows a multistage area probability design that permits the representative sampling of households. NHIS data are collected annually from approximately 43,000 households including about 106,000 persons. Information on the survey can be found on the NCHS Web site (**www.cdc.gov/nchs/**).

Oral Health Resources Data Systems monitor the prevalence of oral diseases and the factors influencing oral health, such as risky or protective behaviors, the availability of preventive interventions and utilization of preventive services (**www.cdc.gov/OralHealth/data_systems/index.htm**). The systems bring together existing data from multiple national and state sources and present the data in useful and accessible formats for the broad community interested in promoting oral health. Some of the systems that are linked include the fluoridation census information and WFRS (described next) and the NOHSS and state synopses (described under ASTDD).

The **Fluoridation Census** provides the fluoridation status for each state. States report each fluoridated water system and the communities each system serves; the status of fluoridation — adjusted, consecutive, or natural; the system from which water was purchased, if consecutive; the population receiving fluoridated water; the date on which fluoridation started; and the chemical used for fluoridation, if adjusted. Data from the 2000 census was posted in early 2002 and can be accessed online at **http://apps.nccd.cdc.gov/MWF/Index.asp**.

Water Fluoridation Reporting System (WFRS) is an Internet-based tool through CDC that allows state and tribal fluoridation managers to login, enter data, and monitor fluoridation quality (**http://apps.nccd.cdc.gov/WFRS/default.htm**). Because the requirements for monitoring vary widely among tribes and states, WFRS allows managers to enter their own criteria to use when determining if a system is optimal. The system displays data on the state-specific proportion of persons on public water systems who receive fluoridated drinking water. A public water system is a system that provides piped water for human use and regularly serves at least 25 people or has at least 15 service connections. WFRS can print standard reports or customized reports. Not all states and territories are currently participating in WFRS. Public access to WFRS is still under construction. CDC plans to use Geographic Information Systems software to place state and county-based fluoridation information on-line.

Pregnancy Risk Assessment Medical Survey (PRAMS) collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy. The PRAMS sample of women who have had a recent live birth is drawn from the state's birth certificate file. Each participating state samples between 1,300 and 3,400 women per year. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons between states. PRAMS provides data for state health officials to use to improve the health of mothers and infants. PRAMS allows CDC and the states to monitor changes in maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breastfeeding, smoking, alcohol use, infant health). Data are collected on dental visits and dental cleanings during pregnancy. As of 2002, 33 states were participating in PRAMS (**www.cdc.gov/nccdphp/bb_prams/index_longdesc.htm**).

Youth Risk Behavior Study (YRBS) is a school-based survey conducted biennially to assess the prevalence of health risk behaviors among high school students. YRBS includes national, state, territorial and local school-based surveys of high school students. The school-based survey employs a cluster sample design to produce a representative sample of students in grades 9 – 12. Survey procedures are designed to protect the students' privacy by allowing for anonymous and voluntary participation. Forty-two states were participating in this survey in 1999. A sample analysis of oral health survey findings from North Dakota is included in the Resources section (page 10) and available on their Web site (**www.health.state.nd.us/ndhd/prevent/mch/dental**). National information is available online at **www.cdc.gov/nccdphp/dase/yrbs/index.htm**.

Behavioral Risk Factor Surveillance System (BRFSS) is a state-based, ongoing data collection program designed to measure behavioral risk factors in the adult, noninstitutionalized population 18 years of age or older. Every month, states select a random sample of adults for a telephone interview. This selection process results in a representative sample for each state so that statistical inferences can be made from the information collected. The BRFSS gathers data on dental visits, teeth cleaning, edentate status, and no tooth loss. The following states have added additional oral health questions to their BRFSS survey.

- Alaska
- California
- Idaho
- Indiana
- Louisiana
- Massachusetts
- Montana
- Oregon
- South Dakota
- Utah
- West Virginia

Information is available online at **www.cdc.gov/brfss**. Users can search the annual data by state, year and category. Trends tables, prevalence tables, *BRFSS at a Glance* and publications are also posted. A few case studies are included of how states and communities have used BRFSS data to support Healthy People objectives and to initiate changes to improve health. An example of how Texas has used BRFSS data to highlight risk factors for oral cancer is included in the Resources section and is available online at **www.tdh.state.tx.us/dental.**

State Tobacco Activities Tracking and Evaluation System (STATE) is an electronic data warehouse containing up-to-date and historic state-level data on tobacco use prevention and

control. It is designed to integrate many data sources to provide comprehensive summary data and to facilitate research and consistent interpretation of the data. The STATE System was developed by CDC, NCCDPHP, Office on Smoking or Health. Data are gathered annually for most data sources, quarterly for state tobacco control legislation. National estimates specifically for Healthy People 2010 are derived by summing the state numbers (for example, number of smokefree indoor air policies) across states. The Web site is **www.cdc.gov/tobacco**. Another helpful resource on the Web site is the report, *Investment in Tobacco Control: State Highlights 2001*. It provides state-based information on the prevalence of tobacco use, health impacts and costs associated with tobacco use, tobacco control funding, and tobacco excise tax levels for all 50 states and the District of Columbia.

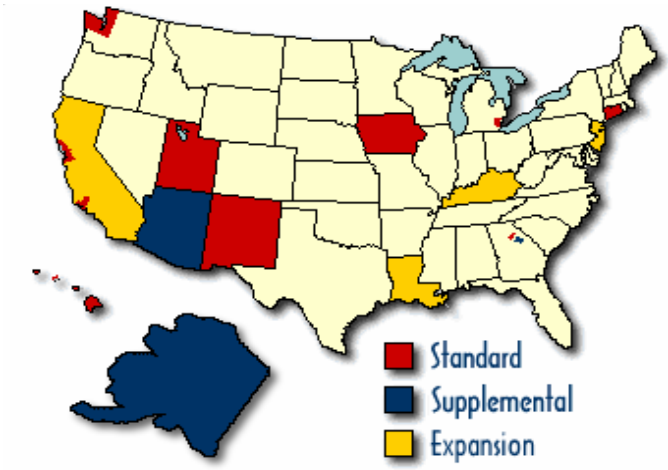
National Center on Birth Defects and Developmental Disabilities monitors the occurrence of major structural birth defects (including cleft lip and palate) through an ongoing surveillance system, and provides technical assistance to states. The Developmental Disabilities Section conducts surveillance and epidemiologic research on developmental disabilities and selected adverse reproductive outcomes. Since 1998 CDC has awarded three-year cooperative agreements to 26 states to address major problems that hinder the surveillance of birth defects and the use of data for prevention and intervention programs. States received funding for three categories of activities; 1) to initiate new surveillance programs where none existed (Louisiana, Maine, Montana, Nevada, New Hampshire, Wisconsin); 2) to support new programs (Florida, Kentucky, Missouri, New Mexico, North Carolina, South Carolina, Utah); and 3) to improve existing surveillance programs (Arizona, Arkansas, Colorado). The agency Web site is **www.cdc.gov/ncbddd**, but the state-based birth defects surveillance data reports are available at **www.nbdpn.org/NBDPN**.

National Cancer Institute (NCI), National Institutes of Health (NIH)

Cancer information can be accessed via a number of NCI Web sites. Aggregate information on more than 50 types of cancer, including facts about treatment, detection, prevention, statistics, etc. can be viewed online at **www.cancer.gov'cancerinformation/cancertype**. CANCERLIT 7 - (**www.cancer.gov/search/cancerliterature**) is a searchable literature bibliographic database that is updated monthly.

The Surveillance, Epidemiology and End Results Program (SEER) and State Cancer Registries currently collects and publishes cancer incidence and survival data from 11 population-based cancer registries and three supplemental registries covering approximately 14% of the U.S. population.

- Alaska
- Atlanta
- Rural Georgia
- Arizona
- Connecticut
- Detroit
- Hawaii
- Iowa
- Kentucky
- Louisiana
- New Jersey
- New Mexico
- San Francisco-Oakland
- San Jose-Monterey
- Los Angeles
- Remainder of California
- Seattle-Puget Sound
- Utah



Information on more than 2.5 million in situ and invasive cancer cases is included in the SEER database, and approximately 160,000 new cases are added each year within the SEER catchment areas. The SEER registries routinely collect data on patient demographics, primary tumor site, morphology, stage at diagnosis, first course of treatment, and follow-up for vital status. Data are reported for oral and pharyngeal cancer by stage at diagnosis and mortality rates per year. The SEER Program is the only comprehensive source of population-based information in the United States that includes stage of cancer at the time of diagnosis and survival rates within each stage. The mortality data reported by SEER are provided by the National Center for Health Statistics. SEER data are updated annually and provided as a free public service in print and electronic formats. The SEER Program provides cancer incidence, mortality, and survival data in an annual cancer statistics review, in monographs on relevant topics, through the SEER Web site (**http://seer.cancer.gov**), in various specially-developed software packages (e.g., SEER*Stat, SEER*Prep), and in a public-use data file.

National Institute of Dental and Craniofacial Research

- National Survey of Oral Health in Employed Adults and Seniors was conducted by NIDR during 1985-86 to assess the oral health status of US employed adults and noninstitutionalized persons aged 65 and older. NIDR-trained dentists performed clinical measurements for coronal caries, root caries, periodontal destruction and tooth loss. Demographic and selected health data, including frequency of dental visits, were collected for both dentate and edentulous persons. The sample of over 15,000 employed adults examined in this survey represented almost 100 million employed persons in the United States. Employed adults were examined at their participating business

establishments. The sample of over 5,000 seniors represented over 4 million older persons. The seniors consisted of persons 65 years of age and older who attended selected multi-purpose senior centers within a designated 12-month period. This survey was the first national dental survey to provide detailed information on root caries and periodontal diseases.

- US School Children Survey. The primary objective of the 1986-87 survey was to provide reliable statistics on the level of dental caries in US schoolchildren (excluding Alaska). A second objective was to evaluate recent progress in reducing caries by comparing the survey data to that from a previous NIDR survey. Additionally, the survey was designed to provide estimates of the prevalence of gingivitis, dental fluorosis, periodontal destruction, and soft tissue lesions in the school-aged population. NIDR-trained dentists performed oral examinations on 40,693 students aged 4 to 22 at schools throughout the US. The sample represented approximately 45 million school children. Questionnaires completed by the children's parents provided extensive residential histories and information on fluoride exposure. Data on smoking history and current use of smokeless tobacco, cigarettes and alcohol were collected from students in grades 6 through 12. These data were collected in personal interviews conducted with the students at the conclusion of their oral examinations.

- The Dental, Oral, and Craniofacial Data Resource Center, sponsored by the NIDCR and the CDC Division of Oral Health, has produced a *Catalog of Surveys Related to Oral Health*. The catalog is a compilation of federal, state, international and other surveys focusing on oral health or containing an oral health component. The database is available in Microsoft Access 97 and Microsoft Access 2000 on a CD ROM. The list of oral health variable fields is included in the Resources section. The information is also available online at **http://drc.nidcr.nih.gov/**.

Health Resources and Services Administration (HRSA) maintains a number of databases, from which they post information on various Web sites.

- HRSA Bureau of Primary Health Care provides information on Dental Health Professional Shortage Areas (HPSAs) and location of community health centers at **http://bphc.hrsa.gov/databases/**.

- HRSA Bureau of Health Professions, State Health Workforce Profiles, are displayed at **www.bhpr.hrsa.gov/healthworkforce/profiles**. These state-based profiles compile accurate and current data on supply, demand, distribution, education and use of health personnel, including dental personnel in the 50 states and the District of Columbia. Estimated numbers of workers indicate the size of the state's health workforce. Per capita ratios facilitate comparisons with other states and the nation. A companion Resource Guide helps you use the data and directs users to sources of more detailed data that address different health workforce issues. A few sample pages from one state's (California) 2000 publication are included in the Resources section.

- HRSA Maternal and Child Health Bureau is helping states map their capacity to provide health services to children. **Geographic Maps** will be linked with existing data to dramatically illustrate areas where families have inadequate access to services such as dental care. Maps will be posted on the HRSA Web site as they are developed. **Title V Information System (Title V IS)** electronically captures data from annual Title V Block Grant applications and reports submitted by all 59 States and Territories. Reach the online database through **www.ncemch.org/titlevis/default.html**, which allows users to search and sort data on key measures of health status for mothers and children, including oral health. Information can be searched and sorted by state, performance measures, types of services, levels of spending and other categories.

Indian Health Service (IHS) maintains a computerized patient registration database, the Resource and Patient Management System (RPMS), in a searchable database at each IHS clinical facility. It contains information from pharmacy prescriptions, laboratory results, radiology reports and patient encounters (history, physical exam and therapeutic interventions). An ICD-9 code is used to record the purpose of each visit.

- In 1999 IHS conducted an oral health survey of 13,000 American Indian and Alaska Native dental patients aged 2-96 years. These data are available on the IHS Web site at **www.ihs.gov/MedicalPrograms/Dental/index.asp**. A more general publication, *Regional Differences in Indian Health, 1998-99*, presents tables and charts, including information on dental services, displayed by IHS Area.

Agency for Healthcare Quality and Research (AHQR)

- The Medical Expenditure Panel Survey (MEPS) comprises four linked, integrated surveys, most of which have at least some oral health or dental care information:

  - Household Component (HC): Computer-assisted, in-person interviews; health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment.
  - Medical Provider Component (MPC): Telephone interviews and mailed surveys; Information on medical care events from medical providers identified by HC respondents, including expense information for events covered under various managed care plans.
  - Insurance Component (IC): Telephone interviews and mailed surveys; data on types of health insurance plans, associated premiums, and numbers of plans offered.
  - Nursing Home Component (NHC): The 1996 NHC gathered information from a sample of nursing homes and residents on characteristics of the facilities and services offered; expenditures and sources of payment for individual residents; resident characteristics, including functional limitation, cognitive impairment, age, income and insurance coverage. Data were also collected on availability and use of community-based care prior to admission to the nursing home.

- Each year, the MEPS HC sample is a nationally representative subsample of the National Health Interview Survey (NHIS), which uses a stratified multistage probability design that permits a continuous sampling of 358 primary sampling units. The 1996 HC collected data on 10,500 families and 24,000 individuals who participated in the 1995 NHIS. The MPC bases its sample on the HC. The IC partially bases its sample on the HC. Data are obtained through employers, unions, or other private health insurance sources identified by the HC respondents. The MEPS homepage is **www.meps.ahrq.gov**.

The Centers for Medicare and Medicaid Services (CMS) provides data on national spending on health care, including dental health services. Data on Medicaid spending are available online at **www.cms.gov/medicaid/mcaidsad.asp** and SCHIP statistics are available at **www.cms.gov/schip/**. CMS publishes a booklet each year that includes statistics about dental expenditures by region. Data to 1998 from the HCFA 416 form are posted on the Web site. More recent state-specific and county-specific Medicaid claims data may be available through each State Medicaid program for the proportion of Medicaid eligible children who had a dental visit or a preventive visit (prophylaxis, topical fluoride treatment, or dental sealants). Data from the CMS Minimum Data Set (MDS), used to assess each nursing home facility resident's health, are available, but appear to under-represent the actual oral health status of residents. (see Folse article cited on page 20 of the Resources section for this chapter).

Other Federal Web sites

Fed Stats (**www.fedstats.gov**) is a Web site that provides a direct link to statistics of states, counties, congressional districts, federal judicial districts and some local data. It also links to statistical agencies.

First Gov (**http://firstgov.gov**) is a useful Web site for links to all types of federal, state, local, tribal and international agencies, including phone directories and laws and regulations.

Other Data Sources

National associations and national centers also collect or house information.

The Center for Health and Health Care in Schools is a program and resource center located at George Washington University. Data are available on school-based health centers, especially from a school-year 1999-2000 survey of 50 states. See their Web site at **www.healthinschools.org**.

The National Maternal and Child Oral Health Resource Center, also housed at Georgetown University, houses an extensive collection of publications on the oral health of children. See the list of publications on their Web site at **www.mchoralhealth.org**.

The American Dental Association and the **American Dental Education Association** publish the results of numerous surveys of their members. See their Web sites at

www.ada.org/prof/prac/issues/surveys/indes.html and **www.adea.org** for a list of their publications. The ADA Survey Center collects, analyzes, and disseminates statistics and trends affecting dentistry. Most are random sample surveys for general practitioners and specialists. Topics in the publication catalog include dental practice, dental health policy analysis, workforce issues, education and institutional issues. Other potential sources of oral health data are Schools of Dentistry and some Schools of Public Health.

Association of State and Territorial Dental Directors (ASTDD) National Oral Health Surveillance System. This cooperative project between CDC and ASTDD is designed to help public health programs monitor the burden of oral disease, use of the oral health care delivery system, and the status of community water fluoridation on both a state and national level. NOHSS includes indicators of oral health, guidelines for oral conditions and oral health care, information on state dental programs, and links to other important sources of oral health information. Eight basic oral health surveillance indicators are the main focus:

- Dental visits
- Teeth cleaning
- Complete tooth loss
- Fluoridation status
- Dental caries experience
- Untreated dental caries
- Dental sealants
- Cancer of the oral cavity and pharynx.

Data can be displayed in tables, graphs, and maps for the nation and for the state, or in combination, e.g., compare state data to national data or compare data from two states. Data sources for NOHSS include national surveys (NHANES, NHIS, Fluoridation Census) and state-based surveys (BRFSS, YRBSS, PRAMS, ASTDD's Basic Screening Survey, and annual State Synopses). Each of these surveys is described in detail in this section. The NOHSS is accessed online at **www.cdc.gov/nohss**.

ASTDD Synopses of State and Territorial Dental Public Health Programs. This information is available on the CDC Web site at **www2.cdc.gov/nccdphp/doh/synopses/index.asp**. Data are updated once a year by submissions from state and territorial oral health programs. In some cases data are from national sources (e.g., American Dental Association), or data may be unavailable or missing because information was not submitted. Data are displayed by individual states/territories. An interactive national trend table aggregates that information to track changes over time. Maps display which states conduct each of 12 types of oral health activities and which states have full-time dental directors. Categories of data include:

1. Demographics: e.g., number of Medicaid and SCHIP eligibles and dentists participating in these programs, percentage of children in free/reduced school lunch programs, number of dental and dental hygiene programs, number of licensed dentists and dental hygienists, number of community/school/local health department-based dental clinics
2. Infrastructure and administration of state dental programs: e.g., FTEs, funding

3. Programs funded/conducted/facilitated by state dental programs: e.g., sealants, water fluoridation, other fluorides, injury prevention, tobacco cessation, access to care; also includes number of persons served.

ASTDD Best Practices Project. ASTDD has collected best practice submissions from states in the categories of Assessment, Policy Development, Assurance, and Oral Health Program Infrastructure. As of October 2002, 39 states had submitted 116 practice descriptions. An analysis and synthesis of the best practice submissions will result in a set of dental public health approaches that include oral health surveillance, community water fluoridation, school-based/school-linked sealant programs, statutory mandate for state oral health programs, state oral health coalition, state oral health plan, and public health efforts to improve access to care for the underserved. The submissions will be housed in a searchable database on the ASTDD Web site, and available to the public in 2003 (**www.astdd.org/**).

Oral health or dental care data can be found on the Web sites of some organizations that support research or collect data in a standardized way.

The Kaiser Family Foundation recently introduced State Health Facts On-line, which shows the number of uninsured adults and children in each state, Medicaid and SCHIP eligibility requirements, new AIDS cases, health care costs, etc. Information can be viewed for a single state and compared to US totals and to all states. Data can also be downloaded and imported into spreadsheet programs for customized comparisons (**www.statehealthfacts.kff.org**).

The Urban Institute has created *State Profiles of Health Insurance, Access and Use* for AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA and WI, based on the 1999 National Survey of America's Families. The profiles provide state and national-level data in easy-to-use tables. Dental access information is reported for any dental visit, average number of visits, and unmet dental needs, displayed by employer-sponsored/other insurance, Medicaid/SCHIP/state coverage, uninsured, all children, all low-income children, all adults, and all low-income adults. These data can be compared to data from the 1997 survey. State profiles are available online at **http://newfederalism.urban.org/html/statefocus.html**.

Oral Health America collects data every year from states to publish an Oral Health Report Card (**www.oralhealthamerica.org**).

Special Olympics, Special Smiles collects oral health information on athletes competing in special Olympic events (**www.specialolympics.org**).

Children's Dental Health Project collects data and publishes articles and reports using national, state and local data, particularly on issues related to access to dental care. Access their Web site at **www.cdhp.org/Oral%20health/**.

Resources

Chapter 3

- ✓ Examples of Oral Health Objectives from State HP 2010 Plans
- ✓ Worksheet: Writing Objectives
- ✓ Summary of Needs Assessment Methods
- ✓ Catalogue of Surveys Related to Oral Health: Oral Health Variables (not included, see Web site http://drc.nidcr.nih.gov/Catalog/catalog_instruction.asp)
- ✓ Setting Target Levels for Objectives
- ✓ IHS Tracking Health Indicators
- ✓ Characteristics of High-Quality and Effective Data for Policy Making
- ✓ Oral Health of North Dakota's Youth: 2001 Youth Risk Behavior Survey Results (http://www.health.state.nd.us/ndhd/prevent/mch/dental/OralHealthYRBS2001.pdf)
- ✓ Texas Risk Factor Report; Oral Cancer Risk Behaviors (www.tdh.state.tx.us/dental)
- ✓ ASTHO Health Care Safety Net Amendments of 2002
- ✓ Legislative Updates: Health Safety Net Amendments
- ✓ References

Examples of Oral Health Objectives from State HP 2010 Plans

District of Columbia

- Increase to at least 85% the proportion of all children entering school programs for the first time who have received an oral health screening.
    - Of those children screened and needing referral, increase to at least 25% the proportion receiving a referral for necessary diagnosis, preventive and treatment services.
        - Of those children being referred for treatment, increase to at least 30% the proportion beginning treatment within 90 days.

(No baseline data)

West Virginia

- Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the proportion of children who have one or more cavities (filled or unfilled) is no more than 60% among children aged 8 and 60% among adolescents aged 15.
  (Baseline: age 8, 65.6%; age 15, 66%)
- Increase to 50% the proportion of school-based health centers (pre-kindergarten through grade 12) with an oral health component.
  (Baseline: 40% in 1998)

Alaska

- Increase the proportion of children and adolescents under age 19 at or below 200% of federal poverty level who received only preventive dental services during the past year to 50%.
  (Baseline: 24%)

North Carolina

- Increase the proportion of adults who visited a dentist within the past year to 73.9%.
  (Baseline: 67.2% in 1999—based on 10% improvement)

Iowa

- Increase to at least 70% by the year 2010 the proportion of seniors aged 75 and over who have had a dental examination in the previous year.
  (Baseline: 50% of rural elders in 1992)
- Increase use of topical fluorides in schools to at least 75% of people not receiving optimally fluoridated public water by the year 2010.
  (Baseline not yet available)

Kentucky

- Increase to at least 70% the proportion of 8 year-olds, 12 year-olds and 15 year-olds who have received protective sealants in permanent molar teeth.
  (Baseline: 10% of 5-9 year-olds; 7% of 14-17 year-olds)

WORKSHEET
Writing Objectives

Priority Area:_____

Goal	
Available Data Sources	
Potential Objectives	A.
	B.
	C.
Potential Strategies	

Healthy People 2010 Toolkit

Summary of Needs Assessment Methods

METHOD	PURPOSE	COST	TIME INVOLVED	ADVANTAGES
A. Secondary Data From National or Regional Oral Health Surveys	Needs or problem analysis	Very Inexpensive	Extremely Fast	Data readily available
B. Other Secondary Data	Needs or problem analysis	Inexpensive	Fast to Moderate	Data available (self-reported and other fiscal or regulatory information)
C. Demographic Indicators	Needs or problem analysis	Inexpensive	Very Fast	Data available from public documents
D. Analyzing Non-clinical Data	Resources analysis	Inexpensive to Moderate	Fast	Can also use for annual reports; trend analysis of activities
E. Analyzing Clinical Program Data	Resources analysis	Inexpensive to Moderate	Moderate	Can also use for annual reports; understand extent of services provided
F. Public Comment	Needs or problem analysis	Inexpensive	Moderate	Invitation of public input and exchange
G. Informant Groups	Needs or problem analysis	Inexpensive to Moderate	Fast to Moderate	Minimal preparation time; facilitates communication from providers and consumers
H. Questionnaire/ Interview Survey	Needs or problem analysis	Moderate	Moderate	Relatively good way to obtain information about knowledge and behavior
I. Basic Screening Survey	Needs or problem analysis	Moderate to Expensive	Moderate to Slow	Assesses individuals; good estimate of population if probability sampling is used

Source: ASTDD Seven-Step Model; Step 3, Table 3: Assessing oral health needs.

Setting Target Levels for Objectives

Population Objectives

To support the national goal of eliminating health disparities, a single national target that is applicable to all select populations has been set for each measurable, population-based objective. Three guiding principles were used in setting targets for the measurable, population-based objectives:

- For objectives that address health services and protection (for example, access to prenatal care, health insurance coverage) the targets have been set so that there is an improvement for all racial/ethnic segments of the population (that is, the targets are set "better than the best" racial/ethnic subgroup shown for the objective). Data points for at least two population groups under the race and ethnicity category are needed to use "better than the best" as the target-setting method.
- For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (for example, physical activity, diet, smoking, suicide, alcohol-related motor vehicle deaths), the target setting method is also "better than the best" group.
- For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (for example, occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

Beyond this general guidance, the exact target levels were determined by the lead agency workgroups that developed the objectives. The workgroups used various methods for arriving at the target levels, including:

- "Better than the best" (described above)
- "Best of the best", benchmarking against the top 10% in any area of the U.S.
- ____ percent improvement
- "Total coverage" or "Total elimination" (for targets like 100 percent, 0 percent, all States, etc.)
- Consistent with _____(another national program, for example, national education goals)
- Retain year 2000 target (the Healthy People 2000 target has been retained).

Health Outcomes and Performance Objectives

The following guidance focuses primarily on setting targets for health outcomes and performance. Formulas and technical examples are given in the Healthy People 2010 Toolkit referenced in Chapter 1.

Using an absolute percent decline

Some Healthy People objectives use an absolute percent decline based on "best guesses"/expert opinion to indicate a “reasonable” change over time. Calculations can be made based on the percent of the target population reached and change expected. For example, an absolute decline of 1% of the current level adds to 10% over the decade. Be careful to calculate the percentage for the numbers from the beginning of the decade or it will be a compounded percentage achieved.

Using peer communities

You can set targets by comparing your community to others like it. Age and poverty distribution and population size and diversity may define peer communities. The following may be used to describe one’s peers: typical values for a specific objective, means or medians, or the variation among peers.

Using the pared-mean method to set data driven benchmarks

The pared-mean method determines "top performance." This is defined as the best outcome accomplished for at least 10 percent of the population. Data sources to use for the pared-mean method include vital statistics and the Behavioral Risk Factor Surveillance System. This method is not feasible for all Healthy People objectives. Data may not be available for some objectives, or the nature of the objective may not lend itself to using the pared-mean method. For example, access to preventive care should be available for 100 percent of the population, regardless of what the data show.

Source: Allison J., Kiefe C.I., Weissman N.W. "Can Data-Driven Benchmarks be Used to Set the Goals of Healthy People 2010?" American Journal of Public Health, 89(1):61-5, 1999.

What if areas in the state have already achieved or surpassed the national Healthy People target for an objective?

You can calculate a new, higher state target that will be challenging for local areas that have achieved or surpassed the national target. You also may wish to note in your plan the jurisdictions that have not achieved your previous targets and redouble your efforts in these areas as well as set equally ambitious targets for year 2010.

Process Objectives

Many process objectives, particularly those that pertain to infrastructure (e.g., data systems, workforce) are new for Healthy People 2010. These should be examined carefully to determine their applicability to the state or community plan. Setting measurable targets for process objectives requires judgment and is not an exact science. To set process targets, planners should consider the current status (baseline) of the state/community's public health infrastructure, seek stakeholder input on the desired level of improvement, and make a realistic assessment of what can be accomplished given past experience and current resources, political opportunities, and partner commitment.

Annual percentage change

This measure can be used to track whether progress is on course and to determine if the HP 2010 objectives will be reached. It provides the amount of decline each year that is needed to reach the target.

Using performance measures

"Performance measurement responds to the need to ensure efficient and effective use of resources, particularly financial resources. It links the use of resources with health improvements and the accountability of individual partners." (*Prevention Report,* Winter 1997) This is of particular importance since the inception of the Government Performance and Results Act of 1993, which aims at holding federal agencies accountable for spending public dollars. This extends to states, local jurisdictions, and other organizations that receive federal funding. Performance measures can be incorporated into or based upon Healthy People objectives.

Source: Adapted from Setting Targets and Measuring Progess. Healthy People 2010 Toolkit. pages 93-94.

Indian Health Service Tracking Health Indicators

INDICATOR	DATA SOURCE	LOGIC	Consistent with GPRA+?
Oral Health			
Indicator 11: During FY 2002, increase the proportion of AI/AN population receiving optimally fluoridated water by 5% over the FY 2001 levels for all IHS Areas.	WFRS (CDC) and reports from Area Fluoridation Coordinators		
Indicator 12: During FY 2002, increase the proportion of the AI/AN population who obtain access to dental services by 1% over the FY 2001 level.	Numerator – NPIRS data Denominator – official user population count		
Indicator 13: During FY 2002, increase the number of sealants placed per year in AI/AN children by 2.5% over the FY 2001 level.	NPIRS data		
Indicator 14: During FY 2002, increase the proportion of the AI/AN population diagnosed with diabetes who obtain access to dental services by 2% over the FY 2001 level.	IHS Diabetes Care and Outcomes Audit		

Characteristics of High-Quality and Effective Data for Policy Making

Technical Characteristics	
Content	Cover one or more major health policy or program concerns with sufficient detail to clarify the implications of alternative policy choices.
Currency (Timeliness)	Appear on a sufficiently timely basis and with the appropriate frequencies that they provide a relatively current profile and can be credibly used.
Completeness	Achieve sufficiently high submissions, reporting, or response rates and item completion, to limit biases leading to distorted conclusions.
Reliability	Provide classification and coding consistency to enhance interpretability and reduce confusion.
Analytical Flexibility	Support both routine and special analyses, particularly on an interactive or real-time basis.
Strategic Characteristics	
Cross-System Flexibility	Allow users to merge, compare, or jointly use data from complementary systems; include compatible and consistent variable definitions, coding categories, and a linkage mechanism.
Adaptability	Allow data content and/or reporting to be readily modified to address changing needs.
Accessibility	Provide clear reports to a non-technical audience; make available diverse reports or information tailored to different decision needs or users, and provide access to public-use data sets at a reasonable cost so they can be independently analyzed.
Translation and Policy Applicability	Effectively translate technical data to policy-relevant information.
Dissemination	Accurately and fully inform potential users or decision-makers about the resources and how to access it effectively.

Source: Feldman P., Gold M., Chu K. "Enhancing Information for State Health Policy." Health Affairs, 13(3):238, 1994.

Oral Health of North Dakota's Youth
2001 Youth Risk Behavior Survey Results

The fifth biennial Youth Risk Behavior Survey conducted during the spring of 2001 shows that the oral health of North Dakota's children needs improvement. Weighted data were obtained from 1,377 seventh and eighth students and 1,599 students in grades nine through 12. Seventh and eighth students were asked about dental visits, while students in grades nine through 12 were asked about dental visits, daily brushing habits and cavities in their permanent teeth.

Daily Brushing

- While three-fourths (75.9%) of students brushed their teeth daily, one-fourth (24.1%) did not.
- Female students (86.1%) were more likely to brush daily than were male students (66.6%).
- Only 70.5 percent of students in grade nine reported brushing daily, while 81.2 percent of students in grade 12 brushed daily.

Dental Visits

- While 75.5 percent of students in grades nine through 12 had visited the dentist within the past year, 16.4 percent had not.
- Of these students, 1.6 percent have never visited the dentist.
- Females (78.9%) were more likely to visit the dentist in the past year than were males (72.5%).
- During the past year, 81.8 percent of students in grades seven and eight visited the dentist.
- Cavities in Permanent Teeth
- More than one-half (57.5%) of students reported one or more cavities in their permanent teeth.
- One-third (34.1%) of students reported no cavities.
- More than 8 percent of students were not sure if they have cavities or have not visited the dentist.

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Oral Health Program
600 E. Boulevard Ave.
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04/02

Texas Risk Factor Report

Behavioral Risk Factor Surveillance System

Texas Department of Health | February 1997 | Volume 4 No. 1

ORAL CANCER RISK BEHAVIORS 1995-1996 Survey Data

Highlights of this Issue

* ***About 4.5 million (33%) Texas adults report at least one risk behavior for oral cancer.*** Risks assessed in 1995 and 1996 included cigarette smoking, smokeless tobacco use, and risky alcohol behaviors.
* ***It is estimated that one million Texans with at least one oral cancer risk behavior had no dental or routine medical visit in the past year.*** Dental and medical visits provide important opportunities for early detection of oral cancers.
* ***Over 900 thousand Texans are estimated to have combined smoking and risky drinking behaviors.*** These behaviors in combination represent the greatest behavioral risk factor for developing oral cancer.

Introduction: Tobacco, alcohol and their combined use are major behavioral risk factors for developing oral and pharyngeal cancers (referred to collectively as oral cancer in this report).* Smokers are 3 to 13 times more likely to develop oral cancer than non smokers and the risk tends to rise with the amount of tobacco smoked.[1] Smoking cessation, however, sharply reduces these risks.[2] Smokeless tobacco (ST) also called spit tobacco, chew or snuff, is not a safe alternative to smoking. The risk of developing oral cancer for ST users ranges from 2 to 11 times that of nonusers.[2-4] Alcohol also presents a risk for oral cancer. After accounting for the risks from smoking, those who drink 15-29 alcoholic beverages per week have about 6 times the risk of developing oral cancer than nondrinkers. Combine smoking and drinking and the risk multiplies: those who combine heavy smoking and heavy drinking have up to 35 times the risk of developing oral cancer of nonsmoker, nondrinkers.[2]

Older adults are at higher risk for developing oral cancer than their younger counterparts, and this may be attributed to longer exposure to carcinogens. The average age at diagnosis is 60 years, with about 95% of oral cancer striking those over 40 years of age.[5] Although oral cancer patients are predominantly men, women may be increasing their risk. A Connecticut study found that the male to female ratio for oral cancer has decreased from 5:1 to about 2:1 since 1950, and may be attributed to an increase in smoking and alcohol use among women.[6] National cancer incidence data show that African American males have the highest incidence of oral cancer, followed by white then Hispanic males.[7,8] Additionally, among women, white females have the highest incidence, followed by African American and Hispanic females.

Oral Cancer Risk Behaviors

· Tobacco use · Alcohol use
· Combined alcohol and tobacco use

Only half of oral cancer patients are alive five years after diagnosis, and the death rates are higher in low income, low educated, under-insured persons, minorities and the elderly.[7-9] This may be attributed to late detection, which allows considerable growth of the cancer. Early diagnosis, however, dramatically improves survival: five-year survival rates for early detected oral cancers are about 76%, compared to 18% for advanced, late detected cases.[11] Routine mouth examinations provide valuable opportunities for early detection. Though traditionally considered the responsibility of dentists, all clinical health care providers are encouraged to provide oral cancer examinations during routine check-ups.[12]

* Other behaviors also may contribute to oral cancer risks, however data were not available to adequately explore these risk factors.

Methods: The Texas Behavioral Risk Factor Surveillance System (BRFSS) is a monthly telephone survey sponsored by the Texas Department of Health, Bureau of Chronic Disease Prevention and Control. Non-institutionalized adult Texas residents with a telephone were interviewed by the University of Texas' Office of Survey Research using a truncated list-assisted sample design for random digit dialing.

Information about alcohol use was collected in 1995 and smokeless tobacco use was assessed in 1996, while smoking behavior was collected during both years. Current smokers were defined as those who ever smoked 100 cigarettes and now smoke every day or most days. Heavy smokers were defined as those who smoke ≥25 cigarettes/day. Smokeless tobacco users were defined as those who currently use smokeless tobacco products. Risky alcohol behavior was defined as having ≥60 alcoholic beverages in the past month, and/or ≥5 drinks on a single occasion in the past 30 days. Heavy smoking/ alcohol users were defined as those who reported smoking ≥25 cigarettes/day and having risky alcohol behavior.

Statistical analyses were performed using SUDAAN[12] and EpiInfo version 6.[13] Data were weighted to reflect the age, sex, and race distribution of Texas as well as the probability of being drawn into the sample. Weighting ensures that each respondent effectively represents a specific number of Texas residents within his or her given socio-demographic group. This method of analysis allows the results of the survey to be generalized to the population represented in the sample frame.

Results:

* **Smoking:** The 1996 Texas BRFSS data indicate that 23% of Texans were current smokers and that 19% of those were heavy smokers. Among 35-44 year olds and 45-54 year olds, about 26% reported were current smokers.(Figure 1) Males were significantly more likely to report smoking than females, with 28% of males versus 19% of females currently smoking ($p < .05$). Smoking prevalence was 18% for Hispanics, 25% for African Americans, and 25% for whites. These differences did not reach statistical significance, perhaps due to the small numbers in each of the race/ethnic subgroups. For more about smoking in Texas, see *Texas Risk Factor Report, Vol3, No2*, Tobacco Use.

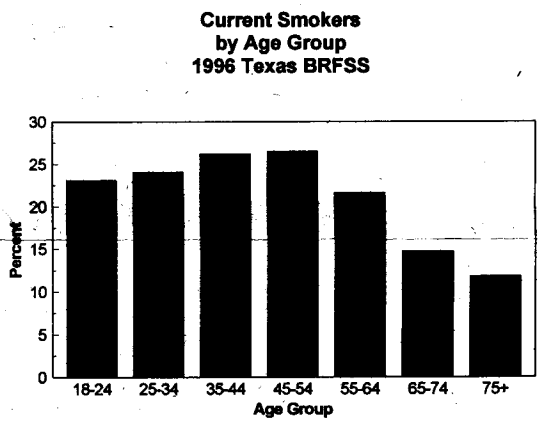

Figure 1

Did you know....?

* About 75% of oral cancers hit smokers who drink heavily.
* Oral cancer incidence peaks in persons aged 65-74, and 10 years earlier in African Americans.
* A mouth examination for oral cancer takes only 2-5 minutes to complete.

* **Smokeless Tobacco** (ST): These data were collected during the 1996 survey year. The largest proportion of ST users were 25-34 year old men. (Figure 2) Only 0.4% of Texas women report its use compared to 8% of men. Of white men, 11% reported current smokeless tobacco use compared to 5% of Hispanic men, however, this difference was not statistically significant. No African Americans in our sample reported ST use.

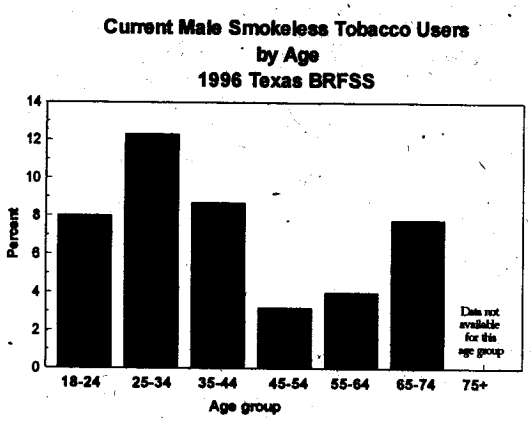

Figure 2

The bulk of ST use was reported by those men in the lowest and highest income strata. (Figure 3) Though this finding did not reach statistical significance, it may suggest a rising trend in ST use among those in higher income groups. While 73% of male ST users reported using only smokeless tobacco, 27% reported combining ST use with smoking.

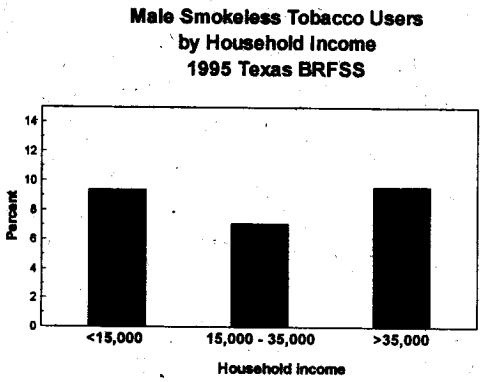

Figure 3

* **Alcohol use:** In 1995, 16% of Texans reported risky drinking behaviors, with 24% of males and 9% of females comprising this high risk group. Of Hispanics, 22% reported risky drinking behavior, while 15% of whites and 13% of African Americans reported similar risk. Hispanics had a significantly higher prevalence of risky drinking behavior than did whites ($p < .05$). Risky drinking behavior showed an inverse relationship with age. (Figure 4)

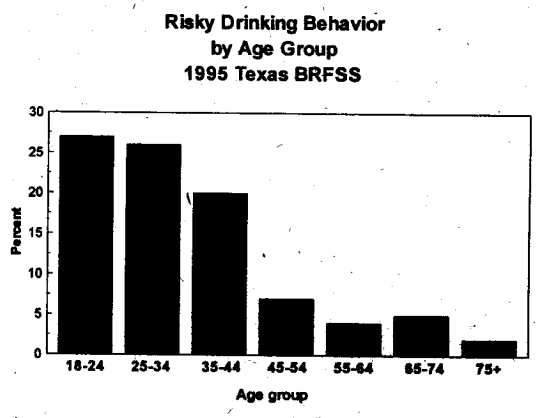

Figure 4

* **Smoking and Drinking:** Data from the 1995 BRFSS indicate that overall 7% of Texans both smoke and drink alcohol, while Texans aged less than 45 most often report these risk behaviors in combination. (Figure 5) Ten percent of males and 4% of females reported combined smoking and risky drinking behaviors. Additionally, 7% of whites, 9% of Hispanics, and 6% of African Americans reported this combination of risk behaviors, however these differences did not reach statistical significance.

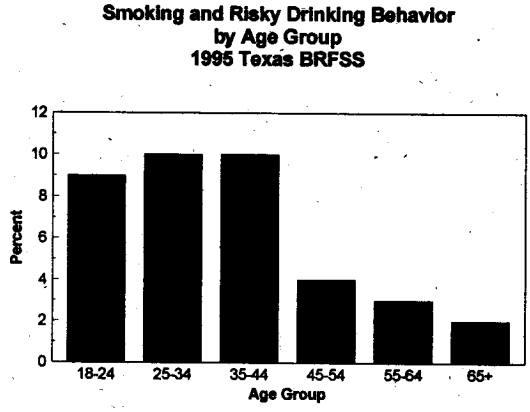

Figure 5

Dental and Medical Care Utilization

* **Smokers:** Of 1996 current smokers, 42% reported not having a dental visit during the past year and 41% reported no routine medical visit. Twenty percent of smokers reported seeing neither health care provider in the past year compared to 13% of nonsmokers. (Figure 6) Of those who reported heavy smoking, 32% reported no dental or routine medical visit in the past year. Among male smokers, there were no significant differences in recent health care utilization by race/ethnicity.

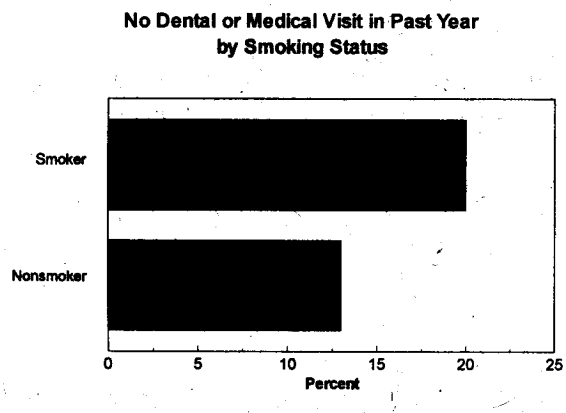

Figure 6

* **Smokeless Tobacco Users:** Of male ST users surveyed in 1996, 48% did not have a dental visit and 46% did not have a routine medical visit in the past year. (Figure 7) However, 23% percent indicated seeing neither a dentist nor physician compared to 17% of nonusers reporting the same. Seventeen percent of male smokeless tobacco users reported their last dental or medical visit was 2 or more years ago. (Table 1)

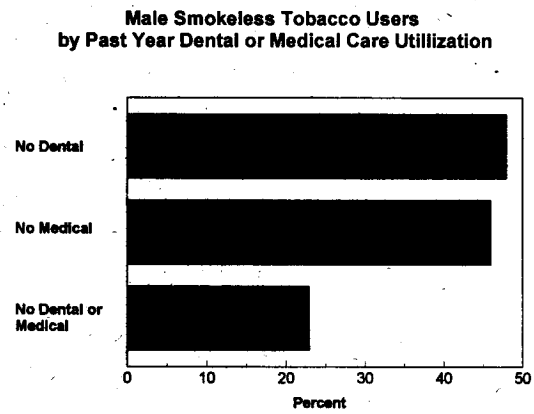

Figure 7

* **Alcohol Use:** In 1995, of those reporting risky drinking behaviors, 23% reported no dental or routine medical visit during the past year, 13% of those not at risk reported the same ($p<.05$). Additionally, 11% of those at risk reported no dental or medical visit in 2 or more years, compared to 6% of those not at risk ($p = .056$). (Table 1)

* **Combined Smoking and Drinking:** Fifty-one percent of smoker/risky drinkers reported no routine medical visit during the past year, and 48% reported no dental visit. (Figure 8) Additionally, 27% of smoker/risky drinkers reported seeing neither a dentist nor physician compared to 13% of those who did not report these behaviors in combination ($p<.05$). Additionally, 52% of heavy smoker/drinkers saw neither a dentist nor a physician in the past year.

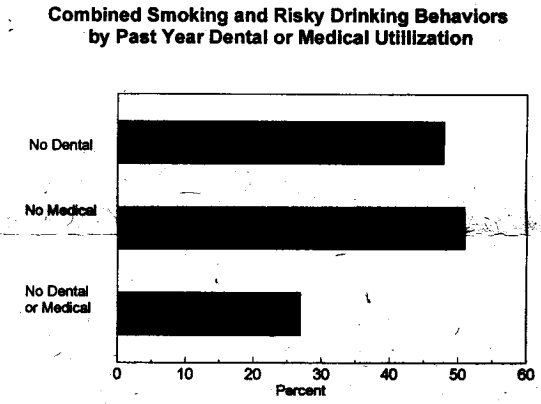

Figure 8

Dental and medical care utilization: Smokers and Male Smokeless Tobacco Users 1996 and 1995 Texas BRFSS

	S 1996	STm 1996	D 1995	S/D 1995
No dental visit past year	.42	.48	.41	.48
No medical visit past year	.41	.46	.43	.51
No dent or med vist past year	.20	.23	.23	.27
No dent or med visit 2 +years	.12	.17	.25	.18

S: smoker STm: male smokeless tobaccco user
D: alcoohol drinker S/D: combined smoking and alcohol use

Table 1

Conclusions:

* Thirty-two percent of heavy smokers reported no past year dental or routine medical visit where they might have received oral cancer preventive services.

* Although typical ST users are described as young white or American Indian/Alaska Native males of low socioeconomic status from the South or rural areas, ST use may be rising among higher income Texans.

* Smokeless tobacco users were more likely than nonusers to report no past year dental or routine medical visits that may have provided an oral cancer examination.

* Risky drinking behavior showed an inverse relationship with age. Twenty-five to 44 year old Texans most often reported combining risky drinking behaviors with smoking.

* Texas respondents who reported combined smoking and risky drinking behaviors reported in smaller proportions a routine medical or dental visit during the past year than those who did not report this combined behavior.

* Over half of those who combined heavy smoking with risky drinking behaviors reported no past year dental or routine medical utilization where that may have received an examination to oral cancer.

Recommendations:

* Public awareness and education efforts should be increased with emphasis on the oral cancer risks associated with tobacco and alcohol use. Although oral cancer typically strikes older adults, interventions targeting younger persons may discourage long-term alcohol and tobacco exposure.

* Increased efforts should be made to encourage those at risk for developing oral cancer to visit a health care provider yearly and receive an oral cancer examination.

* Health professions education curricula should include oral cancer education and intraoral examination techniques.

* Clinical health care professionals should assess oral cancer risk behaviors for their patients and provide oral cavity examinations as recommended. The *Clinician's Guide to Preventive Services, Put Prevention Into Practice*, provides guidelines and instructions for oral cavity examinations.

Early detection dramatically improves the chance of survival from oral cancer. The US Public Health Service and US Preventive Services Task Force recommend early diagnosis for reducing oral cancer deaths. Similarly, the year 2000 national health objectives aim to increase the numbers of adults who receive yearly oral examinations from primary care providers.[15,16]

If you believe you are at risk for oral cancer, ask for an oral cancer check during your next dental or medical visit.

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Additional information about oral cancer is available from:
American Cancer Society
1-800-4 CANCER
1-800-422-6237
National Cancer Institute
(301) 496-5583

For additional information regarding this report contact:

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ASSOCIATION OF STATE AND
TERRITORIAL HEALTH OFFICIALS

Health Care Safety Net Amendments of 2002

On Saturday, October 26, 2003, President Bush signed into law the Health Care Safety Net Amendments of 2002, which reauthorize both the consolidated Community Health Center program and the National Health Service Corps. The law also includes several additional provisions that may be of interest to state health agencies. It is important to note that most of these programs are authorizations and that funding levels, if any, will be determined through the appropriations process, which has not been completed for the current fiscal year.

Highlights of the legislation include:

- **Reauthorizes the Consolidated Community Health Center Program to Provide More Care for the Uninsured**

The bill strengthens the federal Community Health Centers program, the key federal effort to expand care for the uninsured. In signing the bill, the Administration reaffirmed its goal to create 1,200 new or expanded health centers by 2006. The law authorizes the Health Centers program through FY 2006; raises the authorization level to $1.3 billion; and maintains the program's core principles: to target resources to high need areas, deliver health care regardless of ability to pay, and gives the community being served a voice in the governance of the health center. It also encourages initiatives to hold down costs and ensure high quality care, and authorizes grants to eligible health centers with a substantial number of clients with limited English speaking proficiency to provide translation, interpretation, and other such services.

- **Reauthorizes the National Health Service Corps to Support More Doctors, Nurses, and Dentists**

The bill revises and continues funding for the National Health Services Corps and includes a provision to automatically designate all federally qualified health centers and rural health clinics that meet specific criteria as having a shortage. The law also directs the Health Resources and Services Administration to revise the criteria used to designate dental health professional shortage areas to provide a more accurate reflection of oral health care need, particularly in rural areas. A provision directs this to be done in consultation with the Association of State and Territorial Dental Directors, dental societies, and other interested parties. The law raises the overall authorization level of the Corps to $146 million and includes authorization of $12 million for grants to states to support loan repayment programs.

- **Expands Availability of Dental Services**

The law authorizes a grant program to help states in the development and implementation of innovative programs to address the dental workforce needs of designated dental health professional shortage areas in a manner that is appropriate to the states' individual needs. States would be able to use funds for the development of a state dental officer position or the augmentation of a state dental office to coordinate oral health and access issues in each state.

Legislative Updates

107th Congress

Health Care Safety Net Amendents (Loan Repayment Reports)

P.L. 107-251 (H.R. 3450, S. 1533/S. Report 107-83)

Impact of Public Law

P.L. 107-251, the Health Care Safety Net Amendments, repeals the requirement for the Health Resources and Services Administration loan repayment program (LRP) reporting requirements, which also repeals the National Institutes of Health LRP reporting requirements, which were mandated under the National Health Service (NHS) authorities. Specifically, this repeals Section 338B(i) of the Public Health Service Act, which required an annual report to Congress on the NHS Corps Loan Repayment Program.

Legislative History

P.L. 107-251 reauthorizes the Community Health Center program, the National Health Service Corps (NHSC), and rural outreach grants to ensure that both the uninsured and the underinsured have access to quality health care services. The legislation increases the funding authorization for health centers to $1.293 billion and includes language allowing health centers to provide behavioral, mental health, and substance abuse services if they choose. The legislation also reauthorizes NHSC, which serves as a pipeline for health care facilities that have trouble attracting health professionals, and strengthens the service obligation requirements of the program. By strengthening this provision, health care facilities using program graduates can be certain that health corps personnel will fulfill their entire service contract.

Since its creation in 1972, NHSC operates two programs to help meet the needs of underserved communities: the scholarship program, which provides funds to students for educational living expenses during health care practitioner training, and the LRP, which provides financial assistance to help newly graduated practitioners repay their educational loans. For each year that the NHSC scholarship program or LRP provides support, participants are obligated to provide 1 year of medical care in underserved communities.

S. 1533, the Health Care Safety Net Amendments, was introduced on October 11, 2001, by Senator Edward M. Kennedy (D-MA) and was referred to the Senate Health, Education, Labor and Pensions Committee. The bill was reported out of that Committee on the same day and passed in the Senate on April 16, 2002, by unanimous consent.

H.R. 3450, the Health Care Safety Net Improvement Act, was introduced on December 11, 2001, by Representative Michael Bilirakis (R-FL) and was referred to the House Energy and Commerce Subcommittee on Health. On October 1, 2002, the bill passed the House by a voice vote. The bill, as amended, passed the House on October 16, and the Senate concurred with the House-amended bill on October 17. The legislation was signed by the President on October 26 as P.L. 107-251.

Source: **http://olpa.od.nih.gov/legislation/107/publiclaws/healthcare.asp**

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Chapter 4

Identifying and Leveraging Resources

This chapter will cover:

1. **Leveraging resources by integrating oral health activities with other health activities**
2. **General categories of resources that might be needed to accomplish oral health activities in HP 2010 plans**
3. **Tips and resources for fundraising and grantwriting**
4. **Identifying funding opportunities at the national, state and local levels**
5. **Ways to maintain resources.**

Creating a great HP 2010 plan is fruitless unless there are resources to implement the activities. Identifying and securing resources is a constant challenge for states, territories, tribes and communities, especially when competing for limited dollars. Funding, however, isn't the only resource that is needed. This chapter will present opportunities for identifying the resources you will need throughout various stages of your HP 2010 plan and show how to use them to leverage additional resources. Looking at your draft plan in its entirety, including potential timelines for accomplishing activities and objectives, will help you frame appropriate questions about resources.

Tips

- Ask the right questions early
- Recognize that HP 2010 plans require a variety of resources
- Make a wish list of resources you desire
- Recognize that money isn't everything
- Capitalize on what you already have
- Recognize that you can't get it if you don't ask for it
- Spread responsibilities for securing resources among the coalition members
- Don't forget to plan for sustainability
- Coordinate your efforts with other initiatives

Leveraging Resources by Integrating Oral Health With Other Health Priorities

Oral health program budgets often suffer because they have to compete with programs for diseases such as cancer and heart disease that have high mortality rates. Out of frustration, some dental public health professionals have adopted the phrase "What about dental…?" and wear buttons displaying the question to highlight that oral health is often left out of health plans and discussions. When Dr. David Satcher was the Surgeon General, he emphasized the need to integrate oral health efforts with other health activities and to show how oral health is integral to overall health. Surgeon General Richard Carmona has reinforced the concept of the important linkages between oral health and general health and well-being. This integration creates additional opportunities to secure resources, even though they may not be earmarked for oral health efforts. The challenge is to identify opportunities to point out these relationships and to latch on to activities that already receive funding or grants that could include some type of oral health focus.

Although oral health is not one of the ten leading health indicators for HP 2010, there are oral health links to almost all of the indicators, especially tobacco use, obesity, substance abuse, injury and violence, and access to health care. Talking points about potential links with some of the health indicators are included in the Resources section.

In December 2001, during a HP 2010 conference in Washington, DC, Dr. Dushanka Kleinman, Chief Dental Officer, US Public Health Service, likened the process of building resources through partnerships to "currency," citing the concepts of "acquisition," "portfolio management," "purchasing power," and "expected/projected return on investment" as a new way to view oral health partnerships. This is a useful framework to use when attempting to leverage resources and market the HP 2010 plan or any oral health plan to the business community.

Categories of Resources

Two worksheets are included in the Resources section as planning tools. *Potential Strategies to Ensure Resources for Planning and/or Implementation* looks at options that may be important to explore and provides a column for prioritization. *Plan for Securing Resources* is a table that includes columns for listing potential resources and strategies for securing them, including who is responsible and the projected timelines. A template and a sample are included.

Human Resources

Chapter 2 outlined models for creating HP2010 team and coalitions. No matter what model you are using, people are needed for a variety of roles. Creating coalitions of people who will volunteer to perform one or more roles is crucial. Anyone in the community can play a valuable role. The more involvement people have, the more they will own the process and become invested in the outcomes.

Avenues to locate resource people through existing organizations include schools and colleges, health departments or other governmental agencies, cooperative extension programs, non-profit groups, small businesses, large corporations, private consultants, civic or service groups, professional associations (e.g., dental societies, primary care associations), TV or radio stations, newspaper offices, churches or other faith-based organizations, parent organizations, foundations, health clinics, hospitals, recreation or sports organizations, etc. The possibilities are endless. Other ideas for gaining participation were covered in Chapter 2. Some agencies will provide in-kind support by incorporating HP 2010 activities into employees work responsibilities or allow paid time off to participate. If specific skills are needed, but no volunteers are available, money for staff or consultants will need to be included in the budget. Some states have paid staff who oversee all statewide HP 2010 efforts, while local efforts frequently rely on volunteer coordinators.

Potential roles or skill areas include:

- Coordinating or chairing workgroups or coalitions
- Facilitating workgroups, focus groups or other meetings
- Providing clerical and administrative support
- Designing health programs
- Developing and keeping track of budgets
- Designing and implementing evaluation strategies
- Identifying data collection methods
- Collecting data in a variety of ways
- Analyzing and presenting data in many formats
- Providing technical/subject expertise
- Selecting and using information systems
- Preparing health promotion materials
- Marketing HP 2010 objectives and activities
- Creating graphic designs for HP 2010 materials
- Writing and editing a variety of health communication documents
- Fundraising
- Planning conferences
- And lots more!

Equipment and Supplies

This category includes a whole range of items such as copy and fax machines, AV equipment, computers, office supplies, health education materials, dental equipment, preventive dental supplies, etc. Some may be needed throughout the initiative, while others, such as some dental supplies, may only be needed when you begin implementing activities to accomplish the objectives. Those needed for dental activities will vary by the type of activity, e.g., placing dental sealants, oral cancer exams, dental screenings, or fabrication of mouthguards. Coalition members may be able and willing to use equipment or supplies provided through their own agency, business, or home.

Tips to Keep Costs Reasonable

- Generate a list to solicit donations for specific items (e.g., dental products)
- For items you need in large amounts, partner with others to submit larger orders that qualify for bulk discounts
- Compare prices over the Internet
- Check with outlet stores for overstocked or discounted items
- Consider renting/leasing equipment if it is needed on a short-term basis or only periodically.

Beware of donations of used or outdated equipment or supplies. Such donations should be reviewed carefully to see if they meet your needs without compromising the quality of your activities or outcomes.

Meeting Facilities and Other Space Needs

Various venues will be needed throughout the Healthy People 2010 initiative. Small meeting rooms can usually be found at no charge through agencies where team members work. Community-owned buildings such as libraries, schools, town offices or other community centers often have public meeting rooms. Universities and foundations sometimes make their boardrooms, auditoriums or conference rooms available to non-profit groups or coalitions. If meals are held in conjunction with meetings, hotels or restaurants may not charge a fee for the meeting space.

Rotating meetings among venues may create more visibility for HP 2010 activities and reduce the burden on any one agency or facility. Some clinically-oriented activities such as dental screening, oral cancer exams or fluoride varnish applications can usually be done in most any setting as they do not need special equipment. Other clinical procedures such as placement of dental sealants, require access to good lighting, sinks, and space for portable equipment. Schools, hospital, clinics, or private practitioners often donate use of their clinical or laboratory rooms for a limited period of time. Many HP 2010 activities can be integrated into already scheduled

programs such as fairs, pow-wows, Special Olympics, or other sporting events that occur outdoors.

Marketing/Advertising

Involve members of the "media" as coalition members to help market your efforts to the public. Some newspapers or radio stations might provide free or reduced cost advertising. Using public interest stories throughout various stages of the initiative will help to recruit members and secure other resources, as well as provide an avenue for education and recognition of volunteer efforts. Local newspapers, public TV stations and public radio stations are important vehicles for making Healthy People 2010 more meaningful at the local level. More marketing strategies are covered in Chapter 5.

Communication and Travel

Rapid advances in information technology (IT) make communicating with coalition members and the general public relatively easy, fast, and cost-effective. Scheduling meetings, posting agendas, soliciting opinions or assistance, and distributing minutes can be done in a timely and inexpensive manner. Laptop computers and software programs for graphics have made meeting reports and presentations easier and more interesting. Some meetings, especially in rural areas, may be held via teleconferencing or videoconferencing. For example, oral health coalitions in Montana, Idaho, and North Dakota recently held dental summits and Head Start oral health forums using satellite conferencing to solicit widespread participation. This promotes inclusiveness of community representatives, especially in remote areas or during inclement weather or agency-imposed travel restrictions. Some of these IT components may be available to coalitions on an "in-kind" basis from agencies so that the need for funding for travel and staff time is reduced. Otherwise, funding will be needed to support ongoing communication. HP 2010 planners need to weigh the pros, limitations, and costs of different communication mechanisms when developing budgets and fundraising plans.

Fundraising

Fundraising always is a challenge. Someone needs to coordinate all fundraising activities for HP 2010 to assure that efforts are appropriate and productive. Fundraising includes 1) soliciting donations; 2) creating community-based events that raise money; and 3) writing grants. Make sure someone in your coalition has these skills, hire someone who does, or ask for technical assistance from an agency or individual with a successful track record in securing resources.

Use the worksheet *Plan for Securing Resources* to identify what resources you will need to include in a budget and in a specific fundraising plan. The budget should be reviewed on a

regular basis, so you can track income and expenses. You may need to adjust your budget depending on how successful you are in soliciting volunteers and in fundraising.

Donations and Sponsorships

Donations can be solicited in a variety of ways and for a variety of purposes. For example, local businesses can be contacted to donate food, office supplies, advertising or media coverage for meetings and conferences. Dental equipment suppliers and dental products manufacturers can be contacted for contributions of new or used equipment, oral hygiene supplies such as toothbrushes, toothpaste or mouthguards, and supplies such as dental sealant material or disposable mirrors.

The ADTA and member organizations support a number of causes in the dental community and sponsor meetings. ADTA member companies donate dental equipment and supplies to Special Olympic Training Centers, sponsor a DentaCheque dental product coupon book as a fundraising tool for the National Foundation of Dentistry for the Handicapped, and support the National Museum of Dentistry in Baltimore, MD. Members also regularly donate oral hygiene supplies and dental education materials to community-based programs through their sales and marketing representatives. Companies that have traditionally supported public health endeavors include John O. Butler Company, Procter and Gamble Company, Johnson and Johnson, Colgate Oral Pharmaceuticals, Henry Schein Company, Dentsply Corporation, DNTLworks Equipment Corp, Stone Pharmaceuticals, Aseptico International, and Omni Oral Pharmaceuticals and others. Contacts are generally made through the regional sales representatives. Most private dental practitioners and community dental clinics have contact information for the sales representatives from the various companies. Some national initiatives from the manufacturers are focused on Healthy People 2010 objectives.

The Crest Division of Procter and Gamble is sponsoring Healthy Smiles 2010, in partnership with Boys & Girls Clubs of America, Rosie's for All Kids Foundation, and members of the dental community. This program includes oral health education for children grades K through 3 and their families at Boys & Girls Clubs and in schools, public service campaigns, and screenings and treatment, including using mobile dental vans and the resources of dental professionals in dental schools.

Colgate-Palmolive, in conjunction with the American Dietetic Association Foundation, offered financial support of up to $15,000 over a two-year period to support doctoral research in nutrition and oral health/dental education. This is an important new area of focus for this group, and a good example of ways to integrate oral health into related research areas.

Universities may be willing to sponsor meetings. Donations can be solicited through mail campaigns, personal contact, flyers, telethons, or special events. Some HP 2010 coalitions have sought nonprofit status and exemption from federal income tax because it allows them to accept tax deductible donations and also increases eligibility for certain types of grants. A coalition in South Carolina became an independent 501(c)(3) organization to serve as an umbrella organization for single purpose coalitions and to link their activities. Information on how to

establish a nonprofit organization can be accessed online at: **www.1800net.com/nprc/index.html**.

Grantwriting

Grantwriting is both a science and an art. Grantwriting tips are included in the Resources section. Successful grants for HP 2010 activities require: 1) people with a good scientific understanding of the activities they are proposing; 2) someone who can translate those ideas into a concise, well written document that can be understood by reviewers; 3) people who can manage all aspects of the grant if it is funded; and 4) people who know how to evaluate and describe the effectiveness of grant activities and outcomes. Grantsmanship requires teamwork. Many excellent resources are available to help individuals and teams increase skills in grantsmanship.

- Government, philanthropic, and non-profit agencies provide seminars, courses and manuals on grantwriting, some of which are specific to their agency or a specific request for proposals.
- The Foundation Center (**www.fdncenter.org**) provides one-hour free training courses as well as on-line courses through their virtual classroom. Three very useful on-line courses are "An Orientation to Grantseeking", "Guide to Funding Research" and "Proposal Writing Short Course". Also helpful are topical reading lists, an on-line bookshelf and a glossary.
- The Community Tool Box (University of Kansas) includes a tool on grantwriting (**http://ctb.lsi.ukansas.edu**.)
- Non-Profit Guides Web site (**www.npguides.org**) provides grantwriting tools for private and public nonprofit organizations and entities. It includes a 10-point grantwriting guide overview; funding proposal summary and detail; and sample inquiry letter, grant proposal, budget and application; and links to grantmakers.
- See pages 6-8 of the Resources section for chapter for grantwriting tips and a grantwriting glossary.

HP 2010 is, in part, driving resource allocations for disease prevention and health promotion activities in many sectors, especially federal and state governments. Therefore, applications for funding will need to reference how the proposed activities relate to HP 2010 objectives.

Who are the Grantmakers?

Governments: federal, state, county or local governments receive and disburse public funds through a variety of mechanisms such as grants, cooperative agreements, and contracts. Most funds are for specific focus areas or categorical programs, e.g., MCH, rural health.

Private Foundations: non-governmental, non-profit organizations with an endowment that is usually managed by its own trustees or directors. Money for foundation grants is donated from a single source, such as an individual, family, or corporation.

Corporate Grantmakers: company-sponsored foundations or private foundations whose assets are derived primarily from the contributions of a for-profit business. Although it may maintain close ties with its parent company, it is an independent organization with its own endowment. Corporate giving programs are grantmaking programs established and administered within a for-profit business organization. Some companies make charitable contributions through both a corporate giving program and a company-sponsored foundation.

Community Foundations: similar to private foundations but funds are derived from many donors rather than a single source. Community foundations are usually classified under the tax code as public charities [501(c)(3)] and therefore are subject to different rules and regulations than those that govern private foundations.

Grantmaking Public Charities: public foundations that primarily operate grant programs benefiting unrelated organizations or individuals as one of their primary purposes. There is no legal or IRS definition of a public foundation, but such a designation is needed to encompass the growing number of grantmaking institutions.

Source: Office of Minority Health Resource Center. Funding Guide. June 1998.

Identifying Funding Opportunities

Searching for funding either can be viewed as a daunting and frustrating task or as a challenging treasure hunt. Matching your funding needs to the specific funding priorities of various grantmakers is critical.

Tips for Identifying Funding Opportunities

- Take time to research which agencies seem to be the best fit in terms of :
  - ✓ geographic target areas (e.g., national, state, county)
  - ✓ organizational eligibility (e.g., universities, nonprofit organizations, local governments)
  - ✓ topic area (e.g., health, child care, coalition building, tobacco cessation programs)
  - ✓ population age group (e.g., young children, young adults, elders)
  - ✓ ethnic focus (e.g., American Indians in the Northwest, Hispanics in the Southwest, low-income residents in urban areas)
  - ✓ funding resources (e.g., small grants less than $5,000, $35,000-50,000 one-year grants for a special project, $200,000 grants for programs over 3-years.)
- Determine if they have set funding cycles (e.g., once per year) or open cycles for unsolicited grants.
- Do not go after money that marginally fits your needs just because it is "money" and the grant deadline is in two weeks.
- A hastily written proposal that does not exactly meet the funder's criteria and is "padded" to look like it does is a "red flag" and will not even pass the first round of cursory review.

The next section reviews various agencies and organizations that might provide funding opportunities directly or indirectly related to HP 2010. Most of the federal agencies target statewide or tribal activities unless they have a specific initiative related to community-based demonstration projects or community health center expansion.

Federal Resources

Federal Commons was developed in 2001 in conjunction with the General Services Administration's *Catalog of Federal Domestic Assistance* as a one-stop online access to federal grant information (**www.cfda.gov/federalcommons**).

Federal Register: Published daily, the Federal Register is the official government publication that announces notices of funding availability (NOFAs) and other official notices. The Federal Register can be accessed online at **www.access.gpo.gov/su_docs/aces/aces140.html**.

GrantsNet: GrantsNet is an Internet tool created by the Department of Health and Human Services' (DHHS) Office of Grants Management for finding and exchanging information about DHHS and other federal grant programs. GrantsNet serves the general public, the grantee community and grantmakers. It includes information on how to find DHHS grants, current funding opportunities, the application process, standard forms, writing grant proposals and managing grants. It is available online at **www.hhs.gov/grantsnet/roadmap/index.html**.

Office of Minority Health Resource Center: This resource center maintains a database of funding resources that can help support minority health projects and programs. The database lists private and public foundations; pharmaceutical and insurance organizations; journal articles, directories, book; fellowships, scholarships and internships; and federal, state and community resources. Check the Web site at **www.omhrc.gov/omh/fundingdb.htm**.

Centers for Disease Control and Prevention (CDC)

CDC funds many national, state, territorial and tribal activities related to HP 2010. Recent cooperative agreements enhance infrastructure for state/territorial oral health programs, including support for oral health program leadership and additional staff, monitoring oral health behaviors, and evaluating prevention programs. CDC funding has also supported school-based sealant programs, coordinated school health programs, and community water fluoridation. Funding is provided for injury prevention, tobacco use prevention and control, diabetes (and other chronic disease) prevention, and activities related to most of the leading health indicators. CDC funding has also supported and coordinated school health programs, school-based/linked sealant programs and community water fluoridation. The CDC Oral Health Web site provides access to Infrastructure Development Tools, which can be used for planning, designing, implementing and comprehensive evaluation of oral health promotion and disease prevention efforts. In addition, state-by-state reports provide information on current state planning processes and other selected state information (e.g., demographics, infrastructure, workforce, administration and programs. The National Oral Health Surveillance System (NOHSS), available at **www.cdc.gov/nohss**, is designed to help public health programs monitor the burden of oral disease, use of the oral health

care delivery system and the status of community water fluoridation on both a state and national level. See the Oral Health Web site at **www.cdc.gov/oralhealth.**

- **Preventive Health and Health Services (PHHS) Block Grants** are allocated by CDC to give states wide discretion in fund distribution to ensure the best use of resources. States are mandated to show how the funds are aligned with Healthy People Objectives. States also are directed to use the block grants in areas of greatest need, which can mean developing a state plan. Some states use at least some of their PHHS block grant funding for oral health programs. A number of states, including Alabama, Colorado, Maine, Kentucky, Illinois, and West Virginia have used the PHHS Block Grant to fund local initiatives tied to their state objectives. Illinois used some of these funds for a local needs assessment project, including a statewide, computerized data system and training workshops to support local planning. *Making a Difference: The Preventive Health and Health Services Block Grant*, can be accessed online at **http://astho.org/making.html**.

- CDC's **Prevention Research Centers Program (PRCs)** is a congressionally appropriated cooperative agreement program, which currently supports 26 academic health centers for a 5-year funding cycle. Within each PRC, multidisciplinary faculty from schools of public health and medicine collaborate with faculty from other schools (e.g., dental schools), public health organizations and community members on projects related to specific public health themes. Every center conducts at least one demonstration project with a state or local health department or board of education. In 1993, the program established a supplemental funding mechanism through the creation of Special Interest Projects (commonly referred to as SIPs). Ongoing research projects address a wide range of community health issues, including oral health. Information about the PRCs and links to each PRC Web site are available at **www.cdc.gov/prc**.

National Institutes of Health (NIH)

NIH is composed of 27 institutes and centers. The NIH mission is to uncover new knowledge and develop interventions that will lead to better health for everyone. NIH uses grants, cooperative agreements and contract mechanisms for funding. Three of these mechanisms, which are more likely mechanisms for public health projects, are briefly described below. For additional information including funding announcements and the grant application review process use the following Web site: **www.nidcr.nih.gov/funding/index.asp**.

Individual Research Project Grants R01's support a discrete, specified project performed by an investigator in an area of specific interest and competency.
Small Research Grants R03's provide support limited in time and amount for studies in categorical program areas. Generally for preliminary short-term projects. The grants are non-renewable and designed for individuals who have not had previous NIH funding.
Research Conference Grants R13's support recipient-sponsored and directed international, national, or regional research meetings, conferences, and workshops.

Individual experts and current research programs in line with your program interests can be identified by accessing the NIH and NIDCR Web sites and searching on the key words. These individuals and programs can facilitate/inform regarding other federal resources.

The NIH Office of Behavioral and Social Sciences Research has launched a monthly email service to announce NIH funding opportunities in social and behavioral sciences. This service is an excellent source for identifying funding. To join the listserv, mail a message to **listserv@list.nih.gov**, asking to SUBSCRIBE BSSR-GUIDE-L [your full name]; note this is case sensitive. Leave the subject line blank.

- **National Institute of Dental and Craniofacial Research (NIDCR):** NIDCR funds basic, clinical and behavioral research of relevance to the HP 2010 objectives, and includes HP 2010 in their grant announcements and Requests for Proposals. Multiple clinical trials are underway in addressing the diseases and conditions highlighted in the HP 2010 oral health objectives, dental caries, periodontal disease, oral cancer, etc. As an example, in 2001 NIDCR initiated two new programs of relevance to the HP 2010 objectives. To address the issue of oral health disparities, NIDCR funded five new Centers for Research to Reduce Oral Health Disparities at the following universities:

  - Boston University
  - New York University
  - University of California at San Francisco
  - University of Michigan
  - University of Washington.

  - NIDCR will provide approximately $7 million per year over a seven-year period to support activities of the centers through cooperative agreements. These centers have established relationships with multiple community organizations and are a national resource to individuals interested in pursuing health disparities projects. A key partner in this project is the NIH National Center on Minority Health and Health Disparities.

  - Highlights of areas of emphasis in health disparities research and overall research can be accessed online at **www.nidcr.nih.gov/research/health_disp.asp** and **www.nidcr.nih.gov**.

  - NIDCR also funded the states of Florida, Michigan, New York, Illinois and North Carolina for three-year grants of about $100,000 per year to aid in research leading to the development of state models for oral cancer prevention and early detection programs. At the end of the grant period, a subsequent Request for Applications (RFA) will be issued to support the development, implementation and evaluation of interventions promoting oral cancer awareness, prevention and early detection, based on information learned from the first round of research.

  - A periodic electronic news letter that highlights new initiatives at NIH and NIDCR can be accessed online at **www.nidcr.nih.gov/research/newsForResearchers.asp**. You may also

subscribe to the e-newsletter at **http://list.nih.gov/cgi-bin/wa?SUBED1=nidcr-newsletter&A=1**.

- NIDCR also supports training and career development of investigators in areas of relevance to public health and with a focus on recruiting a more diverse workforce—one of the HP 2010 health objectives in the access chapter. Also, NIDCR is initiating a dental school curriculum and infrastructure program to enhance the profession's capacity to apply science to improve care, and is developing a new program to provide clinical research training to all members of the dental team.

Health Resources and Services Administration (HRSA):

HRSA directs programs that improve the Nation's health by expanding access to quality health care for all. HRSA seeks to assure the availability of comprehensive quality health care to low income, uninsured, isolated, vulnerable and special needs populations, primarily through grant assistance to communities and institutions. HRSA oral health programs promote improved dental health for low income and uninsured children, individuals with special health care needs, and for those individuals unable to access primary oral health care.

Those seeking assistance in developing and enhancing oral health programs should not overlook HRSA's Regional Dental Consultants as a source of expert advice and technical assistance. These individuals can share information on a variety of funding opportunities and potential collaborations, as well as being able to refer prospective applicants to organizations who have submitted successful proposals. A listing of HRSA's Regional Offices, along with a listing of the States served by each office, is available online at **www.hrsa.gov/staff.htm**. From the contact numbers listed, callers can ask to be referred to the Regional Dental Consultant.

- **The Maternal and Child Health Bureau (MCHB)** distributes Maternal and Child Health Services Block Grants using Title V funds. Title V is a permanently authorized discretionary grant program of the Social Security Act. Money from these block grants is directed toward improving the health of mothers and children. MCHB dental programs tie public health programs together and link public programs with the private sector. Although not often readily apparent, MCHB supports oral health infrastructure, filling gaps and building bridges, which gives other federal, state supported and foundation programs stability. Oral health systems and services frameworks developed in this way allow more visible programs to prosper.

  Historically, Title V MCH Block Grants have been the genesis for most state oral public health programs in the country, and continue to be the principal federal program supporting state oral health programs. It is estimated that most of the Federal funds used to operate state oral health programs comes from MCH block grant support to states. This support provides the nation with infrastructure at the state level for population-based prevention programs (e.g., water fluoridation, sealants, etc.) and for direct and enabling oral health services when necessary.

MCHB also funds 1) Special Programs of Regional and National Significance (SPRANS) grants to address special areas of emphasis, including oral health projects and programs; 2) Community-Integrated Service Systems (CISS) projects; 3) the National Maternal and Child Oral Health Resource Center in Arlington VA, and the National MCH Center for Oral Health Policy at Columbia University in New York; 4) a cooperative agreement with the Association of State and Territorial Dental Directors (ASTDD) for training, technical assistance and special projects to support national, state, and local dental public health infrastructure projects; 5) Maternal and Child Health Centers for Leadership in Pediatric Dentistry Education; and 6) Innovative Early Intervention Caries Management Grants.

- **The Bureau of Health Professions (BHPr)** grants and cooperative agreements support innovations and targeted expansions in health professions education and training. Emphasis is on increasing the diversity of the health workforce and preparing the health care providers to serve diverse populations and to practice in the nation's 3,000 medically underserved communities. Oral health projects are well represented in the Bureau programs, including grants for residency training in both dental public health and general and pediatric dentistry. Beginning in FY 2001, the Bureau initiated a three-year cooperative program to train primary care medical residents to identify oral health problems in young children.

  BHPr programs help to assure access to quality oral health care professionals in all geographic areas and to all segments of society. BHPr puts new oral health research findings into practice, encourages health professionals to serve individuals and communities where the need is greatest, and promotes cultural and ethnic diversity within the oral health professions workforce.

  A list of grant programs with competitive cycles planned and their due dates can be found online at **www.hrsa.gov/grants**.

  - Within the Bureau, the **National Health Service Corps (NHSC)** is increasing its support for oral health services. The NHSC is implementing President Bush's "Blue Print" for expanding health care access. The President proposes expansion of the National Health Service Corps by roughly 30% in FY 2003. As one of HRSA's "presidential initiatives," the NHSC has established national partnerships with the American Dental Association (ADA) and the American Dental Education Association (ADEA) and state leaders to increase the numbers of dedicated oral health professionals who are committed to serving where the needs are the greatest (e.g., Scholarships and Loan Repayment opportunities).

- **HRSA's HIV/AIDS Bureau** was formed in August 1997 to consolidate all programs funded under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act funds primary care and support services for individuals living with HIV disease who lack health insurance and financial resources for their care. These programs reach more than 500,000 individuals each year. Training, technical assistance, and demonstration projects are also funded. The Dental Reimbursement Program provides support to dental schools, post-doctoral dental education programs, and dental hygiene programs for non-reimbursed care provided to persons with HIV disease. The new Community-Based Dental Partnership

Program supports collaborative partnerships among accredited dental and dental hygiene education programs and community-based dental providers, both to increase access to oral health care for populations with HIV, and to train additional dental and dental hygiene providers to manage the oral health needs of HIV positive patients. Other Ryan White programs provide support directly to states, territories, and local communities and agencies. Information and tools for grantees are found on the Web site at **http://hab.hrsa.gov/**.

- **The Bureau of Primary Health Care (BPHC)** supports community/migrant/school-based and homeless health center programs, and numerous other programs. BPHC's staff assists the general public, funded agencies, Office of Rural Health Policy and Field Offices in understanding application requirements, as well as providing consultation about grants administration, the grants process, and Notice of Grant Award issues.

  The President's *Initiative to Expand Health Centers* has a goal to strengthen the health care safety net for those most in need. HRSA plans to expand the community health center program to 1200 new/expanded health center access points and ultimately serve an additional 6 million people. Oral Health is an integral component of the primary health care services provided in community health centers funded by HRSA. Access to oral health care and preventive services is one of HRSA's major priorities as part of the Presidents Initiative.

  BPHC has engaged three oral health program strategies integrated within the President's Initiative:

  1. establishment of new oral health care capacity in New Start Health Centers and in existing Health Centers that do not have oral health care capacity;
  2. expansion of oral health care capacity in existing Health Centers; and
  3. improvement in the quality of care and management of oral health care programs in Health Centers.

- **The Office of Rural Health Policy (ORHP)** works within government and with the private sector to seek solutions to rural health care problems. In partnership with the DHHS Office of Intergovernmental Affairs, ORHP leads the Secretary's Rural Initiative, a Department-wide effort to improve the lives of 65 million Americans who live in rural areas, where health care and social service programs provide needed support of communities' well-being and represent a significant segment of local economies. In FY 2002 ORHP identified the discrepancies in oral health and access to dental care as one of seven priority issues the Office intended to address in the coming year. More information on ORHP and its grant programs can be found online at **www.ruralhealth.hrsa.gov**.

- HRSA relies on the *HRSA Preview* to profile its discretionary programs--broken down by individual bureaus and offices--for each fiscal year. The publication also lists and explains common grant terminology and provides answers to frequently asked questions. The *Preview* is available online at **www.hrsa.gov/grants.htm**. An additional source of information is the HRSA Information Center accessible online at **www.ask.hrsa.gov** or via telephone at 1-888-Ask-HRSA. The Center publishes monthly updates of new materials available, including fact sheets on various programs and activities.

Indian Health Service (IHS):

The IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives (AIAN) with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs. The goal of the IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all AIAN people. The foundation of the IHS is to uphold the Federal Government obligation to promote healthy AIAN individuals, communities and cultures and to honor and protect the inherent sovereign rights of tribes. To accomplish this, the IHS:

- Assists Indian tribes in developing their health programs through activities such as health management training, technical assistance, and human resources development;
- Facilitates and assists Indian tribes in coordinating health planning, in obtaining and using health resources available through Federal, State, and local programs and in operating comprehensive health care services and health programs.
- Provides comprehensive health care services including treatment, preventive and rehabilitative services and development of community sanitation facilities.
- Serves as the principal federal advocate in the health field for Indians to ensure comprehensive health services for AIAN people.

Three general areas of effort aimed at achieving HP 2010 objectives are described:

The Indian Health Care Improvement Act requires programmatic reporting on progress toward Healthy People objectives to maintain requested levels of funding. In the budget request process for the past 3 years, tribes identified oral health as one of the top five funding priorities for the IHS. The IHS's Division of Oral Health has made $1,750,000 available during the past two fiscal years to fund seven Clinical and Preventive Support Centers as demonstration projects for training and technical assistance to dental programs operated by the IHS, tribes and tribal organizations within the various regions. The support centers can choose a number of activities that address any of the 17 oral health objectives contained in HP 2010. Funded Support Centers include:

- Inter-tribal Council of Arizona
- All Indian Pueblo Council
- Northwest Portland Area Indian Health Board
- Alaska Native Tribal Health Consortium
- Aberdeen Area Indian Health Service
- Oklahoma City Area Office/Inter-tribal Health Board
- Confederated Salish and Kootenai Tribes of the Flathead Nation in cooperation with the Billings Area Indian Health Service.

Oral Health Promotion / Disease Prevention awards. Each year, the Indian Health Service (IHS) Division of Oral Health awards up to $20,000 per program, $100,000 total, to IHS, tribal, and urban programs on a competitive basis for prevention initiatives. Emphasis in the Request for Proposals and on the publicized evaluation form is on fluoridation, access to care, and dental

sealants. During the three years this program has been in existence, 30 initiatives funded through the Division of Oral Health furthered progress toward various HP 2010 objectives.

The IHS Division of Oral Health program objectives drafted in response to the Government Performance Results Act include three general initiatives that foster progress toward meeting or exceeding HP2010 objectives. These objectives are revised each year based on key factors that include immediate past performance, current budget, and constraints brought about by vacancies. In recent years significant increases to access to care and the number of sealants placed have been documented, as well as a limited number of local gains in fluoridation.

Centers for Medicare and Medicaid Services (CMMS)

CMMS funds Medicaid and State Child Health Improvement Programs (SCHIP) and provides federal matching funds to state and local health programs. These funds may help finance a new program or coverage for the expansion of an existing one. In some cases these matching funds may reduce the health costs for general fund dollars. Some suggested opportunities for using Medicaid funds for oral health programs include:

- Medicaid can pay for case management as a medical service or an administrative activity
- Medicaid funds can be linked to Title V monies to cover certain services for children with special health care needs
- Local public health early intervention programs and school districts may enroll as Medicaid providers and receive payment for school-based oral health services, as well as some administrative activities related to outreach, enrollment, coordination of services, and referrals.

Opportunities to Use Medicaid in Support of Oral Health Services is a valuable document available on the HRSA Web site at **www.hrsa.gov/Medicaidprimer**.

Congress

Agency budgets that contain funds for oral health programs and Healthy People projects are dependent on Presidential and Congressional action. Each year a number of bills with oral health implications come before Congress. A good way to track federal legislation that includes potential funding for oral health or HP 2010 activities is through *Thomas Legislative Information on the Internet* at **http://Thomas.loc.gov**.

On October 26, 2002, President Bush signed *Public Law 107-251, the Health Care Safety Net Amendments of 2002,* which reauthorizes the Community Health Center program and the National Health Service Corps, and includes several other provisions significant for oral health and dental care programs.

Foundations

State and local foundation and corporate opportunities can be accessed on each organization's Web site. Sometimes state agencies, primary care associations or other types of umbrella organizations will track and publicize funding opportunities via newsletters, Web sites or listservs. A few major national foundations include a health focus and periodically fund oral health projects.

National Foundations and Resources

Grantmakers in Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the nation's health. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. Formally launched in 1982, GIH is known today as the professional home for health grantmakers, and a resource for grantmakers and others seeking expertise and information on the field of health philanthropy. Although it does not provide direct funding to programs, it is a useful resource for training and for dissemination of grantmaking information.

GIH generates and disseminates information about health issues and grantmaking strategies that work in health by offering issue-focused forums, workshops, and large annual meetings; publications; continuing education and training; technical assistance; consultation on programmatic and operational issues; and by conducting studies of health philanthropy. Additionally, the organization brokers professional relationships and connects health grantmakers with each other as well as with grantmakers in other fields whose work has important implications for health. It also develops targeted programs and activities, and provides customized services on request to individual funders. Further information is available on the Web site at **www.gih.org**.

The Foundation Center is a national independent service organization has over 53,000 private, community, and corporate foundations, direct corporate giving programs, and grantmaking public charities in its database with 1700 links to individual grantmaker Web sites, categorized by grantmaker type and listed alphabetically. The Center also provides educational programs and analyzes trends in foundation growth and giving. Regional offices are located in NY City, Atlanta, Cleveland, San Francisco and Washington, DC. Extensive Web site resources can be found online at **http://fdncenter.org/funding**.

Robert Wood Johnson Foundation's (RWJF) mission is "to improve the health and health care of all Americans." It is the nation's largest philanthropy devoted exclusively to health and health care. To stay up-to-date about RWJF program developments (new ideas and recent calls for proposals) subscribe to the Foundation's free quarterly newsletter, ADVANCES®, read their annual report, or regularly visit their Web site where all new publications and requests for proposals are posted, along with a number of grantee resources and tools (**http://ww2.rwjf.org/index.jsp**).

Two recent initiatives have relevance to oral health objectives and programs. *Pipeline, Profession and Practice: Community-Based Dental Education* is a new $15 million grants program that is designed to help increase access to dental care for underserved populations. Grant funds of approximately $1.5 million were awarded to each of 10 dental schools for five years to develop community-based clinical programs that provide care to underserved populations and to increase recruitment and retention of low-income and underrepresented minority students. See the RWJF web site for a list of grantees.

RWJF also has approved a new $6 million national program, *Improving Access to Oral Health*, to test innovative state approaches to improving access to oral health services for Medicaid, SCHIP, and the uninsured. Under this program, 6 state health departments (Arizona, Oregon, Pennsylvania, Rhode Island, South Carolina and Vermont) were awarded three-year grants of up to $1 million. Grants will support model demonstration projects to test innovative state oral health delivery systems that expand access. This program is managed by the Center for Health Care Strategies located in Lawrenceville, New Jersey.

W. K. Kellogg Foundation The mission of the W. K. Kellogg Foundation is "to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." The searchable grants database is organized around the W. K. Kellogg Foundation's programming interests. The goal of health programming at the W.K. Kellogg Foundation is to improve the health of people in communities through increased access to integrated, comprehensive health care systems that are organized around public health, prevention, and primary health care, and that are guided, managed, and staffed by a broad range of appropriately prepared personnel. Many of these projects are related to achieving the oral health objectives. For example, Kellogg recently made a grant to ADEA to recruit minorities into dental careers.

The Foundation's health programming goal is supported by five strategies to address current health system challenges. The strategies inform policy makers of needed changes in policy and practice; encourage developing models of comprehensive health care based on reorienting services toward public health, primary care and prevention; expand the health work force so that it is more reflective of the racial, ethnic, cultural and geographic makeup of the populations served; increase access, especially for vulnerable populations; and build the capacity of communities to form active partnerships with institutions. Oral health related grant resources and publications can be viewed by searching on "oral health" on their Web site at **www.wkkf.org/grants/default.htm.**

American Legacy Foundation is the national, independent public health foundation established by the 1998 tobacco settlement. The Foundation provides up to $2 million in funds on an annual basis to support unsolicited innovative grants and research demonstration projects that address one or more of Legacy's goals: to reduce youth tobacco use; reduce exposure to second-hand smoke among all ages and populations; increase successful quit rates among all ages and populations. Most of Legacy's grantmaking efforts, however, are through national calls for proposals that provide significant multi-year funding for specific initiatives. See their Web site at **www.americanlegacy.org**.

Oral Health America, America's Fund for Dental Health is a national independent nonprofit organization working specifically to improve oral health. Oral Health America particularly focuses on communicating the importance of good oral health and help sponsor national and community-based solutions to unmet oral health care needs. The organization is especially involved in dental sealant programs, Special Olympics, the National Spit Tobacco Education Program, and promoting community coalitions, especially through their Smiles Across America program. Information about Oral Health America programs can be accessed online at: **www.oralhealthamerica.org**.

Conversion Foundations

Conversions of traditional non-profit hospital and health facilities to for-profit status have had a substantial impact on the field of health care delivery and on philanthropy. A number of new foundations have been created from the sale of non-profit assets—many are now among the largest US philanthropies. See the Foundation Center's *Topical Reading List: Health Conversion Foundations—A Resource List* for more information (**http://fdncenter.org/learn/topical/healthco.html**).

Dental insurance companies (e.g., Delta Dental) or managed health care companies (e.g., Blue Cross/Blue Shield; Kaiser Permanente) may be required by their charters or by state or federal law to donate a portion of their revenues to charitable or public service types of projects. For example, Washington Dental Service Foundation (Delta Dental) (**www.deltadentalwa.com/oral_health/foundation.htm**) has used revenue to support a variety of oral health activities. In Ohio, Kentucky and Colorado, the Anthem Foundation (BC/BS) has been very supportive of oral health activities. The California Endowment, a Blue Cross/Blue Shield conversion foundation, has given over $30 million just to oral health activities, including $15 million for fluoridation.

State and community coalitions will probably be more successful seeking funding from philanthropic organizations that are active in the health care arena in their immediate area or region. Iowa has been able to secure multiple sponsors for its annual "Barnraising" Healthy People conferences, including a grant for $40,000 from the Wellmark Foundation. Oregon secured funding from organizations such as the Oregon Community Foundation and the Portland Area United Way, by using its benchmarks to focus grantmaking priorities. The Connecticut Health Foundation has funded a number of innovative community-based primary and preventive oral health initiatives. The Foundation commissioned a briefing paper on oral health to help them design a framework for funding and an action plan for the next 3-5 years. See their Web site at **www.cthealth.org** for a copy of the briefing paper or examples or funded programs.

Other Philanthropies

United Way of America is a national organization that includes approximately 1,400 community-based United Way organizations. Each is independent, separately incorporated, and governed by local volunteers. United Way partners with various organizations and agencies on specific initiatives. For example, United Way partners with the Bureau of Primary Health Care to expand the number of communities with collaborations working to improve access to health care

and eliminate health disparities. The Mobilization for America's Children® is a call for action by United Way and communities to improve the lives of children, youth and their families. A Birth to Work Agenda was created in 1999 to provide a framework to assist local chapters and their partners to create local and statewide action plans. The various Mobilization initiatives leverage local resources to enhance research-based programs, address systems barriers and mobilize the community. More information about United Way and a list of the community-based partners is available through the Web site at **http://national.unitedway.org**.

Volunteers in Health Care (VIH) is a nationwide, non-profit program established in 1997 as a resource for health care providers looking to organize or expand volunteer-led medical and dental services for the uninsured in local communities. Funded by the Robert Wood Johnson Foundation, VIH offers call-in technical assistance, networking and educational opportunities, seed grants, and other services. Their Web site at **www.volunteersinhealthcare.org** is an online resource for news, tips, notes from the field, publications, tools, and a list of current grant opportunities.

Faith-based organizations play a vital role in community-based health initiatives. For example, Catholic Charities USA is a membership organization based in Alexandria, Virginia. By providing leadership, technical assistance, training, and other resources, the national office enables local agencies to better devote their own resources to serving their communities. Catholic Charities USA promotes innovative strategies that address human needs and social injustices. The national office also advocates for social policies that aim to reduce poverty, improve the lives of children and families, and strengthen communities.

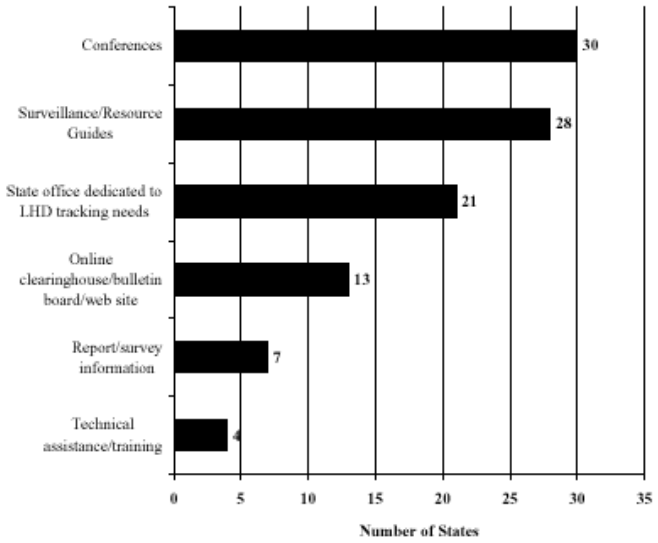
Oral health programs in Kansas have received significant funding from the United Methodist Health Ministry Fund. Their mission is "to be a visible Christian witness of love and concern as we use our resources to minister to those who do not have access to health care; mobilize groups and volunteers to provide health care ministries of healing and wholeness; facilitate health care education and preventive services; and stimulate the development and expansion of innovative programs that improve the delivery of health care." Information on the funds's Oral Health Initiative can be found on their Web site (**www.healthfund.org**).

State and Local Government

Just as certain budget priorities and health outcomes are tied to HP 2010 at the federal level, state and local governments are following suit, especially those that rely heavily on federal funding. Existing resources often are being reallocated to address health objectives, such as in Missouri, New Jersey and Wyoming. For example, Wyoming supplemented carryover funds and human resources for planning with some redirection of discretionary funds to oversee some of the HP 2010 priority areas. The Connecticut Department of Health committed funds for staff and production costs for reports. North Carolina established two foundations that provide funds to counties to implement Healthy Carolinians projects. The Office of Healthy Carolinians alerts counties to requests for proposals and other funding opportunities. Vermont did not have a specific budget for either HP 2000 or HP 2010 planning, but their marketing plan generated enough in-kind support and other local resources to create their HP 2010 plan.

The following graph shows the amount and type of support from state government to local health departments for HP 2000 initiatives.

Fig. 4.1. Number of States that Provided Assistance to Local Health Departments for Year 2000 Initiatives, by Type of Assistance



Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Some branches of state or local government post funding sources on a Web page. For example, the California Rural Health Policy Council Web site includes an extensive list and short descriptions of state, federal, private and other funding sources, with links to each of the organization's Web sites. Ohio's Office of the Attorney General posts funding opportunities.

Oral health activities related to tobacco control can be funded through various state investments. The 2001 CDC publication, *Investment in Tobacco Control* (cited in the Reference list in this chapter and available online at **www.cdc.gov/tobacco**), reports that of the 46 states participating in the Master Settlement against the tobacco industry, 32 appropriated some portions of the settlement dollars specifically for tobacco use prevention and control in FY 2001. Appropriations range from $460,000 to $234,000,000, or from $.10 to $20.69 per capita. Excise tax revenues also are an important source of funding in eight states (Alaska, Arizona, California, Maryland, Massachusetts, Michigan, Oregon and Utah) and generated significant tax revenue through cigarette taxes ranging from $.025 to $1.11 per pack. Forty-five states have an excise tax on smokeless tobacco. In addition, nine states appropriate money from their general revenues to support tobacco prevention and control programs.

Examples of Successful Funding Strategies

African American Health Program-Oral Health Coalition

The African American Health Program's Oral Health Coalition is an arm of Montgomery County Maryland's larger African American Health Program. The African American Health Program (AAHP) was created in 1999, in collaboration with Montgomery County Department of Health Human Services, to develop strategies for eliminating health disparities in Montgomery County. The primary funding sources are the Montgomery County Maryland Cigarette Restitution Fund and the CDC Oral Prevention Grant.

The AAHP Oral Health Coalition membership is comprised of area dentists, community members, county health department representatives, and community-based organizations. The Coalition's primary mission is to promote the benefits and importance of primary prevention and treatment. In addition, the Coalition focuses on providing a positive influence on the knowledge, attitudes, and practices relating to oral health for all African Americans in the county.

The Oral Cancer Screening Program, funded by the Cigarette Restitution Fund, is a county-wide initiative against oral cancer. The program includes oral cancer prevention, education, screening, diagnosis, and treatment and case management for Montgomery county residents. This program targets low-income, uninsured, and minority populations age 40 years or older with special focus on African American men, who have the highest mortality rates from oral cancer. Education includes a presentation of oral cancer severity, symptoms, risk factors, self-examination, and tobacco or alcohol cessation. In 2003, the program provided over 1500 free oral cancer examinations to Montgomery County residents.

The Coalition has conducted various public education and outreach sessions at county dental facilities, community clinics, churches, health fairs, Montgomery County Adult education sites, mosques, homeless shelters, Housing Opportunities Commission (HOC or Section 8) low-income sites, barbershops, historical African American communities, and churches. The most recent oral health education effort—the "Heads Up" Barbershop Health Education Program, began in May 2003 and targets African American men. The program trains local barbers as health ambassadors to educate their clientele about the importance of oral health and cancer prevention.

In 2003, the Coalition coordinated several provider training sessions that focused on the importance of oral cancer screenings and tobacco cessation. The Coalition also planned a county-wide media campaign that included transit, radio, and print advertising that educated over 40,000 people and increased public awareness about the benefits of oral cancer screenings. In addition, a Web site that will include information on oral health and low-cost dental services available to county residents is under development.

Contact: Tina Palmer at tina.palmer@co.mo.md.us

Community Hospitals Support Oral Health in New Hampshire

To fulfill NH Community Benefits legislation, 24 hospitals now have to demonstrate that they provide services in their communities to low-income residents. Three hospitals pursued their charitable mission five years before it was mandated.

Lakes Region General Hospital focused on construction of a state-of-the-art eight-chair dental facility to serve low-income residents in the hospital's service area. Although at first the local dentists were opposed to the construction, some now have begun donating their time providing care in the clinic. Dental residents from Tufts University also rotate to provide care. Children in 22 additional schools will be eligible to receive care through a school-linked program. The Dental Center also received some funding from the NH DHHS as well as other small grants.

Concord Hospital created a community health center within the hospital in 1995 in cooperation with the Dartmouth Medical Residency program to train family practitioners. In response to a community needs assessment, a dental clinic was then added through a $100,000 grant from the NH Community Grants Program. The dental clinic also receives funding from the NH DHHS, and local banks pay for fabrication of full and partial dentures for needy patients.

Exeter Hospital built its Health Reach Children's Dental Center in 2001 to serve insured and uninsured children within the hospital's service area. This is the only hospital-sponsored dental center in NH with a comprehensive payor mix to produce financial sustainability. Local provider response has been fairly positive since they recognize that additional options are needed to treat all children needing preventive and restorative care.

Ways to Maintain Resources

It is not enough to be satisfied with securing resources for a coalition for planning your Healthy People 2010 objectives. More extensive resources and thought are required to implement strategies to fulfill your objectives. Short-term and long-term financial plans are important tools to help accomplish your goals and objectives. One of the mistakes that organizations or groups often make is to keep going back to the same individuals or businesses that have given resources in the past. This is effective on a short-term basis, but becomes less so if people become "burned out" or don't see many tangible benefits from their efforts. Thus, it is very important to keep your partners informed of progress being made.

Tips

- Always share baseline and follow-up reports with all partners.
- Think of new partners in whom you can generate some enthusiasm for your cause.
- Think of "unlikely" partners that you don't normally associate with health care or oral health issues.
- Do not just rely on health professionals! Consider parents who have widely different areas of expertise, school children, college students, elders in retirement communities, the clergy.
- Give people a choice of resources they can contribute.
- Give people a choice of levels of commitment, e.g., "bronze" level sponsor, "silver" level or "gold" level.

Marquette County Health Department Dental program is an example of one program that has continued to build collaborative partnerships since 1993, increasing its budget from $256,000 to almost $1.5 million in 2001. Information on the dental program collaborative partnerships and budget during these years is included in the Resources section.

Many people volunteer their services or make donations because it makes them feel good—they believe they are making a difference and a contribution to their community or to society in general. Methods for recognition and appreciation need to be an integral part of your Healthy People 2010 plan. See pages 5-6 of chapter 6 for examples of ways to recognize and sustain enthusiasm in your members and supporters.

Resources

Chapter 4

- **Links Between Oral Health and Healthy People 2010 Leading Health Indicators**
- **Potential Strategies to Ensure Resources for Planning and/or Implementation**
- ***Plan for Securing Resources***
- **Example of A Plan for Securing Resources**
- **Grantwriting Tips**
- **Grantwriting Glossary**
- **Marquette County Health Department Dental Program, Collaborative Partnerships, Dental Program Development**
- **References**

Links Between Oral Health and HP 2010 Leading Health Indicators

Overweight and Obesity

- Dietary choices, such as frequent consumption of foods that are high in refined sugars, can increase the risk for dental caries. Many of these are eaten as snacks or sweetened beverages.
- General malnourishment impairs normal growth, development and maintenance of the body's tissues and organs and impairs immune responses and wound healing. Reduced resistance of oral tissues to disease can lead to increased colonization by oral pathogens and more sustained and severe oral infections.
- Overweight and obesity raise the risk of illness from Type 2 diabetes, which increases the occurrence and progression of periodontal disease, and sometimes dental caries.

Tobacco Use

- Tobacco use, especially when combined with alcohol use, is the major risk factor for oral and pharyngeal cancers, accounting for 75 to 90% of these cancers in the U.S. (SEER data).
- Smoking increases the risk for periodontal disease and alveolar bone loss, and reduces the rate of wound healing.
- Maternal smoking has been shown to be associated with increased risk for children born with oral clefts.
- Gingival recession is seen in people who use spit tobacco; the prevalence of these and other lesions increases with increasing duration and frequency of spit tobacco use. The sugar content of spit tobacco also creates increased risk for root caries.

Injury and Violence

- Wearing protective mouthguards and headgear during sports can effectively prevent severe injuries to the face and mouth.
- In 1997 and 1998, there were 2.9 million visits to emergency departments from all age groups related to tooth or mouth injuries. Twenty-five percent of these were in children under the age of four. (NCHS 1997)
- Twenty-five percent of all persons age 6 to 50 have had an injury that resulted in damage to one or more anterior teeth. (Kaste et al, 1996)
- The leading causes of head and face injuries include falls, assaults, sports injuries and motor vehicle collisions.

Responsible Sexual Behavior

- Some STDs are transmitted via personal contact or indirect contact with saliva and blood, and some STDs have associated oral lesions that can be detected on oral examination.

Gonorrhea, syphilis, trichomoniasis, chlamydia, mononucleosis, HPV and sometimes HIV can be spread via oral sexual contact.

Substance Abuse

- Alcohol use during pregnancy can lead to birth defects such as fetal alcohol syndrome, which results in significant craniofacial defects and mental retardation.

Access to Health Care

- Approximately 108 million (45%) adult Americans have no form of dental insurance. (NHIS 1995)
- Dental coverage for adults is optional in Medicaid; in about 18 states no services or only emergency services are available for adult dental care. (OIG 1996; GAO 2000)
- Thirty-six percent of U.S. children (23 million) had no dental coverage in 1995. (NHIS)
- Only about 20% of Medicaid-eligible children received any preventive dental services. (HCFA)
- Less than 5% of the dollars spent on dental care is paid by public dollars. About 48% is paid out-of-pocket by individuals, and about 47% by private insurance.

Most statements have been taken or adapted from *Oral Health in America: A Report of the Surgeon General.*

Important to Explore (✓)	Priority	Potential Strategies to Ensure Resources for Planning and/or Implementation
		Request legislators to appropriate additional funds to implement priority activities based upon state-plan objectives.
		Private and public partners create a non-profit organization to raise and distribute funds for Healthy People initiatives.
		Ask public agencies to voluntarily adopt policies to focus their current human and financial resources on priorities or certain objectives.
		Ask private groups to voluntarily redirect current program resources to address health objectives.
		Encourage legislators to evaluate budgets against the plan's priorities.
		Use policy and regulation to focus private sector and public sector efforts on priorities in the plan.
		Ask private foundations to consider state public health priorities when developing grant making programs and awarding funds.
		Request private organizations to provide technical assistance, leadership, administrative support, and donated services to planning efforts, programs, and policy initiatives.
		Require local health departments or community agencies to address health objectives as a condition of using certain public funds. (Recipients choose which objectives to address.)
		Earmark state funding for particular Healthy People activities, objectives, or strategies in the plan, in order to ensure certain priorities are addressed.
		Request local and state health agencies contribute in-kind resources such as personnel to planning efforts.
		Set aside state funding and technical assistance resources to help local jurisdictions with planning efforts.
		Charge dues to organizational members of the state Healthy People coalition.
		Apply for private or public grants to support Healthy People efforts.

Source: Healthy People 2010 Toolkit

A Plan for Securing Resources

Resources Needed	Potential Source	Strategy	Goal	Contact Information	Timeline	Who Responsible	Outcome

Example of a Plan for Securing Resources

Resources Needed	Potential Source	Strategy	Goal	Contact Information	Timeline	Who Responsible	Outcome
Meeting facilities	Community Center	Meet with Director	Waive facility charge for monthly meetings	Donald Acre 850-756-8230	7/01	Jim S	
Announce meetings and feature stories	Local Newspaper	Meet with editors	Free mtg announcement and monthly feature stories	Gary Slade 850-989-0243	8/01	Tracy T	
Instruments, supplies, students for screenings	Dental School	Meet with Community Dentistry Dept Chair	Free supplies and student time with supervisors for 5 screenings	Judy Siegal 850-222-4586	10/01	Roberta B	
Funding for coalition	Cecil Foundation	Grant proposal	Funds for coalition coordinator and meeting facilitator	Toby Grant 875-798-7621	6/01 draft for coalition review 7/01 submit to foundation	Jody M and Terry H	
Computer equipment	Computer Company	Letter	Free or reduced prices on computer and printer	Marianne Hunt 156 Pace Street San Jose, CA 86210	7/01	Naomi J	
Beverages	Joe's Coffee		Beverages for coalition meeting	Joe Deland 850-224-6906	9/01	Ted T (friend)	
Epid TA and data	State Health Department Epidemiology Section	Develop letter of need; meet with Division Director	Data reports and 20 hrs of TA from Division staff	Barbara Hodges 856-224-1436	10/01	Brad S	
List of businesses	Chamber of Commerce	Phone call	Some type of support from at least 50% of businesses	850-889-5862	9/01	Carol M	

Grantwriting Tips

- Carefully read the RFP several times and highlight what the funder wants in a proposal
- Make sure your agency fits the eligibility requirements; do not waste your time or theirs on inappropriate requests
- Determine if the request and funding amounts meet your needs—are they a good fit?
- Follow the guidance, using the same major categories as in the RFP
- Write the proposal in a clear, direct, honest, logical, and compelling style
- Avoid jargon and define all technical terms
- Ensure that each section builds on previous sections and make a smooth transition
- Make sure your information, especially data, is internally consistent
- Adhere to overall and subsection page limitations; more is <u>not</u> better
- In the agency description, assume the funder knows nothing about your program or a particular issue; concisely describe your structure, programs and track record in meeting community/constituency needs, as well as the reasons for why you propose to address a particular issue
- Make objectives specific, measurable, included within a timeframe, and realistic
- Do not propose more than you can deliver
- Do not overstate your case or the need for the project
- Use local or state data whenever possible
- Put a face to any facts—personalize the issue and use examples
- Make evaluation section strong and focus on outcomes
- Include a clear timeline by month or quarter
- Create a budget that is clear, realistic (not padded); follow the RFP suggested format and categories, and include specific in-kind and other support
- Make sure the budget reflects the needs you described in the proposal
- Make sure that letters of support are not a template that everyone uses; they should be customized and say exactly <u>how</u> the organization intends to support your project, not just that "they will support it." Also, these letters should come from the director, president or other head of the organization.
- Include short (1-2 page) resumes rather than long CVs
- Be judicious about materials you include in an appendix
- Have a number of people review the final draft; the primary writer often is too close to it to notice inconsistencies, gaps, etc.

Grantwriting Glossary

Most of these terms and definitions are taken from The Foundation Center's Glossary at www.fdncenter.org.

Annual report: A voluntary report issued by a foundation or corporation that provides financial data and descriptions of its grantmaking activities. Annual reports vary in format from simple typewritten documents listing the year's grants to detailed publications that provide substantial information about the grantmaker's grantmaking programs. The term is also used to describe the report required of a grantee at the end of each year of a multi-year grant awarded by any type of grantmaker.

Capital support: Funds provided for endowment purposes, buildings, construction, or equipment.

Challenge grant: A grant that is paid only if the donee organization is able to raise additional funds from other sources. Challenge grants are often used to stimulate giving from other donors.

Cooperative venture: A joint effort between or among two or more grantmakers. Cooperative venture partners may share in funding responsibilities or contribute information and technical resources.

Encumbered funds: Monies that have been reserved for a specific purpose via a contract, purchase order, or other financial mechanism, to preclude their being spent in another manner.

Endowment: Funds intended to be invested in perpetuity to provide income for continued support of a not-for-profit organization.

Federated giving program: A joint fundraising effort usually administered by a nonprofit "umbrella" organization that in turn distributes the contributed funds to several nonprofit agencies. United Way and community chests or funds, the United Jewish Appeal and other religious appeals, the United Negro College Fund, and joint arts councils are examples of federated giving programs.

501(c)(3): The section of the tax code that defines nonprofit, charitable (as broadly defined), tax-exempt organizations; 501(c)(3) organizations are further defined as public charities, private operating foundations, and private non-operating foundations.

Form 990-PF: The public record information return that all private foundations are required by law to submit annually to the Internal Revenue Service.

General/operating support: A grant made to further the general purpose or work of an organization, rather than for a specific purpose or project; also called an unrestricted grant.

Grassroots fundraising: Efforts to raise money from individuals or groups from the local community on a broad basis. Usually an organization's own constituents — people who live in

the neighborhood served or clients of the agency's services — are the sources of these funds. Grassroots fundraising activities include membership drives, raffles, auctions, benefits, and a range of other activities.

Guidelines or guidance: Procedures set forth by a funder that grantseekers should follow when approaching a grantmaker.

PA: An acronym for Program Announcement. It announces increased priority and/or emphasizes particular funding mechanisms for a specific area of science; applications accepted on standard receipt dates on an on-going basis.

Query letter: A brief letter outlining an organization's activities and its request for funding that is sent to a potential grantmaker in order to determine whether it would be appropriate to submit a full grant proposal. Many grantmakers prefer to be contacted in this way before receiving a full proposal.

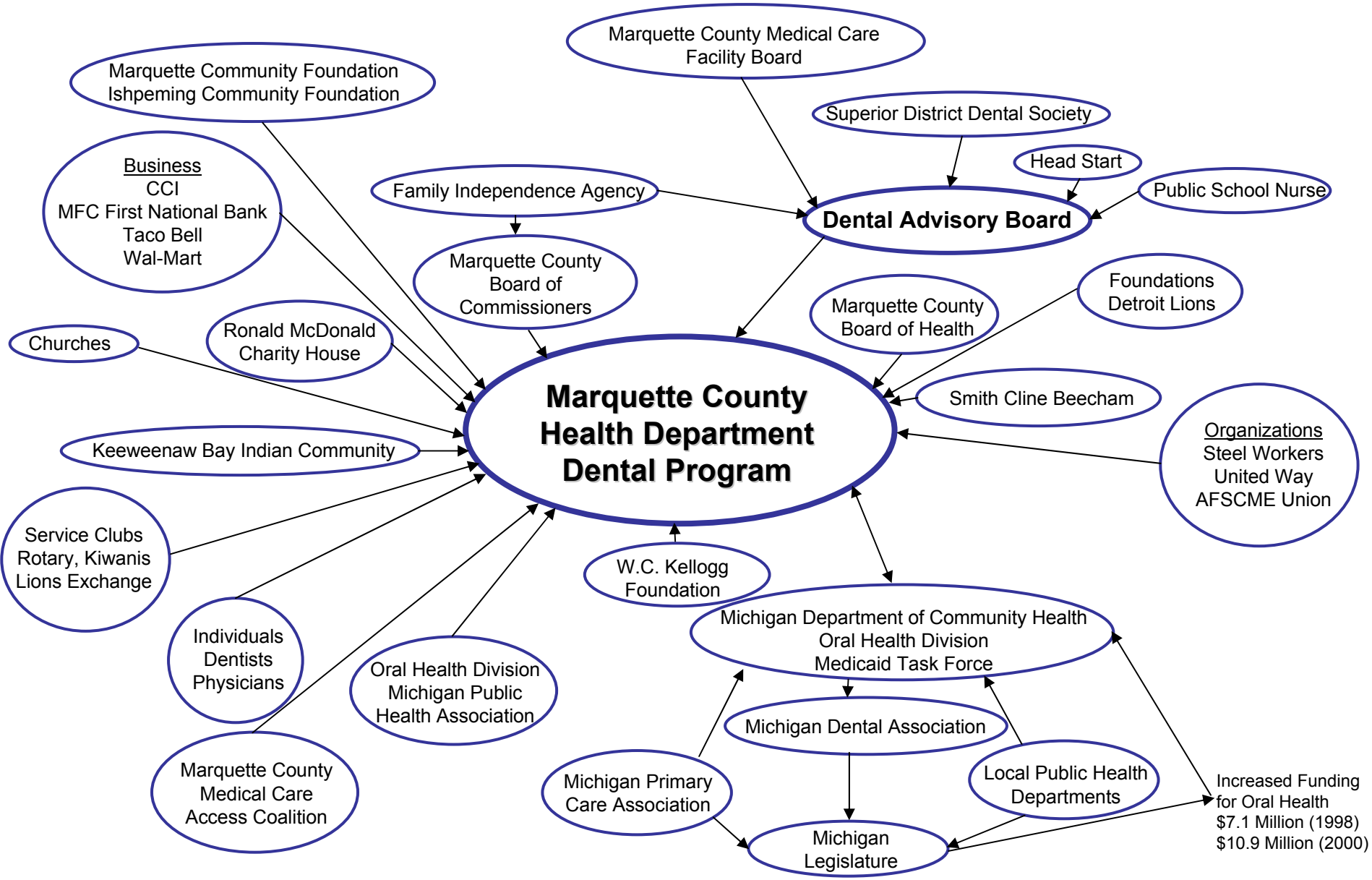
RFA: An acronym for Request for Applications. It identifies a more narrowly defined area for which one or more NIH institutes have set aside funds for awarding grants; one receipt date, specified in RFA.

RFP: An acronym for Request for Proposal. When the government issues a contract or grant program, it sends out RFPs to agencies that might be qualified to participate. The RFP lists project specifications and application procedures. While a few foundations occasionally use RFPs in specific fields, most prefer to consider proposals that are initiated by applicants.

Seed money: A grant or contribution used to start a new project or organization. Seed grants may cover salaries and other operating expenses of a new project.

Technical assistance: Operational or management assistance given to organizations or potential grantees. It can include fundraising assistance, budgeting and financial planning, program planning, legal advice, marketing, and other aids to management. Assistance may be offered directly by the staff of a foundation, corporation, or government agency, or it may be provided in the form of a grant to pay for the services of an outside consultant.

Collaborative Partnerships



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Chapter 5

Promoting HP 2010 Oral Health Plans and Activities

This chapter will cover:

6. **Developing promotional/marketing plans**
7. **Specific communication strategies for Healthy People 2010 plans and activities, including Web sites, listservs, conferences, newsletters and media coverage**
8. **Media advocacy tips and examples**
9. **Formatting ideas for marketing and publishing HP 2010 oral health plans and materials**
10. **Resources for learning more about health communication programs and strategies.**

Any Healthy People 2010 plan is meant to be a "living entity"--an active plan for involving anyone who wants to play a role. It is not meant to be just a written document that sits in a bookcase or is used by only a few individuals. To infuse a plan with life requires making it interesting, relevant to people's lives, understandable, doable, and capable of motivating people to action. Capturing the public's attention in an era of information overload and global coverage, however, is a major challenge. The ideas discussed in this chapter are meant to be starting points that trigger innovative ideas to use in your own community, tribe, territory or state.

Tips

- Enlist champions and advocates early in the planning process to market your HP 2010 plan.
- Enlist the expertise of marketing and communications professionals.
- Identify how and when you want to promote the plan to potential audiences.
- Think of your promotional efforts in terms of "selling points."
- Clearly define what you want people to do with the plan.
- Identify key messages and incorporate them into promotional materials and presentations.
- When designing key messages, review the information collected during the needs assessment phase to address people's priorities and interests.
- Think about how to personalize the issues to capture people's attention.
- Communicate key messages in different formats and languages.
- Keep in mind that a picture is worth a thousand words.

Health Communication

> "Health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health… Communication occurs in a variety of contexts; through a variety of channels with a variety of messages; and for a variety of reasons. One of the main challenges in the design of effective health communication programs is to identify optimal context, channels, content and reasons that will motivate people to pay attention to and use health information."

Communication can be thought of as the "conveyor belt of interaction." As noted in Chapter 2, communication strategies and the speed of information dissemination are constantly changing with advances in technology. Information is a critical element of informed participation and decision making. Health communication, media advocacy and social marketing strategies are becoming more sophisticated and are assuming a greater role in efforts to improve health outcomes. Health communication has emerged as a separate Focus Area (#11) in the national Healthy People 2010 objectives (view chapter online at **www.health.gov/healthypeople/Document/tableofcontents.htm#volume1**.) Before embarking on designing and implementing health communication strategies to disseminate your HP 2010 plan and activities, however, you will need to develop a promotional/marketing plan.

Developing a Promotional/Marketing Plan

Increasingly, health professionals are turning to the field of social marketing to develop and implement health promotion plans. Social marketing is a technique that has been used since the 1970s to increase public awareness of the relationship of behaviors to diseases and to influence people to take action. This is an important mechanism for emphasizing the link between oral health and general health, and how certain health behaviors can prevent oral diseases.

According to Edmonds and Fulwood (see reference on page 25 of the Resources section for this chapter), the goals of a social marketing strategy are to 1) increase awareness of a problem; 2) convey a message that the problem can be solved; and 3) describe the solutions. Social marketing uses five basic public health steps:

- learn about your target audience
- plan your health messages, communication channels and timeline
- shape your messages so they are relevant to your audience, and pretest them
- implement your plan—deliver the messages
- evaluate the effectiveness in trying to change behavior.

These steps can and should be reinforced by other strategies such as policy initiatives, legislation, funding and programs.

A recent study by Sorien and Baugh (see reference on page 25 of the Resources section for this chapter) of almost 300 government policymakers (legislators, legislative staff, and executive managers of health agencies) found that these officials are inundated with information that they must review and digest to make funding and policy decisions. The researchers estimated that about one half of this information is not relevant to their current work. All policymakers did not

have the same information needs, but most preferred that information be presented in a concise 1-2 page format that summarizes in non-technical terms the main issues or research relevant to legislative policy and recommendations. Preferred format was short bulleted lists with explanatory tables, charts or graphs. Staffers, however, needed more detailed information appended to the summary. In general, older policy officials preferred printed materials, while younger ones were comfortable accessing electronic information.

Information resources and studies such as these are valuable for creating a HP 2010 marketing plan. The following marketing tools from the chapter on Communicating Health Goals and Objectives in the *Healthy People Toolkit* are included in the Resources section and also can be downloaded from the Healthy People Web site, (**http://health.gov/healthypeople**):

- Simple Market Research Strategies
- Sample Market Research Questions
- How to Develop a Marketing Plan
- Evaluate Your Marketing Plan.

Healthy Delaware Marketing Objectives is available online in the State Healthy People 2010 Tool Library at **www.phf.org/HPtools/state.htm**.

An excellent CD ROM and training course produced by the Centers for Disease Control and Prevention and facilitated by trainers from the Society for Public Health Education, is *CDCynergy.* This is a multi-media CD ROM used for planning and managing health communication programs. This tool can assist teams in generating comprehensive health communication programs, placing them within a larger public health framework, and incorporating accountability and evaluation. There is no specific tailored version for oral health yet, although there is for cardiovascular disease, diabetes, immunization, tobacco use prevention, and micronutrients. For more information see **www.cdc.gov/cdcynergy**.

All of these tools will help you gather additional information and use the information to develop a promotional/marketing plan. They provide a general framework that can be adapted for oral health plans.

Specific Strategies to Communicate About HP 2010 Plans

One-dimensional communication approaches are ineffective for achieving HP 2010 oral health goals and objectives. Successful initiatives rely on multi-dimensional interactions to reach diverse audiences. Although diversity usually is defined by social and demographic variables such as race, ethnicity, age, gender and socioeconomic status, behaviors *within* groups using these classifications often are as heterogeneous as those *among* the groups.

> A recent publication by the Institute of Medicine suggests that communication programs need to focus on more meaningful ways to describe differences in populations. "Specifically, they should focus on cultural process, on understanding the life experiences of the communities and individuals being served, and on the sociocultural environment of individuals within the population to be reached."
>
> IOM, *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations, Executive Summary,* pg 9, 2002.

Involving individuals from the community who have specific knowledge about cultural characteristics, health behaviors, language preferences, and preferred media channels of community members is crucial when developing messages and marketing plans. Public-private partnerships and collaboration can help identify and leverage appropriate resources and strengthen the impact of your efforts. Various channels used for disseminating or acquiring HP 2010 information will be discussed in detail before giving tips on creating specific messages. An excellent summary of the pros and cons of various communication channels and activities is presented in the National Cancer Institute publication, *Making Health Communication Programs Work,* (Available online at **http://oc.nci.nih.gov/services/HCPW/HOME.HTM** and downloadable from **www.cancer.gov/pinkbook.** Print or CD-ROM copies can be ordered online at **http://cancer.gov/publications** **or** by calling 1-800-4-CANCER (1-800-422-6237)).

Web Sites

The Internet is an excellent vehicle for communicating information to a broad audience, providing regular updates, highlighting activities, linking users to other resources, and gaining feedback on proposed activities or plans. Research is needed in each community, however, to determine if information should be provided in more than one language, and which groups will be missed by using an electronic communication medium. Do not assume everyone has Internet access. Some people are intimidated by, prefer not to use, or cannot afford electronic forms of communication.

All of the national Healthy People materials published since 1995 are available on the national Healthy People Web site at **www.health.gov/healthypeople**.

A number of states have posted their Healthy People 2010 Plans on their state health department Web site or a separate Web site dedicated to Healthy People activities. An updated list of the state Web sites is maintained on the Healthy People Web site. Examples of ways that some of these sites are formatted or used follow.

- North Carolina's Web site, *Healthy Carolinians*, (**www.healthycarolinians.org/healthobj2010.htm**) includes the following items in its site map:

  - ✓ NC 2010 Health Objectives
  - ✓ County Profiles
  - ✓ Certification Process
  - ✓ Governor's Task Force
  - ✓ Office of Healthy Carolinians
  - ✓ Community Assessment
  - ✓ Training and Resources
  - ✓ Conference Information
  - ✓ Web Links.

  The Web site's User's Guide provides an overview of the process, criteria, and definitions used for developing the objectives, describes the difference between

measurable objectives and developmental objectives, includes notes on the standard data tables and sources of data, and discusses target-setting methods. The six health goals are described, and chapters for the individual focus areas are accessed separately from a dropdown menu.

- Maryland's Health Improvement Plan (**www.cha.state.md.us/ohp/html/hip.html**) includes a useful section that discusses the question, "What is public health?" Data and other information are presented by state and county for each focus area, including oral health. Objectives and action steps are also presented.

- Vermont uses a concise format to highlight its oral health objectives (see pages 6-7 of the Resources section for this chapter). In addition to the HP 2010 Plan, Vermont's Web site (**www.HealthyVermonters.info/admin/pubs/hv2010/hv2010.shtml**) includes a personal letter to Vermonters from the Commissioner of Health, emphasizing that HP 2010 is everyone's plan and thanking all of the volunteers who continue to contribute to its success.

- Alaska has a large chapter on oral health (**www.hss.state.ak.us/dph/deu/ha2010/PDFs/13_Oral_Health.pdf**) that discusses oral health status and disparities related to dental caries, periodontal disease, edentulism, cleft lip and palate, oral cancer, fluoridation and fluorides, and sealants, as well as provider issues, strategies and resources for addressing needs, and data issues. Volume II of Alaska's strategic plan (**www.hss.state.ak.us/dph/deu/ha2010/volume_2.htm**) addresses the targets and indicators in Volume I through 14 stories of community-based efforts for public health improvement.

- Minnesota (**www.health.state.mn.us/strategies/index.html**) uses charts and examples of strategies, discusses evidence for each strategy and potential benefits of reaching the objectives. Minnesota uses a Q & A (question and answer) format.

- People and organizations in two counties where Fargo, North Dakota and Moorhead, Minnesota are located have formed a collaborative known as Healthy Communities Without Borders. They have launched a health data/education Web site using HP 2010 as the information framework. The Web site (**www.hcwb.org**) is administered from North Dakota's state data center.

> The Internet is a visual medium, so writing for Web sites is different than writing reports that are primarily narrative text. Reading on-line is not as easy as reading printed text. Web site users are more likely to scan documents quickly, so the Web site needs to be graphically interesting and easy to navigate. Anything that helps people scan quickly also improves readability. Too many graphics, however, will increase the time it takes to access each page.

The primary language of population groups you want to reach will affect how useful information presented on an English-only Web site will be. Some Web sites allow users to select language

options, while others are created entirely in a specific language such as Spanish. Data from the 2000 US census indicate that Hispanics are now the largest minority group in the United States, and many recent immigrants or older individuals still do not read English. A recent analysis of reading levels of Web sites devoted to presenting health information to the public showed that those in English were written at a collegiate level, while Spanish language sites were geared to a 10th grade reading level (see Berland citation on page 25 of the Resources section for this chapter). Both of these are far above the levels of 6th-8th grade recommended by many professionals who work in the field of health literacy. Some Web sites have addressed this problem by creating a "public" area and a separate area for "health professionals," with the information written and tailored differently.

Two excellent resources for writing on the Web are:

- **www.eeicommunicate.com/eye/links.html** includes articles on writing and editing, especially on utilizing the Web
- **www.usability.gov/methods/collecting_writing.html** covers methods for designing readable Web sites.

Tips on Writing for Web Sites

- Be concise—try to chunk information to fit on one screen so the reader will not have to scroll down the screen.
- Provide a single sentence overview to a page to help readers decide if they want to click on that page.
- Put the most important information in the first sentence or paragraph.
- Write useful headings and subheadings to guide the reader.
- Highlight key phrases in boldface or in a different color.
- Substitute bulleted lists to break up text of long paragraphs.
- Avoid jargon and abbreviations.
- Use white space to avoid a cluttered, dense look.
- Use hypertext links to other parts of the document, the Web site, or other Web sites.
- Do not get carried away with graphics that clutter the page and confuse the user.
- Keep in mind that graphics require a lot of memory and frustrate users who have slow Internet access or limited memory in their hard drive or printer.
- Offer a "printer-friendly" version of the Web page.

Adapted from Writing for the Web. Chronic Disease Notes & Reports. 14(2):14-16, 2001.

Conferences

Conferences are an excellent method to bring a diverse group of people together to present information and discuss strategies. Such meetings are conducive to a variety of formats such as oral presentations, keynote addresses, panels, roundtable discussions, posters, brainstorming

sessions, workgroups, and informal networking. Some states use satellite conferencing technology to enable people in rural or geographically dispersed communities to participate. Town hall meetings are another useful method for gaining community input in a number of sites. When planning conferences, consider the special needs of some attendees, such as accessible facilities for disabled attendees, sign language interpretation and translation services.

Many states have launched their draft or final HP 2010 Plan or their Oral Health Plan with kick-off events or conferences.

- Alaska held a kick-off event, *Healthy Alaskans 2010: Hitting the Targets,* in December 2000 with over 120 people attending. Attendees received an update on the status of the target-setting process, gave feedback on the draft indicators and targets selected by chapter leads and committees, and identified priorities and strategies to improve the health of Alaskans in the upcoming decade. As individual chapters were posted on their Web site, the public could provide additional feedback via the Web site.

- Illinois held a number of community input sessions and a brief dental summit to present its draft statewide oral health plan. The state has have since created follow-up strategies to implement the plan.

A number of states hold Healthy People conferences annually or periodically.

- North Carolina marketed its 10th Annual Carolinians Conference for October 12, 2001 on its Web site with on-line registration.

- Iowa periodically holds *Barn Raising* conferences that focus on different aspects of keeping people in Iowa healthy. *Barn Raising II* held in June 1999 brought together 700 public health and community leaders to solicit input into the state HP 2010 plan and to assist participants in developing local plans. *Barn Raising III* in June 2001 paired national experts with local health practitioners and consumers who had been successful in initiating programs with positive, measured outcomes. This conference was also available nationally and internationally via Webcast.

Many national and regional health conferences have sessions devoted to HP 2010 or weave the HP 2010 theme into a variety of sessions.

- The annual National Oral Health Conference (sponsored by ASTDD and AAPHD) and the American Public Health Association annual meeting generally include sessions on HP 2010.

- In December 2001 an oral health workshop, *Building Healthy Communities, States and a Nation through Partnerships,* was held in Washington DC. Numerous states and communities highlighted their collaborative efforts to accomplish HP 2010 oral health objectives.

- Community-Campus Partnerships for Health holds annual conferences, with a number of sessions devoted to HP 2010 projects and use of the new curriculum planning guide *Advancing the Healthy People 2010 Objectives Through Community-Based Education* (see reference on page 25 of the Resources section for this chapter).

Listservs

Listservs are an excellent way to disseminate information in a timely manner to a large target group. They also are useful for distributing minutes, announcing meetings, sharing resources, discussing issues and soliciting feedback. Listservs can easily be expanded to include new members. Someone needs to be responsible for maintaining and monitoring any listserv for it to be credible and current. One listserv that sometimes includes discussions or announcements regarding HP 2010 oral health activities is the dental public health listserv. Individuals can join this listserv by sending an email message to: **Majordomo@list.pitt.edu**. In the BODY of that message (not the subject line) type the following message: subscribe dental-public-health (The message must be typed exactly as shown here, including the hyphens between the words).

Newsletters

Newsletters provide a regular mechanism for reaching a defined audience and are relatively inexpensive to produce, but require maintenance of mailing lists if the newsletter is not just posted on a Web site.

- CDC's Office of Disease Prevention and Health Promotion publishes a quarterly newsletter on the Healthy People Web site for HP 2010 Consortium members to share news about their prevention activities related to achieving the nation's health objectives.

- Maryland publishes a quarterly oral health newsletter that discusses HP 2010 plans and other oral health activities; it is available on Maryland's Web site (**www.cha.state.md.us/ohp/html/hip.html**).

- North Carolina publishes *Communities in Action,* a newsletter for members of Healthy Carolinians, and produced through a partnership with the State Center for Health Statistics and the Office of Healthy Carolinians. It is posted on North Carolina's Web site along with regional news and monthly email news (**www.healthycarolinians.org/healthobj2010.htm**).

- Some statewide oral health newsletters may not be available on Web sites but programs will add individuals or agencies to the mailing list. Check the state oral health Web sites on the ASTDD Web site (**www.astdd.org**).

Media Coverage

A variety of public media channels are available to disseminate information about HP 2010 and oral health.

- Local TV or radio stations offer public affairs talk shows, some of which may be specifically focused on health issues. Try to contact a producer at least one month in advance of when you would like your piece to air, and prepare a short written summary of the main points you would like to make.

- Public Service Announcements (PSAs) for TV or radio can be effective for delivering messages if aired at the time when the target audience is listening. Paid PSAs versus those aired for free usually have better placement. PSAs generally are one minute or less, so choosing the words and visuals is crucial. Field-testing each of the planned PSAs with members of the target audience is extremely important. Bill Cosby has been featured/cast in a number of PSAs for Healthy People 2010, including one on oral health (**www.healthypeople.gov/Implementation/billcosby.htm**).

- Press conferences often are scheduled to draw attention to a major conference, successful programs, or release of a report. The downside of using this method is that reporters may chose not to attend, or there may be many competing stories that day.

Tips for Press Conferences

- Hold it in a unique setting and use audiovisuals to gain attention.
- Send an initial press release to each local station's assignment desk, describing the significance of the press conference.
- Make the event short and have the primary speaker available for one on one interviews afterward.
- Have fact sheets and background information available.

- If you do not want to stage a press conference, press releases are a good alternative. Press releases can be used to announce an upcoming meeting and its importance or to report on health disparities or progress made in achieving objectives and reducing disparities. More details about formats of press releases are included in the Resources section.

Tips for Press Releases

- Develop a list of news media and contacts for sending specific types of press releases.
- Determine how editors prefer to receive the information—electronically, fax, or mail.
- Send the press release well in advance of an event you want to highlight.
- Include at the top: Who, what, when and where, with contact person information.
- The headline is the most important part; it needs to engage the reader.
- The press release needs to be brief, concise and well-written; a busy reporter won't read past the first few paragraphs to make a decision.
- Discuss why the public should be interested; it needs to be compelling.
- Use active verbs in the present tense, if possible.
- Use one or two quotes to lend credibility (use respected person) or reality (use parent or someone affected by the issue).
- Be clear about what actions you are recommending or what dates and timelines you want to communicate.
- If anyone in the coalition knows a reporter personally, ask them to contact the reporter directly.

Source: Baker, Lois. How to Write a Press Release. Roundtable at American Medical Writers Assoc Annual Meeting, San Diego, CA, October 2002.

Pitfalls to Avoid with Press Releases

- scientific jargon and not explaining scientific or health concepts
- missing the main point
- not knowing the target audience
- including too much or too little information
- improper reporting or analysis of statistics.

Source: Baker, Lois. How to Write a Press Release. Roundtable at American Medical Writers Assoc Annual Meeting, San Diego, CA, October 2002.

- Another option is to write letters to the editor. Remember that editors receive hundreds or thousands of these, and the impact of the letter may be limited. It is much more effective to write a letter directly to reporters, columnists, and news managers to get their attention about your HP 2010 or oral health issues. One Web site (**www.americanreview.net**) suggests being "cool, astute, professional, succinct and persistent" in this type of letter.

Media Advocacy

> ***"Media advocacy is the strategic use of mass media to support community organizing to advance a social or public policy initiative."***
>
> **Berkeley Media Studies Group**

Media advocacy is a useful strategy for advancing HP 2010 objectives to the implementation and policy stages. Media advocacy moves the focus from health behaviors of individuals to the behaviors of policy makers who make decisions that affect the environment in which actions occur. Media advocacy organizes activities around two interrelated concepts:

- framing for access: shape the story to get attention and gain access to the media
- framing for content: tell the story from a policy advocacy perspective.

The Berkeley Media Studies Group provides the following tips for media advocacy.

Framing for Content

- Translate individual problem to social issue
- Assign primary responsibility
- Present policy or solution
- Make practical appeal
- Develop story elements

Newsworthiness

- Controversy, conflict, injustice
- Irony or uniqueness
- Population of interest
- Significance or seriousness
- A breakthrough or milestone
- Good pictures

General Issues

- Public health issues are matters of life and death and are too important to be left to public service time slot; invest in paid or sponsored advertising
- Media advocacy focuses on policy because we want to create healthy and safe environments
- You need to monitor what's in the media and develop a press list
- You can create news and use breaking news.

The *Watch Your Mouth* Campaign, produced by the Citizens Watch for Kids' Oral Health with support from the Washington Dental Service Foundation and the Annie E. Casey Foundation, is a good example of a media advocacy program focused on oral health. This campaign was based on marketing research conducted by the Frameworks Institute that showed how to "reframe" oral health issues to make people 1) connect oral health to general health; 2) prioritize oral health as an important health issue; 3) assign responsibility for the development of dental problems to

systems rather than primarily to parents; and 4) believe that there are systemic solutions to the problems.

The campaign has chosen key messages and media channels that:

- emphasize prevalence of the problem
- explain severity of the problem
- identify consequences of the problem
- underscore the efficacy of prevention in solving the problem
- mainstream the issue.

Examples of their materials and an overview of "framing the issue of oral health for the public" can be viewed at **www.KidsOralHealthWatch.org**. Evaluations to date have shown such success in increasing access to preventive and restorative services. Other communities are replicating this model.

To create a strong media plan, invite people who are connected to the media to participate in the HP 2010 planning committee or an oral health coalition advisory committee. For more information on media advocacy see the Reference list (see Wallach citation on page 26 of the Resources section for this chapter).

Options for Formatting Information

The way that information is formatted is crucial to how people will see and understand the messages. Not everyone wants to read a detailed report, especially if most of it is text and complicated graphs. Even highly educated readers appreciate formats that are concise, easy and quick to read, colorful, and include a variety of photos and graphics. Computer software programs and Internet access to "public use" graphics have made it easy and inexpensive to design materials that fit these criteria.

Research in the area of health literacy has provided valuable information about ways that people learn and apply information. Interesting findings from the 1992 National Adult Literacy Survey showed that about one-half of adults in the U.S. have difficulty:

- reading graphs and tables
- interpreting instructions
- reading and comprehending health information
- completing medical history, informed consent and insurance forms.

Other research findings show that people with low literacy skills, in comparison to those with higher literacy skills:

- have poorer overall health
- are less likely to make use of screening services
- present with later stages of disease

- are more likely to be hospitalized
- have poorer understanding of treatment needs
- have lower adherence to medical regimens. (*Source: Rima Rudd, presentation at APHA, Oct 2001*)

All of these findings suggest that we need to get the HP 2010 information to diverse groups in the population, especially the "underserved and uninsured" populations, many of whom are recent immigrants and experience language or literacy problems. For more information on health literacy and creating easy-to-read materials, go to the Web site at **www.hsph.harvard.edu/healthliteracy**.

Other resources for designing and formatting materials include:

- *Scientific and Technical Information, Simply Put*, published by the Centers for Disease Control and Prevention (see reference on page 25 of the Resources section for this chapter). Selected pages from this booklet are included in the Resources section to highlight tips for the following areas:

  ✓ text appearance
  ✓ visuals
  ✓ layout and design
  ✓ translation.

  *Also included is a checklist for easy-to-read print materials.

- National Cancer Institute, *Making Health Communications Work,* is a comprehensive approach to planning, conducting and evaluating health communication programs. It includes resources, tips, worksheets, and samples, and reviews planning frameworks, social science theories, and models for change. This publication is available online in Adobe PDF file format at **http://cancer.gov/pinkbook** and also can be ordered as a CD ROM from **https://cissecure.nci.nih.gov/ncipubs/details.asp?pid=1138**

- HRSA has created a number of fact sheets on oral health that serve as information and advocacy pieces. Many of these can be downloaded from the Web site **www.mchoralhealth.org**.

- For those who want to understand and present data and statistics in a valid way using charts and graphs, Web sites such as the Pennsylvania Department of Health's Health Statistics Technical Assistance, Tools of the Trade at **www.health.state.pa.us/stats/** are extremely useful.

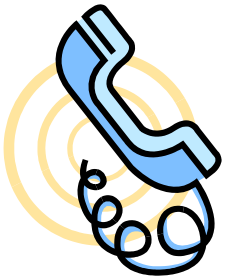
Resources

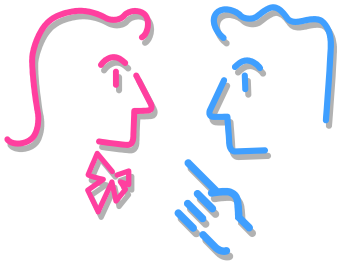
Chapter 5

- Simple Market Research Strategies
- Sample Market Research Questions
- How to Develop a Marketing Plan
- Evaluate Your Marketing Plan
- Vermont's HP 2010 Oral Health Chapter
- Formatting Press Releases
- NCI - Communication Channels and Activities: Pros and Cons
- Scientific Information, Simply Put, Selected Pages
  - Text Appearance
  - Visuals
  - Layout and Design
  - Tips on Translation
  - Checklist for Easy-to-Read Print Materials
- References

Simple "Market Research" Strategies

Learning the needs, desires, and preferences of the target audiences does not need to be time consuming. Whether this learning takes place at the water cooler or from a marketing consultant, the point is to know your audience. Below are some of the many ways to learn from and about the people and organizations considered partners in state plan development, as well as those who will use and implement the plan.





Telephone Strategies	Face-to-Face Strategies	Electronic Strategies
Brief, informal calls to partners	Conduct face-to-face interviews with key partners	Email or post requests for ideas
Structured conference calls with groups or individuals	Hold structured discussions at scheduled association, staff, or community group meetings	Research known audience perspectives, exposure to similar initiatives, and communication preferences
Telephone surveys Telephone focus groups	Convene focus groups	Put draft materials or surveys on the web for feedback

Sample "Market Research" Questions

Carefully designed questions will help focus learning on the most important areas. The right questions will depend upon the audience, project goals, level of input desired and the stage in the 2010 planning process. For example, if the steering committee and work groups were already formed, planners would focus questions on how to develop and implement the plan rather than how to engage key partners and the community in the planning process.

Planning Process

- How does your organization participate in planning processes?
- What kinds of organizations have approached you to be a part of an advisory committee? How do you choose which ones you will join?
- If you were inviting others (members of the target audience) to attend a work group meeting for this project, what would you say to get them to come? What would you avoid saying?
- What was your impression of the state's year 2000 planning process? What worthwhile came out of it?
- Tell me about a good experience that you have had working with public health.

Design and production

- What makes a plan useful? What kinds of plans are not useful?
- If you need detailed information about a topic, do you prefer to have it included at the back of a publication, in a separate publication, or on a web site?
- Which of these formats is easy to use (present two or more visual formats)?
- What do you think the people who wrote this page want you to do?

Marketing

- Where do you get ideas for your work or community activities?
- What kinds of published recommendations and plans have you seen from other state agencies?
- What impression do you have of government planning efforts?
- When you receive plans from other agencies, what do you do?
- If you were in charge of marketing the state's health plan to others (members of the target audience), what would you do?
- What do you read?
- How do you like to get information about emerging objectives in public health?

Implementation

- What makes a healthy community?
- How do you contribute to your community's health? In what areas would you like to do more?
- Have you ever used another agency's plan or objectives in your own work? What was the most important factor in your decision?
- How important are goals and plans to your daily work? What would be an incentive to tie your program activities to the state health objectives?
- What would it take for you to commit to help achieve a state health objective?
- If your supervisor asked you about how you used the state's year 2000 objectives, what would you say?

How to Develop a Marketing Plan

A marketing plan clarifies how a state can share the HP 2010 vision with others, promote the published plan, and "make things happen." To develop marketing goals and objectives, planners must determine priority audiences, desired results, key messages, strategies and tactics, and marketing partners.

1. Priority audiences
Whose opinions or actions are most important to the success of the HP 2010 process and the implementation of objectives? Identify potential target audiences and choose two to three of most importance.

Sample Target Audiences for 2010 Marketing Plans:

- ☐ Policymakers, including elected officials
- ☐ Private sector health organizations, including managed care organizations
- ☐ Private sector employers
- ☐ Medical societies and other health professional associations
- ☐ School and education leaders
- ☐ State voluntary organizations with local affiliates
- ☐ Public health leaders and program managers
- ☐ Front-line public health staff
- ☐ Grass roots groups with the capacity to address health objectives
- ☐ Potential community advocates for priorities

2. Desired Results
What do you want each target audience to do or believe? Be specific! The final 2010 plan and marketing materials should, explicitly or subtly, be designed to achieve the desired outcome.

As examples, you might want the target audience to…

(do)	***(believe)***
…use the state's 2010 objectives to develop policies to improve public health infrastructure	…be eager to work toward achieving objectives in their communities
…use objectives and recommendations in the 2010 plan to evaluate proposed legislation relevant to focus areas	…support the planning and evaluation role of public health
…incorporate components of the plan into agency strategic plans	…believe the plan boosts accountability
…commit resources and staff to develop new data sources	…feel personal responsibility to be healthier for a healthy state
	…think the 2010 priorities are fair
	…believe that state and local resources should be tied to objectives

3. Key Messages
For each audience, what are the main messages to communicate? Perhaps your main message is that this is a "people's plan," a governor's plan, a call to action, or a measure of the current path to success. Whatever your message, be sure to identify key words and phrases that support it. If your market research has identified that your target population responds favorably to "milestones," "action plans," and "steps to success" but responds unfavorably when it hears "objectives" or "benchmarks" include the preferred words in your key messages. Remember to be consistent with vocabulary. Key messages should be reinforced in all communications about the plan, including slogans, conference presentations, press releases, and executive summaries.

4. Marketing Strategies and Tactics
How will you reach each audience?

Strategies describe your general marketing approach. For some audiences and purposes, the best strategy may be to blanket the audience with messages about 2010 in a short period of time. For others, your strategy might be to selectively promote 2010 in connection with timely events (e.g., budget hearings) over several years.

Tactics are the methods of communication, such as:

posters	bumper stickers
television ads	fax or electronic newsletters
newspaper articles, editorials	individual meetings
conference booths	brochures
training and presentations	calendars
letterhead	web sites

Assess the communication environment of the target audience. The way to reach policy makers may be through their staff or targeted newsletters, whereas the way to reach public health program managers may be through an annual conference or posters at work. List marketing strategies with a budget in mind. However, a longer menu of marketing options can help identify marketing opportunities and resources in the future.

5. Marketing Partners
General media, special interest media, advocacy organizations, public relations offices, health education units, graphics departments, private health care organizations, and professional organizations with newsletters or web sites may be excellent partners in promoting year 2010 objectives. Healthy People steering committees may include many potential marketing partners who have experience with campaigns and already have an interest in promoting the 2010 plan.

Exclusive arrangements with a few marketing partners who are committed (e.g., "Channel 12 Cares") may sometimes be more effective than multiple, less focused partners. Explore options with marketing professionals and check your agency policies.

Evaluate Your Marketing Plan

Just as a marketing plan can clarify how a state can share the HP 2010 vision with others, the marketing evaluation plan can identify whether efforts were effective. The following factors can be used throughout the process internally as well as periodically be posed to the target audience throughout the decade.

- Was the planning process effective in preparing the marketing goals and action plan?
- Was there timely follow-through on marketing activities such as information requests?
- Is the marketing strategy a clear representation of the primary vision of the state plan?
- Is the marketing plan sensitive to the community's cultural dynamics?
- Did the development process include input from a diverse group of people?
- Were various media employed effectively to promote the state plan's goals, actions, and accomplishments? Was there media coverage (e.g., newspaper articles)? Did associations and other community partners use the logo, articles, or other marketing materials in their communications?
- How was input from partners used in developing and refining the marketing plan?
- Through what mechanisms was input collected (e.g., surveys, focus groups, consultants)?
- Has the marketing process assisted progress in meeting the state plan's specific objectives?
- How does the marketing plan mirror the goals and objectives of the overall state's plan?
- Has marketing generated funding or other resources for the initiative?
- Were messages designed to clarify what audiences should do with the state plan or what they should believe? Were marketing messages clear to targeted audiences?
- Did marketing efforts meet state objectives to influence the actions or beliefs of target audiences? (e.g., Did policy makers propose or pass legislation based on or using the state plan?)

Oral Health

Today about half of all Vermont elementary school students and one-third of high school students are cavity-free. Still, sine dental decay and gum disease are both largely preventable, there is ample room for improvement. With the best dental care and personal oral health habits, most people should be able to keep their teeth for a lifetime.

Objective 1
Fluoridate the Water Supply

Every dollar spent on community water fluoridation saves $80 in dental care costs. Since it was introduced in the 1940s, water fluoridation has been consistently demonstrated to be safe and effective. In communities that add fluoride to their drinking water, children have a 20 to 40 percent lower rate of cavities. Tooth decay among adults decreases by a similar percentage.

Objectives 2-3-4
Regular Dental Care

Regular dental checkups, that include professional cleaning and evaluation for early signs of tooth decay and gum infection, have been proven to be effective in maintaining oral health. However, many people do not seek care. 1995 survey found that the two most common reasons Vermonters give for not visiting a dentist are "no reason to go" and "cost." Even people with dental health insurance may not get regular care. In 1998, only 25 percent of adults and 46 percent of children with Medicaid coverage were receiving regular dental care.

Objective 5
Increase Use of Dental Sealants

May studies have shown that with the use of sealants and fluoride, tooth decay can be virtually eliminated. Placing sealants (plastic coatings applied to the tooth biting surface) on permanent molar teeth shortly after they come in protects the teeth from bacteria that cause tooth decay.

Objective 6
Tobacco Counseling by Dentists

Dentists and dental hygienists have a unique opportunity to influence their patients about tobacco use. Dentists often see adolescents and young adults at regular intervals, around the time when smoking begins and becomes a habit. A clinical trial has shown dentists to be effective counselors in getting their patients to quit smoking.

Oral Health Objectives

Objective 1. Increase the percentage of the population served by community public water systems that receive optimally fluoridated water.

Goal	75%
VT 1999	69%
US 1992	62%

Objective 2. Further reduce the percentage of children (age 6-8) with untreated dental decay in primary and permanent teeth.

Goal	21%
VT 1993-94	19%
US 1988-94	29%

Objectives 3. Reduce the percentage of youth (age 14-15) with untreated dental decay.

Goal	15%
VT 1993-94	22%
US 1988-94	20%

Objective 4. Increase the percentage of people who use the dental system each year.

Goal	83%
VT 1999	74% (age 18+)
US 1997	56% (age 2+)

Objective 5. Increase the percentage of children who receive sealants--

at age 8:

Goal	50%
VT 1993-94	43%
US 1988-94	23%

at age 14:

Goal	50%
VT 1993-94	45%
US 1988-94	15%

Objective 6. Increase the percentage of dentists who counsel patients about quitting smoking.

Goal	85%
Vermont survey under development	
US 1997	59%

Formatting Press Releases

(use 8 ½ x 11 letterhead, double spaced text)

Release date and time
Name of contact person
Email address
Phone #

Headline (short--one line if possible, concise and eye-catching)

Dateline (where the news originates)---Start text here for lead paragraph. Usually only 1-2 sentences to encapsulate the main idea and tell the reader why they should care about the issue.

Second paragraph should expand on the lead, if necessary, and maybe include a comment from someone regarding the importance of the news, event, report finding, etc.

Body of the press release should include:

- background/history of the issue
- description of study methods or other relevant info
- a summary of the findings, etc.
- conclusion that is a summary statement or closing comments from someone
- source of funding for project, research, etc if not mentioned before.

Try to keep to one page, but include the most important information in first 1-2 paragraphs.
Use subheads if it helps focus the reader.

(indicates end)
if more than one page, signify by "more" and number pages

Communication Channels and Activities: Pros and Cons

Type of Channel	*Activities*	*Pros*	*Cons*
Interpersonal Channels	• Hotline counseling • Patient counseling • Instruction • Informal discussion	• Can be credible • Permit two-way discussion • Can be motivational, influential, supportive • Most effective for teaching and helping/caring	• Can be expensive • Can be time-consuming • Can have limited intended audience reach • Can be difficult to link into interpersonal channels; sources need to be convinced and taught about the message themselves
Organizational and Community Channels	• Town hall meetings and other events • Organizational meetings and conferences • Workplace campaigns	• May be familiar, trusted, and influential • May provide more motivation/support than media alone • Can sometimes be inexpensive • Can offer shared experiences • Can reach larger intended audience in one place	• Can be costly, time-consuming to establish • May not provide personalized attention • Organizational constraints may require message approval • May lose control of message if adapted to fit organizational needs
Mass Media Channels *Newspapers*	• Ads • Inserted sections on a health topic (paid) • News • Feature stories • Letters to the editor • Op/ed pieces	• Can reach broad intended audiences rapidly • Can convey health news/breakthroughs more thoroughly than TV or radio and faster than magazines • Intended audience has chance to clip, reread, contemplate, and pass along material • Small circulation papers may take PSAs	• Coverage demands a newsworthy item • Larger circulation papers may take only paid ads and inserts • Exposure usually limited to one day • Article placement requires contacts and may be time-consuming
Radio	• Ads (paid or public service placement) • News • Public affairs/talk shows • Dramatic programming (entertainment education)	• Range of formats available to intended audiences with known listening preferences • Opportunity for direct intended audience involvement (through call-in shows) • Can distribute ad scripts (termed "live-copy ads"), which are flexible and inexpensive	• Reaches smaller intended audiences than TV • Public service ads run infrequently and at low listening times • Many stations have limited formats that may not be conducive to health messages • Difficult for intended audiences to retain or pass on material

Continued on next page...

Communication Channels and Activities: Pros and Cons *Continued...*

Type of Channel	*Activities*	*Pros*	*Cons*
Radio continued...		• Paid ads or specific programming can reach intended audience when they are most receptive • Paid ads can be relatively inexpensive • Ad production costs are low relative to TV • Ads allow message and its execution to be controlled	
Television	• Ads (paid or public service placement) • News • Public affairs/talk shows • Dramatic programming (entertainment education)	• Reaches potentially the largest and widest range of intended audiences • Visual combined with audio good for emotional appeals and demonstrating behaviors • Can reach low income intended audiences • Paid ads or specific programming can reach intended audience when most receptive • Ads allow message and its execution to be controlled • Opportunity for direct intended audience involvement (through call-in shows)	• Ads are expensive to produce • Paid advertising is expensive • PSAs run infrequently and at low viewing times • Message may be obscured by commercial clutter • Some stations reach very small intended audiences • Promotion can result in huge demand • Can be difficult for intended audiences to retain or pass on material
Internet	• Web sites • E-mail mailing lists • Chat rooms • Newsgroups • Ads (paid or public service placement)	• Can reach large numbers of people rapidly • Can instantaneously update and disseminate information • Can control information provided • Can tailor information specifically for intended audiences • Can be interactive • Can provide health information in a graphically appealing way • Can combine the audio/visual benefits of TV or radio with the self-paced benefits of print media • Can use banner ads to direct intended audience to your program's Web site	• Can be expensive • Many intended audiences do not have access to Internet • Intended audience must be proactive—must search or sign up for information • Newsgroups and chat rooms may require monitoring • Can require maintenance over time

Adapted from: DHHS, PHS, NCI: *Making Health Communications Programs Work.*

Scientific Information, Simply Put

Text Appearance

The way your text looks can greatly affect readability. Follow these simple tips:

- Use font sizes between 12 and 14 points.
  - Anything less than 12 points can be too small for many audiences. Older people and people who have trouble reading may need larger print. Use a font size at least 2 points larger than the text size for headings.

    Example of font sizes:

    This is 8 point.
    This is 10 point.
    This is 12 point.
    This is 14 point.
    This is 16 point.
    This is 18 point.

- For the body of the text, use fonts with serifs, like the one used in this line.
  (Serifs are little 'feet' on the letters.)

- Fonts without serifs (sans serifs), like the one used in this line, are harder to read.
  Limit sans sarifs fonts to headings and subheadings.

- Do not use FANCY or *script* lettering.

- Mix upper and lower case letters (like in this line).
  ALL CAPS ARE HARDER TO READ.

- Use bold face or underlining to emphasize words or phrases.
  Limit using *italics*.

- Use dark letters on a light background.
  Light text on a dark background is harder to read.

Source: Text Appearance: pg 9, Visuals: pgs 11-16, Layout and Design: pgs17-20, Tips on Translation: pgs. 21-22, Checklist for Easy-to-Read, Print Materials: pgs 29.

Visuals

Visuals can enhance your materials when used correctly. This section provides 5 steps to help you choose effective, appealing visuals.

1. Use visuals to help communicate your messages.

- Present one message per visual.
  - When you show several messages in one visual, readers may miss some or all of the message.
- Create visuals that help emphasize or explain the text. Steer clear of visuals that decorate your materials or are very abstract.

  For example: Images A and B are illustrations for the cover of a brochure on what to do if you get hurt on the job at a construction site. Image A, and abstract image for first aid, does not enhance meaning. But image B, which shows two workers using a first ad kit, clearly relates to the subject of the brochure—and it shows an action the brochure will discuss.

Image A

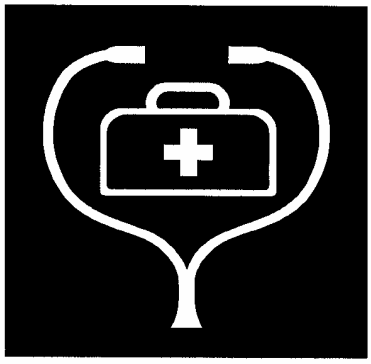
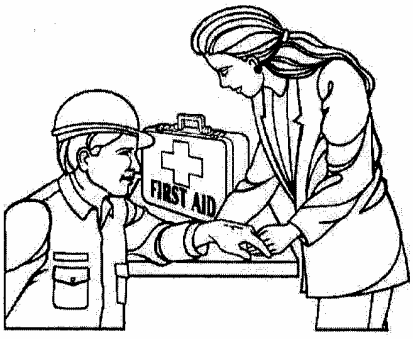


Image B



- Show the actions you want your readers to take. Avoid images that show what the reader should not do.

  For example: If you are telling reader to choose healthy snacks, such as fruit, instead of sweets and junk food, image A is more affective because it shows readers what to eat. It reinforces your message. Image B shows readers what they should not eat, but it gives them no visual link to what they should eat. Also, some cultures do not understand wand and "X" through an item means "no."

Image A

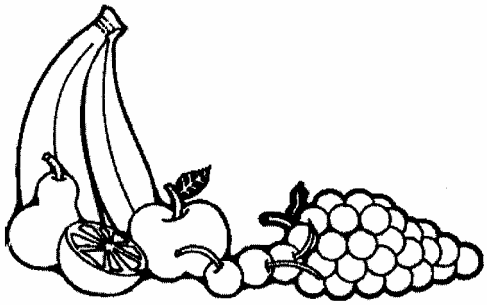
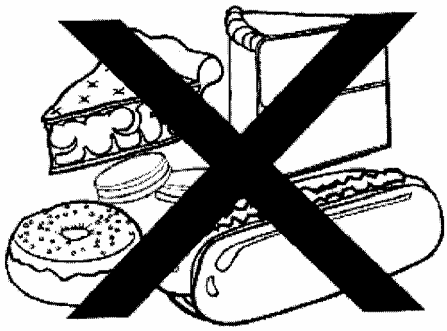


Image B



2. Choose the best type of visual for your materials.

- Photographs may work best for depicting "real life" events, showing people, and conveying emotions.
  - If you use photos, be sure that materials in the background will not distract your reader.
- Simple illustrations or line drawings may work best for showing a procedure (drawing blood), depicting socially sensitive issues (drug addicts), and explaining an invisible or hard-to-see situation (airborne transmission of TB).
  - Use simple drawings and avoid unnecessary details. Steer clear of abstract illustrations that could be misinterpreted.
- Cartoons may be good to convey humor or set a more casual tone.
  - Use caution with cartoons; not all audiences understand them or take them seriously

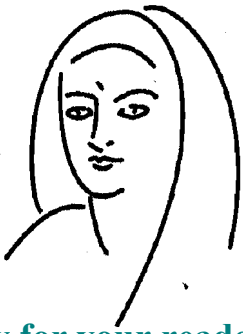
Pretesting visuals with your target audience will help you decide which type is best.

3. Make visuals culturally relevant and sensitive.

- Use images and symbols familiar to your audience.

  For example: Not all cultures understand that this image means "no smoking".

- If you show people in your visuals, make them of the same racial or ethnic group as your target audience.
  - Choose clothing styles that your target audience would wear. For materials designed for diverse audiences, show people from a variety of ethnic, racial and age groups.



For example: You might use a drawing like this one if your audience were Indian women.

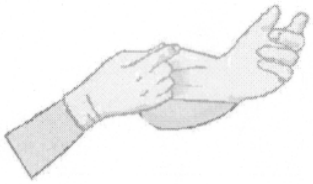
4. Make visuals easy for your reader to follow and understand.

- Place illustrations near the test to which they refer.

  For example: if you place a drawing in the top, right-hand corner that related to the text found in the lower left-had corner, readers may not connect the drawing thy out written message.

- Use brief captions that include your key message.

  For example: From the caption, the reader knows exactly what the visual is trying to convey. The caption also repeats a sentence found in the body of the document, which helps to reinforce the message.



Wear gloves to avoid spreading disease.

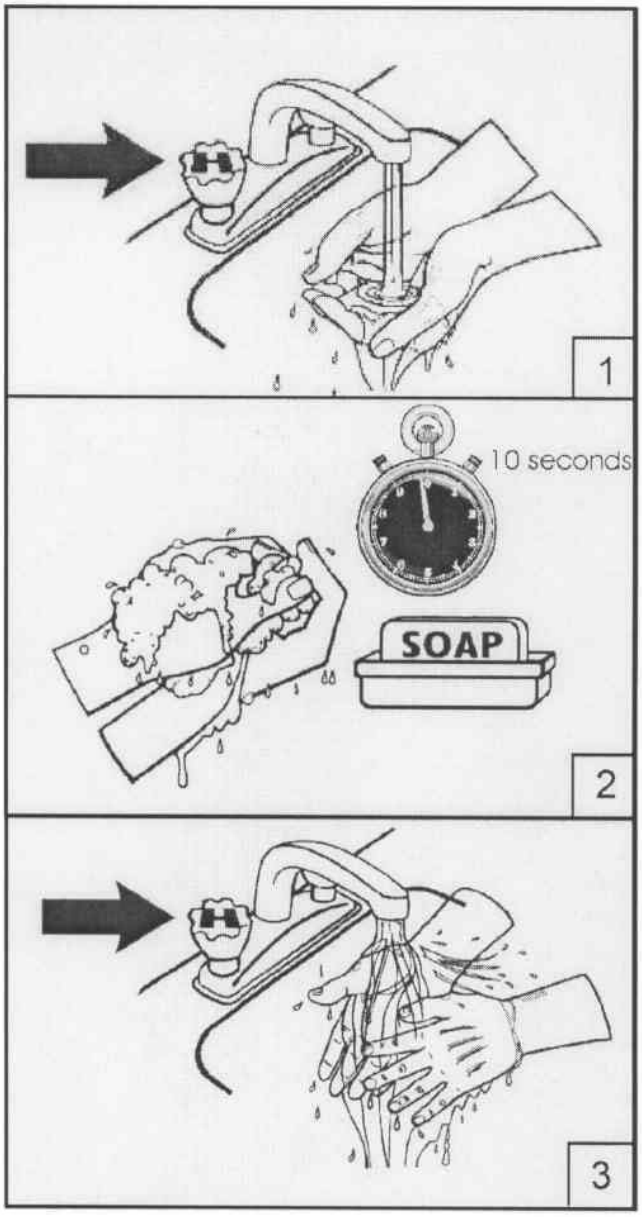
- When showing a sequence, number the images.

  For example:

1. Wet hands with warm water.

2. Rub hands together with soap for 10-15 seconds.

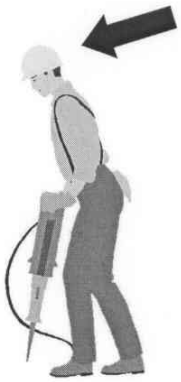
3. Rinse off all of the soap using warm water.



- Use cues like arrows and circles to point out key information in your visuals.

  For example: The image below is for a brochure on how to avoid injuries at a construction site. The arrow directs readers to the hard hat, the most important item in the drawing.

Always wear a hard hat
at the job site.



5. When illustrating internal body parts or small objects, use realistic images and place them in context.

- When showing internal body parts, include the outside of the body.
  - Avoid cutting off body parts.

    For example: Without showing the body for context, readers may not know what Image 1 is. Image 2 is much more clear.

Image 1

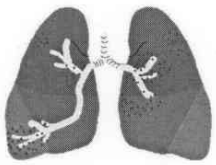


Image 2

- Do not use cartoon-like drawings of body parts or other health related images.

- Draw small objects larger to show detail, but also show to scale compared to something familiar to your audience.

  For example: The mosquito below is drawn several times larger than the actual size to show readers what it looks like. Then it is shown next to a penny so readers can see how big it really is.

Enlarged to show detail

Shown to scale

6. Use only professional, adult looking visuals.

- Avoid poor quality visuals.
  - They make your messages less credible. And adults may not even pick up your material if they contain childish or "cutesy" visuals.

Layout and Design

You can present your information and visuals in ways that make your materials easier to read and more appealing to your audience. Here are 4 ideas.

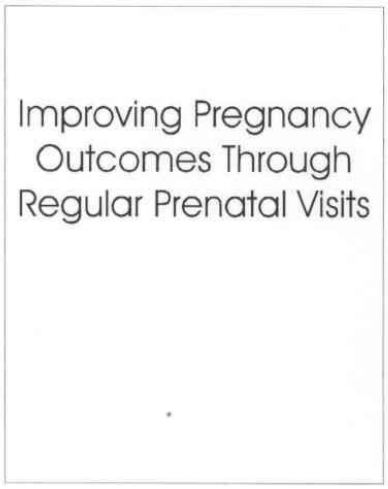
1. Design an effective cover.

- Make the cover attractive to your target audience.
  - If the cover does not include images and colors your intended readers like, they may not pay attention to it.
- Show the main message and target audience on the cover.
  - Readers should be able to grasp your main idea just by looking at the cover.

    For example: Cover A is much more effective than Cover B in getting the attention of your audience (pregnant women) and in telling readers what they can expect to find inside.

Cover A

Cover B



1. Organize your messages so they are easy to act on and recall.

- Present a complete idea on one page or two facing pages.
  - If readers have to turn the page in the middle of your message, they may forget the first part of the message.
- Place the most important information at the beginning and end of the document.
  - The best method is to state your main message first thing, expand on your message in the middle of the document, and repeat the main message at the end.
- Organize ideas in the order that your target audience will use them.

  For example: In a brochure about what to do if you find a chemical spill, tell readers to 1) leave the area right away, 2) note the location of the spill, 3) report it to the police or fire department, and 4) warn others to stay away from the area.
- Use headings and sub-headings to "chunk" text.
  - These cue the reader to upcoming message content. Use headings that express a complete idea, rather than just a word or two.

    For example: In a brochure about injury prevention, heading A communicates much more than heading B.

    Heading A: Wear your seatbelt—it could save your life.
    Heading B: Seat Belts

Questions often work well as subheadings. Readers can skim the questions to see which ones apply to them or are of greatest interest. And questions can make your materials seem interactive.

Leave more space above headings and subtitles than below them. This gives stronger visual link between the heading and the text that follows.

3. Leave lots of white space.

- Leave at least ½ inch to 1 inch of white space around the margins of the page and between columns.

- Limit the amount of text and visuals on the page.

For example: The document on the left is easier to read than the one on the right because is has more white space and just one visual.

4. Make the text easy for the eye to follow.

- Break up the text with bullets.

For example: The bullets used in the example on the left make the items in the list easier to read than in the paragraph on the right.

Children should get these shots by		By age 2, children should get shots
age 2: • measles/mumps/rubella • *Haemophilus influenzae* type b • Polio • Diphtheria, tetanus, pertussis • Hepatitis B • Varicella		against Measles/mumps/rubella; *Haemophilus influenzae* type b; polio; diphtheria; tetanus, pertussis; hepatitis B; and varicella.

- Do not justify the right margin.
  - Right justified margins cause an uneven spacing between words. Uneven spacing can confuse unskilled readers. Compare the samples below.

Sample 1	*Sample 2*
This column does not have a right-justified margin. The spaces between words are even. The jagged edge also makes it easer to distinguish one line form the others.	This column has right-justified margins. The spaces between words are uneven and the lines are all the same length. This can confuse readers, especially unskilled readers, and make it harder to differentiate one line from the others.

- Use columns.
  - Columns with line lengths of 40-50 characters are easiest to read. Compare paragraphs A, B, and C below.

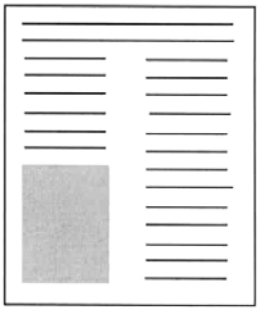
Paragraph A		*Paragraph B*
This column is only 20-25 characters long and is hard to read. Your eye jumps back and forth too much and gets tired quickly.		This column is the best length. It is 40-50 characters long. Your eye can return to the beginning of the next line easily, and it doesn't jump back and forth very much. Try to design your materials with columns like this one.

Paragraph C

This paragraph is hard to read, especially for unskilled readers, because the lines are so long. After reading only line, the eye has to move back across the entire page to find the start of the next line. Paragraphs that run across the whole page also look very dense and don't allow for much white space on the page.

- Place key information in a text box..
  - Text boxes make it easier for your reader to find the most important information on the page.

    For example: The eye is drawn to the shaded box on the sample page on the right.



Tips on Translation

While it is best to develop your materials in the language of your target audience, translating them from English (or another language) is often all you have time or resources for. This section will help you ensure that translations of your materials are both culturally and linguistically appropriate.

> ***Remember***. Messages that work well with an English-speaking audience may not work for audiences who speak another language.
>
> Find out about your target audience's values, health beliefs, and cultural perspectives. You can do this by conducting focus groups or other kinds of audience research.

Design material for minority populations based on subgroups and geographic locations.

All members of a minority population are not alike. Mexican Americans, for example, may respond differently than Cuban Americans to certain words, colors, and symbols. Likewise, Korean women living in New York City may view a health issue very differently from Korean women living in Los Angeles.

Get advice from community organizations in the areas you wish to reach.

Local groups that work regularly with your target audience can give you valuable insight about your audience. They can also recruit participants for focus group testing and help you gain the trust of your audience.

Carefully select and instruct your translator.

Hire a translator who knows a lot about your target audience and has translated many types of documents. Tell your translator the purpose of the materials, the appropriate reading level, and the main messages to convey. Review any medical or technical terms the translator does not know.

Avoid literal translation.

Allow your translator to select from a wide range of expressions, phrases, and terms used by the target audience. This flexibility will result in more culturally appropriate material.

Use the back-translation method.

Once the material has been translated to the target language, translate it back to English. (This step should be done by someone other than the original translator.) This will make sure the meaning and tone of the message have stayed the same.

Field test draft materials with members of the target audience.

This step will allow you to get feedback from your actual readers and to make changes based on their comments and suggestions.

Avoid these common pitfalls:

- Do not translate English slang phrases or idioms literally.
- Do not translate into a dialect unless it is used by your target audience.
- Do not omit accents-make sure your word processing and desktop publishing software have all the accents used in your target language.

Note: If you list a phone number to call for more information, make sure staff fluent in the target language are available during business hours (or around the clock if on a 24-hour hotline). You will frustrate your readers if they cannot reach someone who is fluent in their language at the phone number they were given. This can undermine your overall communication efforts.

Checklist for Easy-to-Read Print Materials

- ☐ Have you limited your messages to 3-4 per document (or section)? Have you left out information that is "nice to know" but not necessary?
- ☐ Is the most important information at the beginning of the document, and repeated at the end?
- ☐ Have you identified action steps or desired behaviors for your audience?
- ☐ Is information presented in an order that is logical to your audience?
- ☐ Is information chunked, using headings and subheadings? Do lists include bullets?
- ☐ Is the language culturally appropriate? And the visuals?
- ☐ Have you eliminated as much jargon and technical language as possible? Is technical or scientific language explained?
- ☐ Have you used concrete nouns, active voice, and short words and sentences? Is the style conversational?
- ☐ Is the cover attractive to your target audience? Does it include your main message?
- ☐ Are your visuals simple and instructive rather than decorative? Do they help explain the messages found in the text?
- ☐ Are your visuals placed near related text? Do they include captions?
- ☐ Does your document have lots of white space? Are margins at least 1/2 inch?
- ☐ Is the print large enough (at least 12 points) and does it have serifs?
- ☐ Have you used bold, underlining, and text boxes to highlight information? And avoided using all capital letters?
- ☐ Is text justified on the left only? Did you use columns?

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Chapter 6

Implementing Strategies, Managing and Sustaining the Process and Measuring Progress

This chapter will cover:

11. **Resources for locating and evaluating best practices and strategies that work**
12. **Suggestions for moving HP 2010 agendas forward**
13. **Considerations for tracking and reporting progress**
14. **Ways to sustain coalitions and HP 2010 activities.**

After you have developed your HP 2010 plan, published and made it available to the public, it is time to regroup and implement the strategies for meeting your objectives. This part of the process may actually be easier than the planning process because all of the "doers" that were bored with the planning process are now ready to spring into action. The key to successfully implementing activities and tracking progress, however, is effective management of the process. This involves delegation of responsibilities, creation of timelines, an effective and efficient communication system, and periodic rekindling of people's enthusiasm. Strategies for accomplishing these challenging tasks are presented throughout this chapter.

Tips

- Identify a person (single point of contact) to manage the oral health portion of the HP 2010 initiative for your state, territory, tribe or community.
- Develop an implementation plan and assign responsible parties for each task.
- Develop realistic timelines; establish checkpoints to determine if the timelines or the implementation plan should be adjusted.
- Establish a coordinated and consistent way to communicate with key partners.
- Integrate HP 2010 activities with other ongoing activities and vice versa.
- Keep reinforcing the goals and objectives and key messages in the media.
- Bring in new partners to revitalize and review the process and progress.
- Celebrate milestones and recognize groups and individuals for their contributions.

Strategies for Implementing Objectives

While some states and communities still are in their HP 2010 planning stages, others already have published their HP 2010 plans and are in the process of implementing strategies to meet their objectives. At this point, systems to track progress on the objectives and the leading health indicators should be in place.

The national HP 2010 Oral Health Chapter (Chapter 21) and numerous other references and Web sites listed in this toolkit provide examples of effective strategies to prevent or reduce oral diseases and conditions and address other HP 2010 issues. It is beyond the scope of this toolkit to present all of these strategies. A few resources that highlight "best practices," however, may be helpful.

- *Partners in Information Access to Public Health Professionals,* (**http://nnlm.gov/partners/hp**) makes information and evidence-based strategies related to HP 2010 easier to find. Oral health is not yet one of the focus areas included, but some of the information from other related areas might be useful. Eventually the Partners hope to expand the range of searches to cover all Healthy People 2010 focus areas.
- HRSA's Bureau of Primary Health Care maintains a "Models that Work" database where communities describe dental and other health programs that appear to be successful in addressing access to care issues (**www.bphc.hrsa.gov/databases/mtw**, search on "dental"). Contact and Web site information are provided for each program.
- The Association of State and Territorial Dental Directors is in the process of finalizing a Best Practices for State Oral Health Programs database, which can be accessed via **www.astdd.org**. The Web site will be searchable by topic and state, and will summarize best practices that meet established criteria in various categories.
- The DHHS Assistant Secretary for Health is showcasing best practices in public health from around the country to foster an environment of peer learning and collaboration. View the current listings or sign up for their email listserv at **www.osophs.dhhs.gov/ophs/BestPractice/default.htm**.

When selecting, implementing and evaluating strategies, the following factors should be considered:

- evidence of effectiveness in community-based programs
- appropriateness for each target audience (e.g., age, culture)
- cost-effectiveness
- sufficient human resources to implement them
- sufficient financial resources to implement them
- political will to make them happen
- criteria for documenting "progress"
- mechanisms available for tracking progress.

Moving the HP 2010 Agenda Forward

There are many ways to make sure your implementation plan keeps moving. A national conference, "Steps to a Healthier US: Putting Prevention First" was held on April 15-16, 2003 in Baltimore, MD. Portions of the conference highlighted exemplary programs in communities.

The Governor's Task Force for Healthy Carolinians held a series of four forums around North Carolina after presenting their draft HP 2010 objectives. Through public input the Governor's Task Force arrived at numerous ways to move their objectives and health agenda forward. Uses for the objectives fell into eight categories:

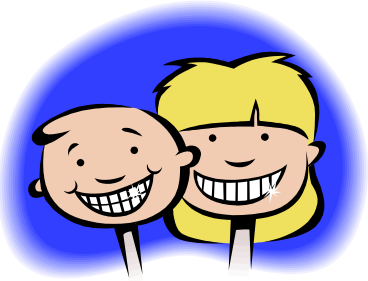
- Partnerships (Coordination and Collaboration)
- Funding
- Policy
- Planning
- Evaluation
- Education
- Media
- Organizational use.

The Governors Task Force also identified barriers to implementation, which fell into five categories:

- Resources
- Community
- Logistics
- 2010 Health Objectives
- Politics-Politics-Politics.

View these online at **www.healthycarolinians.org/2010objs/movingforward.htm**.

The Healthy Iowans HP 2010 plan was completed in the summer of 2000. Chapter teams that developed the plan evolved into monitoring teams to track progress. These teams developed strategies to assist communities in developing local plans. Chapter teams meet on a quarterly basis. Midcourse review is set for 2005-06.



One way to integrate HP 2010 activities into ongoing annual activities is through national health observances such as Children's Dental Health Month, Give Kids a Smile Day, National Nutrition Month, World Health Day, etc. View a list of national observances by month at **www.healthfinder.gov/library/nho**.

Assessing and Reporting Progress

"The ability to quantify and assess progress on health objectives is at the heart of the Healthy People Initiative" (Source: Edward Sondik, *Tracking Healthy People 2010*). One of the deficiencies noted in the Surgeon General's Report on Oral Health and ASTDD's Infrastructure report (see reference on page 23 of the Resources section for Chapter 2) is the lack of state-based oral health surveillance systems and the need for enhanced systems at the national level. As noted in Chapter 3, some of the HP 2010 oral health objectives and other oral health data are being tracked through various databases at federal agencies such as CDC and NIH. DATA 2000 is the Healthy People database that can be accessed online at **www.wonder.cdc.gov**. Users can create tables that contain baseline and tracking data for each HP 2010 national objective.

States continue to experience difficulty collecting and submitting data in a usable and comparable format for a variety of reasons. The July 27, 2001 issue of *Mortality and Morbidity Weekly Report* provides an excellent overview of guidelines for evaluating public health surveillance systems (**www.cdc.gov/mmwr**).

Most national objectives are tracked by a single measure (e.g., percentage reduction in dental caries in primary teeth.) For these objectives, progress will be assessed by the change from the baseline measure toward the target. Some objectives seek to increase positive behaviors or outcomes (e.g., percentage of adults who report having had an oral cancer exam), while others are stated in terms of decreasing negative behaviors or outcomes (e.g., percentage of adults whose activity is limited due to chronic lung and breathing problems.) A number of your objectives may contain multiple measures. Progress will need to be assessed separately for each measure. For these objectives, therefore, the progress may be mixed if some measures are progressing toward the target and others are regressing. Whenever possible, assessment of progress should consider the standard errors associated with the data (see a statistician or epidemiologist for help with this.) For some objectives, precise measures that match the objective are not available. In these cases, similar proxy measures may be used to track progress.

For specific details on the national oral health objectives, see *Tracking Healthy People 2010* at **www.cdc.gov/nchs/hphome.htm**. For each objective (or subobjective), the following are included:

- national data source
- state data source
- HP 2000 objective
- measure (e.g., percentage)
- baseline (including year)
- numerator
- denominator
- population target
- questions used to obtain national data
- expected periodicity
- comments

Part C of the document discusses major surveys for HP 2010 data, some of which are also described in Chapter 3 of this toolkit.

A progress review for the oral health objectives is scheduled for March 2004. The tracking data and methods for assessing progress will be reviewed at that time and again during the midcourse review in 2005, and a determination will be made at that time whether any changes will be made. Reports of midcourse reviews from other years were included in Chapter 1 of the toolkit. States should establish similar timelines for review of their objectives prior to 2010. For semi-annual updates on HP 2010 activities, see **www.health.gov/healthypeople**.

Progress reports can be written and disseminated in a variety of formats, using the techniques described in Chapter 5. Vermont chose to display its HP 2000 progress in a simple report card format (see page 2 in the Resources section of this chapter) by categorizing progress as 1) goal met; 2) progress made; 3) baseline data collected; 4) data not available; and 5) no progress made. These categories help facilitate discussion about celebrating successes, conducting follow-up surveys for those objectives with baseline data, considering new strategies where inadequate or no progress was made, developing tracking systems, or finding resources to collect data where no data are currently available.

Case studies also are an innovative way to report on progress toward a specific objective or cluster objectives on a particular topic. This approach also translates well to articles for newspapers or newsletters and to human interest stories for radio, TV or community presentations.

Plan your approach to track the progress of your objectives:

- Develop methods for measuring objectives that do not have existing data sources
- Gather and evaluate other data and information to include in state plan
- Plan regular intervals to measure and track achievement of targets
- Maintain consistency of terms and data definitions
- Produce progress reports focusing on: age, racial and ethnic populations, level of education, geographic areas, and/or priority issues
- Incorporate objectives in periodic reports (e.g., state oral health report cards and journal articles)
- Plan an annual Healthy People 2010 update.

Assessing and Creating Sustainability

Periodically reassess the membership of your coalition to see if the stakeholders have changed and if the current participants are still committed and active. Washington's *Community Roots for Oral Health* lists reasons why people stay or leave coalitions and how to celebrate the working relationships. The following list is an adaptation of the list.

- People change, as do their interests, job descriptions and priorities. They need to be thanked for their contributions and feel that it's OK to move on to another project.
- Relationships change. Celebrating new opportunities for working together on new or different projects is one way to support on-going success. Find new ways for people to contribute to the HP 2010 effort.
- Organizations that have assigned or allowed their employees to contribute their time and effort should be recognized for this contribution. If they need to reduce their employees' time because of workloads or budget cuts, this needs to be respected.
- Coalitions build on friendships and create new ones. Maintaining a friendly, fun, supportive environment is crucial to sustain initiatives.
- Sustained momentum needs consistent leadership. Make sure you have a coordinator or coordinating group that is committed to a long-term process.

Another list of tips for successful community or tribal program sustainability, from the Seven Circles Coalition, part of the Southeast Alaska Regional Health Consortium, can be viewed at http://www.searhc.org/sevencircles/seven-pdfs-partner/sustain.pdf.

It might be helpful to review your Plan for Securing Resources (see worksheet on Page 4 of the Resources section for Chapter 4) to determine what additional resources are needed for implementation and how they will be acquired. Be sure to include who is responsible for each activity. This plan can then be translated into a sustainability plan, which should be reviewed and revised, if needed, every 2-3 years.

A good worksheet that you can use to create sustainability goals and identify new funding resources is available through the Ohio Community Service Council at http://www.serveohio.org/GOAMS1.pdf. You can also go to the Afterschool Alliance Web site at http://www.afterschoolalliance.org/prog_sustain.cfm to print worksheets on 1) vision; 2) building collaboration; 3) advocating for support; 4) finding funding; and 5) template for a sustainability plan.

Another resource is the *Sustainability Toolkit: 10 Steps to Maintaining Your Community Improvements* (see references). The Sustainability Toolkit contains 1) Examples and stories from communities throughout the nation; 2) a CD ROM with activities to complete; 3) sample plans, timelines, and completed activities; and 4) tips and resources.

Two examples are presented here to exemplify ways that states or organizations have developed a series of strategies to sustain interest and funding for oral health activities and coalitions. Other state coalition activities can be reviewed via dental summit reports at http://www.mchoralhealth.org.

UTHSC San Antonio Dental School, Department of Community Dentistry Project

With funding from HRSA's Bureau of Health Professions, this Department organized a Texas Institute for Dental Public Health/Community Oral Health Infrastructure Development Conference. The workshop was developed to enhance ongoing local, state and national activities such as the NGA Oral Health Policy Academies, HP 2010, the Surgeon General's Report on Oral Health, Texas Department of Health Strategic Plan, and the ASTDD 1999 Onsite Evaluation Report of the Texas Oral Health Program. Thirty-eight people representing various organizations attended the workshop on May 30 – June 1, 2001. After plenary sessions conducted by guest speakers, attendees divided into 3 workgroups:

- Education of the Workforce
- Legislation and Policy Development
- Community-Based Activities through Collaboration and Advocacy.

Each workgroup outlined several strategies to resolve the identified priority issues. These were later mailed to attendees as a reminder of their commitments. All of the workshop materials including the final report, presentations, background papers and bibliography have been posted on a Web site (http://www.dental.uthscsa.edu/texasaccess). A workshop was held in January 2002 in Texas Public Health Region 6 by the UTHSC Houston Dental School. It focused on recent assessments of population oral health needs at the Regional level and planning to meet those needs. *Contact: John P. Brown at Brown@uthscsa.edu*

Connecticut Health Foundation and the Children's Fund of Connecticut, Inc

These two philanthropic organizations commissioned two nationally recognized experts in public health policy, Drs. Jim Crall and Burton Edelstein, to develop a report in conjunction with the Connecticut Department of Public Health's Oral Health Program to guide future oral health funding strategies. The report, *Elements of Effective Action to Improve Oral Health and Access to Dental Care for Connecticut's Children and Families,* also serves as a document to communicate the unmet oral health needs of Connecticut's children and families, emphasizing the HP 2010 oral health objectives for Connecticut and for the nation (see http://www.cthealth.org). The report recommends five strategies:

- Maximize utilization of existing public and private delivery resources
- Expand the numbers of both public and private delivery resources
- Build bridges to connect families to dental services
- Reduce disease burden through prevention
- Put in place data-driven systems that implement accountability and quality improvement systems.

The funding agencies released a request for proposals for the first phase of funding. Phase 1 is intended to support implementation of locally designed programs to substantially increase the number of low-income (Medicaid and SCHIP eligible) children who receive preventive and restorative dental services in five urban centers. Other requests for proposals will be issued over a five-year period. This funding will enhance the ongoing community integrated service system projects initiated in recent years. Check the website listed above for further information about the funded projects and opportunities for future funding cycles.

Contact: Patricia Baker at pat@cthealth.org

Acknowledging Successes and Contributions

Successful coalitions and projects usually are maintained through appropriate incentives and acknowledgment of efforts by individuals and agencies. These can range from a simple "thank you" to public acknowledgments and awards. The Sierra Health Foundation's *We Did it Ourselves* series on coalition building and evaluation lists six important R's to keep in mind to keep collaboratives and community members engaged (see box on the right→).

Examples from HP 2010 or oral health projects include:

- Healthy Delaware's Heroes Nomination, a way to feature individuals, businesses or organizations in each of their 13 focus areas (see http://www.phf.org/HPtools/state/DE_heroes_nomination_form.pdf)
- Newspaper recognition of sponsors for clinical services at Dientes Community Dental Clinic in Santa Cruz, CA (see Resources section, page 1)
- Community Campus Partnerships in Health Award to recognize exemplary partnerships between communities and higher education institutions (see http://futurehealth.ucsf.edu/ccph)
- HHS Secretary's Award to students in health professions schools who submit an innovative health promotion or disease prevention project; awards range from $1,500 to $7,500 (see http://www.bhpr.hrsa.gov/interdisciplinary/innovations.htm.)

The Six R's of Participation

Recognition
- Awards
- Dinners
- Highlighting contributions
- Public recognition
- Thank-you letters

Respect
- Meet needs of members, e.g., meeting times
- Acknowledge and celebrate cultural differences

Role
- Provide opportunities for involvement
- Share power
- Share decision making
- Utilize each individual's unique gifts and talents

Relationship
- Provide opportunities for getting to know one another
- Provide opportunities for networking with each other and with other organizations

Reward
- Regularly assess whether members' needs are being met
- Respond to each individual's self-interests

Results
- Create small wins
- Demonstrate progress towards goals
- Celebrate success
- Make results visible in the community

Center for Collaborative Planning, We Did it Ourselves. A Guide Book to Improve the Well- Being of Children Through Community Development. Sierra Health Foundation, 2000, pg. 64.

Be creative! Think of innovative ways to reward efforts and maintain high levels of motivation for accomplishing or exceeding established goals and objectives.

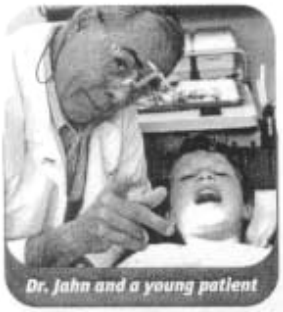
Resources

Chapter 6

- ✓ **Dientes! Community Dental Clinic Acknowledgment Ad**
- ✓ **Healthy Vermonters 2000: Report Card**
  www.state.vt.us/health/_admin/pubs/2000/hv2010/pdf/hv2010cover.pdf
- ✓ **References**

Thanks

to the many people and businesses who make our work of providing healthy smiles possible (an additional 900 donors gave through Dientes' golf 2000 marathon):



Dr. John and a young patient

Leadership Donors:
The Kenneth and Gabrielle Adelman Fund
David and Rebecca Kashtan
The Richard & Mary Solari Charitable Trust

Major Donors:
Aptos Lions Club
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Gary Bloom and Katy A. Stone-Bloom
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Debra Woo
Ruth Updegraff
James Ziegler
Ten Anonymous Donors

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GraniteRock
Hutton-Sherer Design
Joyce Matlack Design
Monterey Bay Properties
MVP Network, Seattle
Polar Bear Ice Cream
Salyer American Fresh Food
Seagate Technology
Santa Cruz Medical Clinic
Van Meter Construction
Watsonville Press

Volunteers who make a difference are: **Jack Chamberlain, DDS, Marc Grossman, DDS, Sherry Hamm, RDH, Noel Kelsch RDH, Deanna Mah, DDS, David Shin, DDS, Jim Smith, DDS, and Joseph Valle, RDH**

IN THE NEWS

Metro Santa Cruz, Nov. 9 2000 described Dientes' "Herculean efforts."

Santa Cruz County Sentinel, Dec. 12, 2000 noted that our school-based program "means the difference between comfort and pain for many children in South County."

San Jose Mercury News, Feb. 1, 2001 our Letter to the Editor supported the Santa Clara Health Trust's goals to increase public health insurance reimbursements, increase insurance coverage for children and fluoridate water supplies.

KION Channel 46 News, Feb. 5, 2001 Romney Dunbar reported on our Watsonville Children's Clinic, highlighting the education and prevention value of the program. Four lively kids described the lessons in proper brushing and nutrition they received.

VOLUNTEERS
Working Together to Provide Healthy Smiles

On January 27, with the generous help of four volunteer dental hygienists, Dientes! provided free preventive care to 35 children from Branciforte Elementary School. These hygienists gave their time and skill to benefit children for whom dental care seems like a luxury: Beverly Cornell of Nipomo; Ann Havlik of San Luis Obispo; Noel Kelsch of Salinas and Maureen Titus of Los Osos. The hygienists were paid in intangible currency—healthy smiles. That kind of exchange is priceless!

Healthy Vermonters 2000 Report Card

Goal Met

- Develop statewide violence prevention group
- Enact clean indoor air act
- Improve hospital protocols
- Increase flu shots (adults 65+)
- Increase mammograms (women 50+)
- Increase Pap tests (women 18+)
- Increase physician counseling - cancer screening
- Increase recycling
- Increase safe drinking water
- Increase schools teaching conflict resolution
- Reduce alcohol-related motor vehicle deaths
- Reduce child abuse
- Reduce head injuries
- Reduce infant mortality
- Reduce lead poisoning
- Reduce spinal cord injuries

Baseline Data from one-time survey

- Physician counseling - alcohol/drugs
- Physician counseling - blood pressure
- Physician counseling - HIV/STDs
- Physician counseling - immunizations
- Physician counseling - smoking
- Physician counseling/referral - STDs
- Reduce college binge drinking

Progress Made

- Increase servings of fruits, vegetables & legumes
- Increase action to control overweight
- Increase early prenatal care
- Increase exercise (adults 18+)
- Increase immunization
- Expand immunization laws
- Increase mammograms (women 40+)
- Increase radon testing
- Increase safety belt use
- Increase schools teaching HIV prevention
- Increase schools teaching STD prevention
- Increase youth condom use
- Reduce binge drinking (HS seniors)
- Reduce heart disease deaths
- Reduce residential fire deaths
- Reduce stroke deaths
- Reduce suicide
- Reduce worker injuries
- Reduce youth alcohol use
- Reduce youth smoking

Data Not Available

- Control high blood pressure
- Increase servings of grains
- Increase Hepatitis B immunization
- Increase injection drug prevention
- Increase injection drug treatment
- Increase primary care for kids
- Increase worksite alcohol policies
- Increase worksite health policies
- Increase worksite seat belt mandates

No Progress Made

- Reduce adult overweight
- Reduce adult smoking
- Reduce low birth weight
- Reduce smoking during pregnancy
- Reduce youth cocaine use
- Reduce youth marijuana use

References: Implementing Strategies, Managing and Sustaining the Process and Measuring Progress

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