ORAL HEALTH PLAN FOR THE STATE OF TEXAS, 2012

Submitted by the Board of Directors of

The Texas Oral Health Coalition

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EXECUTIVE SUMMARY

This State Oral Health Plan for Texas is a roadmap to improve the oral health of the people living in the State of Texas. The development of the plan was funded by a cooperative agreement with the Department of State Health Services, Texas Oral Health Program (OHP) from the Centers for Disease Control and Prevention (CDC) and was written under a sub-contract by the Texas Oral Health Coalition (TxOHC). The Plan reviews the state's oral health efforts and recommends programs and priorities based upon sound public health principles and practices. It is written for public policy professionals and individuals providing oral health services who are collaborating on oral health issues in the State. This plan will serve as the basis for program development, prioritization, and funding for the state's oral health program.

The Plan is organized around the Core Functions of Public Health described in the CDC Oral Health Strategic Plan. The Core Functions are the standard by which a state oral health program is measured. They comprise: 1) Monitoring/Surveillance, 2) Research, 3) Communications, 4) Preventive Strategies, 5) State Infrastructure, 6) Evaluation, 7) Partnerships, and 8) Policy Development.

In this narrative, each Core Function has four sections: Background, Existing Activity at the State Level, Gaps, and Action Items. The Background comprises material from the 2005 Oral Health Plan, information from the scientific literature and the Texas Oral Health Program. Existing activities are drawn from reports and publications of the Oral Health Program as well as its web site. Existing activities are compared to the CDC Core Functions and the Oral Health Program Core Functions and identified Gaps, that is, areas for program improvement. The Action Items are recommendations to close the gaps identified in this process.

Surveillance is the preeminent Core Function since it is a critical precursor for program development and evaluation. While there are limited ongoing surveillance efforts, current surveillance effort should be expanded substantially. A continuous oral health surveillance system should be implemented by individuals who have expertise in data collection and analysis (*i.e.*, dental public health epidemiology, and statistics)

employed by the State and guided by the Texas Oral Health Coalition and its designated consultants. The creation and implementation of the state oral health surveillance program should include key stakeholders and experts in the field of oral epidemiology to include the dental schools and schools of public health. Moreover, the State should budget sufficient funds to contract with Texas Dental Schools that possess dental public health expertise to provide support for an oral health surveillance program.

This Plan can be used to advocate for additional resources from the State to support the Oral Health Program in the Department of State Health Services. It sets the bar for what the Oral Health Program can do for the state with adequate resources. The State should allocate resources to those modalities that have a scientific evidence base; specifically, 1) the design, implementation, and monitoring of community water fluoridation, 2) school-based dental sealant programs, and 3) fluoride varnish programs. The First Dental Home Program is supported but not endorsed by the Coalition until a longitudinal study can assess the cost effectiveness of the program, and an outcomes assessment can determine if this preventive initiative decreases the rate of dental caries as well as the severity of dental caries among children needing operating room care for pediatric dental rehabilitation.

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1.0 BACKGROUND

The State Oral Health Plan for Texas is a roadmap to improve the oral health of the people living in the State of Texas. It reviews the state's oral health efforts and recommends programs and priorities based upon sound public health principles and practices. It is written for public policy professionals and individuals providing oral health services who are collaborating on oral health issues in the state. According to the CDC, "A state oral health plan is a roadmap for accomplishing the goals and objectives that have been developed by the state oral health program in collaboration with partners and stakeholders, including the state oral health coalition and members of the public health and dental communities." The previous Oral Health Plan was written in 2005 (1). The current plan identifies broad areas of policy identified by stakeholders in a collaboratively sponsored policy workshop as well as oral health programs and policies based on published scientific evidence, sound existing policies, and guidelines or recommendations from recognized public health authorities and professional organizations. In future development of the state oral health plan, workgroups or groups convened by the Texas Health and Human Services Commission (HHSC) or the Department of State Health Services (DSHS) may further assign priority and develop action items and annual work plans which will specifically address the policies needing revision or promulgation after being identified in this document. The Texas Oral Health Plan will also explore potential partnerships to enhance the oral health of people living in Texas.

1.1 The History of the Oral Health Plan

In May 2000, the U.S. Surgeon General's report, Oral Health in America, described both the "marked improvement in the nation's oral health in the past 50 years" and the simultaneous "silent epidemic of oral disease affecting our most vulnerable citizens" restricting activities in school, work and home and often diminishing the quality of life (2). The Report noted that oral disease burden is disproportionately borne by poor children, adults, and the elderly with low incomes and other vulnerable population groups. It further detailed how oral health is promoted, how oral diseases and conditions

are prevented and managed, and what needs and opportunities exist to enhance oral health. Water fluoridation and dental sealants were noted as two interventions that have reduced dental caries and the Report noted the ongoing need to reduce oral health disparities and inequities (2). While the overall prevalence of dental caries among children has decreased during the past 50 years, the reduction in caries burden has not been shared equally (3), the remaining caries is concentrated with low-income and non-white individuals (4). The Centers for Disease Control and Prevention (CDC) has been assisting states through collaborative agreements to improve the dental public health of those states over the past few years.

Texas was chosen to receive this collaborative agreement assistance to develop a State Oral Health Plan, form a state-wide coalition, develop surveillance and program monitoring plans, and improve oral health infrastructure (5). The Texas Oral Health Coalition, which was formed with the assistance of an initial CDC collaborative agreement (6), was subcontracted by the Texas Department of State Health Services to continue the process and update the collaborative State Oral Health Plan from its original form drafted in 2005.

The Texas Oral Health Coalition conducted listening sessions throughout the state, presented perceptions from the listening sessions on the existing state of dental/oral health in the state of Texas to the Coalition, and asked for input on the core components of dental public health activities and other dental programs which exist in the state during the first half of 2011. Appendix 1 presents an outline with results of the listening sessions.

In addition, the Coalition sponsored a policy workshop. The five policy/systems change suggestions that received the most votes during the policy workshops were (7):

- Support the development of the dental home through professional education
- Create a statewide oral health surveillance system to collect oral health data across the lifespan
- Improve oral health literacy across Texas
- Integrate oral health into all elder-care services and facilities
- Fluoridate all community water systems

This Oral Health Plan for the State of Texas is designed to be a living document and should be modified as the oral health status environment of the state of Texas evolves. Since the organizational structure of the Texas Health and Human Services Commission and Department of State Health Services is not static, the plan may not specify which agency or department may be called upon to implement provisions identified in the plan. In light of this fact, the plan may refer to "the State" or "the HHSC" rather to specific individuals, departments, or agencies in the Health and Human Services Commission in its recommendations. The plan includes priority policies that were identified by a group of stakeholders from a variety of disciplines and geographical areas of the state that convened to outline recommendations.

2.0 INTRODUCTION

The Oral Health Plan for the State of Texas is organized around the Core Functions of Public Health described in the Centers for Disease Control and Prevention Oral Health Strategic Plan (8). These Core Functions, developed by the preeminent public health entity in the United States, are the standard by which a state oral health program should be measured for evaluation. They include:

- ***Monitor/Surveillance:*** *Monitor the burden of disease, risk factors, preventive services, and other associated factors.*
- ***Research:*** *Support public health research that directly applies to policies and programs.*
- ***Communications:*** *Communicate timely and relevant information to impact policy, practices, and programs.*
- ***Preventive strategies:*** *Support the implementation and maintenance of effective strategies and interventions to reduce the burden of oral diseases and conditions*
- ***State infrastructure:*** *Build capacity and infrastructure for sustainable, effective, and efficient oral health programs.*
- ***Evaluation:*** *Evaluate programs to ensure successful implementation.*
- ***Partnerships:*** *Identify and facilitate oral health partnerships to support CDC strategic priorities and enhance community efforts.*
- ***Policy development:*** *Develop and advocate sound public health policies.*

2.1 Structure of the Plan

In this narrative of the Plan, each core function has four sections: background, existing activity at the state level, gaps, and action items. The Background comprises material from the 2005 Oral Health Plan, information from the scientific literature and the Texas Oral Health Program. Existing Activities are drawn from reports and publications of the Oral Health Program as well as its web site. The existing activities were compared to the CDC Core Functions and the Oral Health Program Core Functions and then Gaps were identified, that is, areas for program improvement were specified in this step. The Action Items are recommendations to close the gaps identified in the process.

The Texas Oral Health Program (OHP) has developed its own Core Functions[1] (9, Appendix 3). These Core Functions are the OHP's program goals and, like CDC's Core Functions, are standards by which to assess the Program. They are:

1. *Promot*[ing] *effective evidence-based strategies and preventive oral health practices through population-based services.*
2. *Serv*[ing] *as an oral health subject matter expert and provide support for internal and external partners.*
3. *Gather*[ing]*, provid*[ing]*, and maintain*[ing] *oral health data required by local, state, and federal policy makers for decision making, support, and documentation of oral health trends.*
4. *Develop*[ing] *a collaborative network of community and professional partners to increase delivery systems for the implementation of preventive dental services programs.*
5. *Serv*[ing] *as support for disaster related response teams.*

2.2 Demographics of the State of Texas

The population of the state of Texas has grown substantially in the ten years between the 2000 and 2010 censuses (Appendices 4 and 5, respectively). Over the past decade, the percentage of persons living in Texas has grown by 20%, which is the second highest percentage growth in the nation. Much of the growth of the population in Texas has been attributed to the proportionate increase in the Hispanic/Latino population while the non-Hispanic white population proportion is declining. The non-Hispanic black proportion is approximately the same in both census surveys. Minorities

[1] Each Core Function has several elements.

in general and Hispanics in particular are less likely to be insured, either with medical insurance (10) or dental insurance (11,12,13). The implications are clear: there will be an increased need for dental care in Texas and the populations with the least resources will bear the burden of the most disease, with striking oral health policy implications. As the diversity of the state increases, the need for culturally competent oral health care providers will also increase. The general population is also aging along with national trends in the United States. These challenges will have an impact on the existing oral health infrastructure in the state.

2.3 Methodology

The recommendations in this Oral Health Plan were developed using an evidence-based approach consistent with CDC recommendations. Priority was given to those modalities where internationally recognized systematic approaches were used to assess the strength of scientific evidence by national organizations and agencies (*e.g.*, CDC, Agency for Healthcare Research and Quality (AHRQ), U.S. Preventive Services Task Force (USPSTF), and American Dental Association Evidence-Based Clinical Recommendations. In addition, we are guided by Healthy People 2020 Oral Health Objectives (14).

In developing this oral health plan, the outcomes of the Texas OHP were compared with the Core Functions specified by the CDC and Texas Oral Health Plan Program to assess the extent to which the Texas data most currently published support them. In addition, publications about oral health in Texas such as Oral Health in Texas 2008 (15), and Building Better Oral Health: A Dental Home for All Texans (16) were used in comparisons and preparation of the plan. Moreover, we were informed by the five calls to action articulated in the National Call to Action to Promote Oral Health (17):

- Change perceptions of oral health
- Overcome barriers by replicating effective programs and proven efforts
- Build the science base and accelerate science transfer
- Increase oral health workforce diversity, capacity, and flexibility
- Increase collaborations

2.4 The Texas Oral Health Program (OHP)

The mission of the OHP is: “Promoting oral health through leadership in public health practices, policy development, education, and population-based preventive services” (9). The program is located in the Department of State Health Services, Division for Family and Community Health Services. Appendix 6 shows the organizational chart of the Department of Health Services.

The Oral Health Program is guided by the *Texas Oral Health Improvement Act* (18)[2]. It was the intent of the legislature that the Act should be “construed liberally so that eligible individuals may receive appropriate and adequate oral health services in a timely manner” (18, §43.002).

It may conduct field research, collect data, and prepare statistical and other reports relating to the need for and availability of oral health services (18, §43.005). Moreover, it may administer or oversee 1) clinical care, 2) oral disease prevention (*e.g.*, community water fluoridation, school-based fluoride mouth rinse and pit and fissure dental sealant programs, 3) public health education for patients and providers, 4) the facilitation to access care to oral health services, 5) the improvement of the oral health services delivery system for low-income residents, 6) outreach activities to inform the public of the type and availability of oral health services to increase the accessibility of oral health care to low income residents, and 7) assistance and cooperation in promoting better distribution of dentists and oral health professionals throughout the state (18, §43.004). Moreover, the Oral Health Program “is not required to provide oral health services unless funds are appropriated … for that express purpose” (18, §43.013).

In addition to providing services with its staff, the Oral Health Program may enter into contracts and agreements “to facilitate the efficient and economical provision of oral health services” (18, §43.014). The proposals outlined in this plan are within the scope of the *Texas Oral Health Improvement Act*.

[2] *The Texas Oral Health Improvement Act* uses the term “Department” which we take to be the Health Department, of which the Oral Health Program is a component. In this section, we substitute the Oral Health Program for the Health Department.

3.0 ORAL HEALTH PLAN

3.1 Monitoring /Surveillance

3.1.1 Background

Monitor/Surveillance: *Monitor the burden of disease, risk factors, preventive services, and other associated factors* (8)*.*

Monitoring (surveillance) measures the prevalence and burden of oral diseases; describes the potential risk factors that impact the disease burden and other associated factors, and identifies available preventive services, workforce capacity, and other factors that impact the burden of oral diseases in the State of Texas. This process provides oral health information for stakeholders and policymakers to evaluate current systems and identify potential resources needed to improve the oral health of all Texans in the future and enables comparisons with other data such as the National Oral Health Surveillance System (NOHSS), jointly developed by the CDC and the Association of State and Territorial Dental Directors (ASTDD), and Healthy People 2020 (HP2020), which is maintained by the US Department of Health and Human Services (19). Moreover, the data help policy makers and public health personnel target available resources to best meet the state's oral health needs (20).

3.1.2 Existing Activity at the State Level

Monitoring (Surveillance) is OHP Core Function 3 (9) which comprises:

Gather[ing]*, provid*[ing]*, and maintain*[ing] *oral health data required by local, state, and federal policy makers for decision making, support, and documentation of oral health trends.*

a. Collect[ing] oral health data that is statistically valid by calibrated dentists.

b. Evaluat[ing] the effectiveness of implemented oral health strategies through annual strategic planning and programmatic evaluation activities.

c. Implement[ing] statistically valid Basic Screening Surveys (BSS) for targeted populations.

d. Submit[ting] data reports to management per program reporting requirements.

e. Collect[ing] convenience data for preventive dental services clinics.

f. Establish[ing] oral health surveillance system that utilizes various data sources (BRFSS, YRBS, Birth Defects, Cancer Registry, *etc*.) that describe oral health status.

g. Coordinat[ing] and conduct[ing] routine utilization reviews on randomly selected Medicaid dental providers.

3.1.2.1 The Texas Oral Health Surveillance System (TOHSS)

Oral health surveillance, the systematic collection, analysis, and interpretation of health data, is performed by the Texas Oral Health Surveillance System (21). Its purpose is to:

> *monitor trends in oral disease, such as early childhood caries, loss of teeth, and oral and pharyngeal cancer; effectiveness of preventive services, such as dental sealants, community water fluoridation, and fluoride varnish; and dental service utilization, through such programs such as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program and the Children's Health Insurance Plan (CHIP)* (21)*.*

The National Oral Health Surveillance System provides a snap-shot of the nation's overall oral health as well as that of migrant families, and children with disabilities. It tracks eight basic oral health surveillance indicators: 1) dental visits, 2) oral prophylaxis, 3) complete tooth loss at age 65 or older, 4) percent of the population with fluoridated water, 5) percent of third graders with dental caries experience, 6) percent of third graders with untreated dental caries, 7) percent of third graders with dental sealants on at least one permanent molar, and 8) number of people with oropharyngeal cancer (20).

3.1.3 Gaps

Surveillance is accomplished by analyzing primary data[3] (collected or sponsored by the DSHS-Oral Health Program) and secondary data[4] collected by other agencies – primarily the Centers for Disease Control and Prevention and The National Cancer Institute (Surveillance, Epidemiology, and End Result (SEER)), and data from other statewide and national registries.

While the TOHSS provides many useful data, its coverage is limited. For example, oral health surveillance data are not available for nursing home residents, state prisoners, the uninsured, home-bound elders, and the perinatal population. DSHS does have oral health surveillance data available on children with special health care needs through secondary data from the National Survey of Children's Health and the National

[3] For example, Basic Screening Survey (BSS) and Texas data for Water Fluoridation Reporting System (WFRS).

[4] Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance System (BRFSS), Texas Cancer Registry, Pregnancy Risk Assessment Monitoring System (PRAMS), utilization data from Medicaid EPSDT / CHIP, School Based Health Center (SBHC) Contract Reporting, Uniform Data System (UDS), and the Texas Birth Defects Registry.

Survey of Children with Special Health Care Needs. However, the oral health program does not have adequate funding to build the necessary infrastructure to support dental public health trained epidemiologists and biostatisticians to collect and analyze primary data or to analyze secondary data, nor perform program evaluation. (Core Function 3, *supra)*.

Though there are no formally trained dental public health specialists within OHP, the program does have access to and utilizes trained epidemiologists, researchers, and statisticians through the DSHS Office of Program Decision Support (OPDS) and Center for Health Statistics (CHS) and the HHSC Strategic Decision Support (SDS) staff. Due to the functional organizational structure of both HHSC and DSHS, programs within these agencies (to include OHP) are supported by epidemiological and research staff maintained by OPDS, CHS, and SDS.

As a result, the state lacks surveillance data in several critical domains, i.e., elderly institutionalized, adult working poor, adolescents and the quality of the analysis and reporting has been inadequate for program evaluation and development.

It is critical that surveillance study design and analysis be of a high quality to be considered credible by public health experts at the state and federal levels. The Texas Health and Human Services System Strategic Plan for 2011-2015 (22) recognizes several factors contributing to this issue, including the lack of available epidemiologists (23,24,25,26).

3.1.4 Action Items

- The HHSC should develop and implement a continuous oral health surveillance system in the State of Texas that is managed by the Department of State Health Services in consultation with the Texas Oral Health Coalition and its designated consultants. The creation and implementation of the state oral health surveillance program should include key stakeholders and experts in the field of oral epidemiology.
- The State should provide the various oral health program staffs with a sufficient number of individuals who have expertise in data collection and analysis (*i.e*., dental

public health epidemiology, and statistics) that can maintain a comprehensive oral health surveillance program in the State.[5,6]

- The Legislature and the HHSC should budget sufficient funds to contract with Texas Dental Schools and Dental Hygiene Programs that possess dental public health expertise to provide support for an oral health surveillance program. The Dental Schools and Dental Hygiene Programs would be contracted by collaborative interagency agreements to fill 'gaps' within the existing state program and should not be used to circumvent the state surveillance system. This should not be *ad hoc*, but a part of a multi-year plan developed in a partnership with the dental schools.
- The HHSC and Oral Health Program should build collaborations with existing local health departments and not-for-profit agencies that collect valid and reliable data to enhance the state data collection infrastructure.
- The HHSC and the Oral Health Program should explore opportunities to use secondary data to supplement the surveillance plan for the state.

3.2 Research

3.2.1 Background

Research: *Support public health research that directly applies to policies and programs.* (8)

Research is a broad activity that ranges from basic science research (*e.g.*, cellular-level) research to epidemiologic research (*e.g.*, oral health status) and health services research. Research can encompass the collection and analysis of clinical data (*e.g.*, periodic Basic Screening Survey [BSS]) or survey data (*e.g.*, Behavioral Risk Factor Surveillance System (BRFSS)) data. Epidemiologic and health services research are inextricably entwined with surveillance. Also, research can also include the gathering of data and information to guide policy development and for systematic planning of education initiatives for key stakeholders. One key component to research is the

[5] There are no dental public health specialists, epidemiologists, or statisticians in the Oral Health Program. This will be addressed in the Infrastructure section.

[6] These specialists should have graduate level training and the proven ability to publish in peer-reviewed journals.

dissemination of data to partners and stakeholders that can lead to an improvement in the oral health of all Texans.

3.2.2 Existing Activity at the State Level

The State Oral Health Program published a burden document, Oral Health in Texas, 2008 (27) that described the oral health of Texans. This document provided a well-crafted surveillance summary that could be used in program planning and to identify oral health issues to key stakeholders. No additional information has been made available since that time.

Currently, Texas participates in the Water Fluoridation Reporting System (WFRS) and reports fluoride levels to the Centers for Disease Control and Prevention. The data gathered from this activity allow the state to identify municipal water districts (MUD) that are in compliance with community water fluoridation standards and those systems that have challenges with community water fluoridation.

The Texas Cancer Registry (TCR) is a collaboration between the Texas Department of State Health Services, the National Program of Cancer Registries, the Centers for Disease Control and Prevention, and the Cancer Prevention and Research Institute of Texas. The TCR is a statewide population-based registry that serves as the foundation for measuring the Texas cancer burden, comprehensive cancer control efforts, health disparities and inequities, progress in prevention, diagnosis, treatment, and survivorship. In addition, it supports a wide variety of cancer-related research. These priorities cannot be adequately addressed in public health, academic institutions, or the private sector without timely, complete, and accurate cancer data (28).

An oral health workforce project is ongoing at the University of Texas Health Science Center at San Antonio. This project is a collaboration between the University, the San Antonio Metropolitan Health District and the State Oral Health Program. This program seeks to expand capacity by developing a model for population-based prevention at the community level and to assess the dental health workforce in the state.

A survey of oral health status of elders living in assisted living centers in the Dallas-Fort Worth region has been initiated by the Texas A & M Health Science Center, Baylor

College of Dentistry through a grant provided by Delta Dental to assess quality of life issues and oral health needs of this population group.

Additional workforce data are available through the Texas State Board of Dental Examiners (TSBDE). While this is not meant to be an exhaustive list of available data resources, the Oral Health Program should serve as a clearinghouse or resource providing investigators with sources of data for analysis.

3.2.3 Gaps

Current statewide data were published in 2008 and no continuous process is in place to evaluate the data. The Texas Department of State Health Services, Oral Health Program, developed a Surveillance Matrix that spans 2010-2018. According to the schedule (Appendix 6, *infra*), there will be no primary data collection until 2013 and the surveillance plan relies on secondary data sources. At this time, the state has not established ongoing collaborations with possible partner state organizations involved in research, including dental schools and dental hygiene schools, to analyze data from systematic surveillance. The Texas Oral Health Coalition, Surveillance Workgroup is no longer active. Surveillance is a core function of public health. Ongoing and continuous monitoring of the health of the population along with periodic reporting of the findings should be a primary function of the Department of State Health Services.

3.2.4 Action Items

- The HHSC should implement an organized, systematic and continuous data plan that utilizes the talents of all stakeholders (*e.g.*, Texas Oral Health Coalition, dental schools, dental hygiene schools, state epidemiologists, the State Dental Director for Medicaid and CHIP) to analyze and disseminate primary and secondary oral health data.
- The HHSC should develop an infrastructure within the state oral health program to promote oral health research utilizing data sharing agreements with key research stakeholders.
- The HHSC should establish collaborative, ongoing partnerships with the three Texas dental schools, dental hygiene schools, and the Texas Oral Health Coalition to develop research protocols, identify research questions, and to produce results that

are sufficiently robust to be publishable and disseminated to interested parties. These collaborations will fill gaps that cannot be easily met through the State Oral Health Program alone.

- The HHSC and Oral Health Program should provide the Texas Oral Health Coalition with research findings to disseminate to partners across the state.

3.3 Communications

3.3.1 Background

Communications: *Communicate timely and relevant information to impact policy, practices, and programs* (8)*.*

3.3.2 Existing Activity at the State Level

Currently the HHSC State Dental Director for Medicaid and CHIP holds quarterly stakeholder meetings in Austin. Incurred Medical Expense (IME) workgroup meetings are held annually. Notification of the meeting is sent by email. In 2012, for the first time, the meeting could be accessed via conference call. However, other than these meetings we are unaware of any other systematic communications from the State to any other stakeholders. There is a newsletter In Touch (29) published online by the HHSC which contains medical and programmatic information, and limited information related to oral health issues. However, the newsletter must be accessed actively or subscribed to by users via the internet.

3.3.3 Gaps

Currently there is no formalized system for either the Texas HHSC Office of Health Policy and Clinical Services or the Texas Oral Health Program to communicate to all stakeholders interested in oral health issues[7]. While some oral health related information is disseminated by other Texas agencies, it is not conveyed to all stakeholders through a systematic approach.

3.3.4 Action Items

- The HHSC should produce a quarterly electronic communication that would provide updates on Medicaid / Chip and Maternal Child Health (MCH) breaking news,

[7]For example, dentists, dental hygienists, dental assistants, legislators, and organizations with an interest in oral health.

community water fluoridation status, policy changes, and other issues that have an impact on the oral health of all Texans. This newsletter should be widely communicated to all stakeholders and broad array of potential stakeholders, including the state legislators, public health committee members, members of the dental and dental hygiene community, and not-for-profit agencies (*e.g.*, United Way), partners (Texas Association of Community Health Centers [TACHC], Texas Association of School Nurses [TASN]) or other agencies which have a vested interest in overall health in general, and/or oral health in particular.

- The HHSC and Oral Health Program should empower the Texas Oral Health Coalition to assist in the maintenance of electronic mailing lists or establishment of a social media application for such a communication tool at a low cost. To assume this role, the Coalition must have access to all pertinent communication and this access should be facilitated by Texas Oral Health Coalition partners.
- The HHSC should make the Medicaid Stakeholders meeting widely available and interactive via electronic means, using web-based technology.

3.4 Preventive Strategies

3.4.1 Background

Preventive Strategies: *Support the implementation and maintenance of effective strategies and interventions to reduce the burden of oral diseases and conditions (*8*).*

Prevention is Texas Oral Health Program Core Function 1 (9). It comprises

a. *Screen*[ing] *and identify*[ing] *populations needing dental services.*
b. *Provid*[ing] *preventive dental services and treatment referrals.*
c. *Develop*[ing] *and promot*[ing] *evidence-based strategies and interventions to prevent and control oral diseases.*
d. *Provid*[ing] *dental sealant and fluoride varnish programs through a school-based delivery model.*
e. *Provid*[ing] *oversight and coordination of public health dental functions.*
f. *Educat*[ing] *Texans regarding good oral health and how it relates to overall health.*
g. *Address*[ing] *disparities in oral health.*
h. *Facilitat*[ing]*, monitor*[ing]*, and evaluat*[ing] *sealant program effectiveness.*

Not all preventive services are supported by a strong evidence base. For example, only community water fluoridation and school sealant programs are endorsed by the CDC. Other preventive services have been recommended by ADA/CDC Evidence Based Guidelines and Cochrane Reviews, *i.e.,* fluoride varnish and pit and fissure dental sealants. In developing the oral health plan our recommended preventive services were limited to those with a strong evidence base.

3.4.1.1 Community Water Fluoridation

Community water fluoridation involves adding fluoride (which prevents dental cavities) to community water sources, then adjusting and monitoring the amount of fluoride to ensure that it stays at the desired level. The Guide to Community Preventive Services developed by the Community Preventive Services Task Force endorses community water fluoridation (30). Results from the 21 studies qualified for Systematic Reviews showed the following findings:

- Dental caries rates measured before and after community water fluoridation: median decrease of 29.1% among children ages 4 to 17 years when compared with control groups (21 study arms).
- Dental caries rates measured after water fluoridation only: median decrease of 50.7% among children ages 4 to 17 years when compared with control groups (20 study arms).
- Community water fluoridation was found to help decrease tooth decay both in communities with varying decay rates and among children of varying socioeconomic status.

Nine studies qualified for review of the economic efficiency of community water fluoridation programs (30).

- Median cost per person per year for 75 water systems receiving fluoridated water: $2.70 among 19 systems serving <=5000 people to $0.40 among 35 systems serving >=20,000 people (7 studies).
- Community water fluoridation was cost saving (5 studies).
- In smaller communities (5000 to 20,000 residents), community water fluoridation was estimated to be a cost-saving where decay incidence in the community exceeds 0.06 tooth surfaces per person annually.

3.4.1.2 School-Based Dental Sealant Programs

School-based sealant programs are identified by the Centers for Disease Control and Prevention and recommended by the Community Preventive Services Task Force, Guide to Community Preventive Services (31), as one of two community-based preventive measures that has strong evidence demonstrating its effectiveness in the prevention of dental caries. Statewide or community-wide sealant promotion as an intervention has insufficient evidence for endorsement. School-based or school-linked pit and fissure dental sealant delivery programs directly provide pit and fissure dental sealants to children unlikely to receive them otherwise.

School-based programs are conducted entirely in the school setting, and school-linked programs are conducted in both schools and clinic settings outside schools. Such programs define a target population within a school district; verify unmet need for sealants (by conducting surveys); get financial, material, and policy support; apply rules for selecting schools and students; screen and enroll students at school; and apply sealant at school or offsite in clinics.

School-based dental sealant programs target what are referred to as high-risk children with high-risk teeth. High-risk children include vulnerable populations that are less likely to receive dental care in the private sector, such as children eligible for free or reduced-cost lunch programs. High-risk teeth (*i.e.*, those with deep pits and fissures) are the first and second permanent molars that erupt into the mouth around the ages of 6 and 12 years, respectively. School-based and school-linked sealant programs are strongly recommended on the basis of strong evidence of effectiveness in reducing caries on occlusal surfaces of posterior teeth among children.

3.4.1.3 Fluoride Varnish Programs

Fluoride varnishes applied professionally two to four times a year would substantially reduce dental caries in children (**Error! Bookmark not defined.**). Fluoride is a mineral that prevents tooth decay (dental caries). Since widespread use of fluoride toothpastes and community water fluoridation, the value of additional fluoride has been questioned in the literature. Fluoride varnishes can be professionally applied at a frequency from two to four times a year. The review of clinical trials found that fluoride varnish can substantially reduce dental caries in both primary and permanent teeth. However, more

high quality research is needed to assess the difference this preventive modality provides as well as to evaluate the effects and acceptability (**Error! Bookmark not defined.**).

A meta-analysis of nine studies comprising 2,709 children found a substantial caries-inhibiting effect of fluoride varnish in both the permanent and the primary dentitions based largely on clinical trials without treatment controls (31).

3.4.1.4 First Dental Home Program

A dental home is "[t]he ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate" (32).[8] The First Dental Home (FDH) program is uniquely aimed at children enrolled in Medicaid and is an initiative of the *Frew vs. Suehs*[9] corrective action plan. Based on available paid claims and encounter data during the period March 1, 2008, through February 28, 2011, "FDH services were provided to more than 456,600 children (unduplicated count)—this represents an increase of FDH services to more than 44,600 children over the previous quarter."(33)

3.4.2 Existing Activity at the State Level

3.4.2.1 Community Water Fluoridation

Texas currently[10] reports 79.3% of the population drinking fluoridated water. The Healthy People 2020 goal is 79.6% for the United States (34). The scientific evidence is irrefutable that community water fluoridation is effective in reducing tooth decay in adults and children.

3.4.2.2 School-Based Sealant Programs

The Oral Health Program in Texas, for the latest year for which statistics are available (FY 2011), provided direct patient care preventive services to 10,489 unduplicated children. Approximately 3,683 children received a total of 15,354 dental

[8] The American Dental Association definition is not materially different.

[9] Formerly known as *Frew v. Hawkins*.

[10] December 2011.

sealants in 168 sites across the state. A national report card found that Texas in 2010 had school-based dental sealant programs in place in less than 25 percent of the high-risk schools (35).

3.4.2.3 Fluoride Varnish Programs

In FY 2011 the State Oral Health Program provided fluoride varnish to 10,684 children in 168 sites across Texas.

3.4.2.4 First Dental Home Program

From a 2010 DSHS report evaluating the First Dental Home (FDH) and the Oral Evaluation and Fluoride Varnish in the Medical Home, 815 pediatric and general dentists participated in FDH training with 674 of those dentists billing for FDH services (82.6%). This represented a participation rate of 78.3% of pediatric dental Medicaid providers and 20.1% of general dental Medicaid providers (36). However, these numbers of FDH providers represent just 5.7% of the state dental workforce and 15.7% of dental Medicaid providers who billed at least one paid claim in FY2010 (37).

3.4.2.4.1 Initiative Purpose

The First Dental Home (FDH) strategic initiative provides routine preventive dental services to infants and very young children enrolled in Medicaid to reduce the incidence of dental caries in early childhood and to avoid additional dental health issues or dental procedures, such as restorative and oral surgery (*e.g.*, extractions) in an operating room. Parents or caretakers accompany their young children during FDH examinations and this provides dental professionals the opportunity to provide parental education and anticipatory guidance based on national standards. This project is expected to meet all four strategic initiative objectives of the *Frew v. Suehs* corrective action plan including improving participation and utilization of Medicaid services among clients and providers, improving appropriate utilization of medically necessary services, and improving coordination of care.

3.4.2.4.2 Status

The target population is children who are six through 35 months of age and are enrolled in Medicaid. The Health and Human Services Commission (HHSC) received approval for this project in December, 2007. The Department of State Health Services (DSHS) began the FDH provider education for pediatric dentists in March, 2008, and for general dentists in May, 2008.

DSHS continues to offer FDH in-person education to senior dental students and pediatric dental residents at the three Texas dental schools and to dentists working in private practices. These professional education efforts are held in conjunction with collaborations offered at the three dental schools and through continuing education programs coordinated at annual meetings of Texas dental professional organizations. In June 2010, the FDH on-line module became available, which offers dental providers and their staff members an additional continuing education option.

3.4.2.4.3 Class Members Served

Based on available paid claims and encounter data, during the period March 1, 2008, through February 28, 2011, FDH services were provided to more than 456,600 children[11] - this represents an increase of FDH services to more than 44,600 children over the previous quarter.

3.4.3 Gaps

There are no prevention programs identified for other age groups other than children. Prevention models for the vulnerable institutionalized elderly are nonexistent and must embrace integrated approaches which include medical and social services rather than isolated strategies.

3.4.3.1 Community Water Fluoridation

There are still many communities in Texas which have never fluoridated the public water supply, have allowed community water fluoridation to cease, or who have actively opposed fluoridation.

3.4.3.2 School-Based Dental Sealant Programs

[11] Unduplicated count.

Limited funds are targeted for school-based sealant programs in the State of Texas. The Oral Health Program's sealant initiative is underfunded for the number of children who are in need of this preventive service. The State of Texas has stipulated that the new managed dental care organizations embrace a "main dentist" concept. This requirement may deter some agencies and organizations from reaching high-risk children and providing evidence-based services through school-based dental sealants programs if these programs are dependent upon Medicaid or CHIP to sustain these community-based preventive services recommended by national agencies.

The Oral Health Program continues to support and provide dental sealants and other preventive dental services in a school setting. However, due to federal Medicaid regulations, if health care services are offered to a non-Medicaid/CHIP individual at a discount or free, then the same discount (including free services) must be afforded the state Medicaid/CHIP programs. As many of the school-based dental sealant programs offer services free to children who do not have Medicaid/CHIP services, then they must also refrain from billing Medicaid and CHIP for the dental sealants and other services or be in violation of federal statutes.

3.4.3.3 Fluoride Varnish Programs

There is no funding specifically targeted to fluoride varnish programs in the state of Texas. The Oral Health Program's fluoride varnish program is underfunded for the number of children who could benefit from this preventive service. Also, some fluoride varnish programs may be diminished in the very near future under the "main dentist" model specified by the State of Texas and used by the managed dental care organizations if these community-based programs were reimbursed through Medicaid or CHIP funding in the past.

3.4.3.4 First Dental Home Program

While the First Dental Home Program has been implemented in Texas, and reports show an increase in the number of services provided since its inception, its effectiveness in preventing disease and its cost-effectiveness are being subjected to a longitudinal scientific evaluation. A report of the longitudinal findings for the first three years of FDH should be forthcoming within the next several months.

In several states, physicians, nurse practitioners, and physician assistants are taught to perform a risk assessment, provide a fluoride varnish application and anticipatory guidance to the parents, and refer, if necessary, to a dentist for care (38). These programs have been shown to be effective since children will often visit the pediatrician before visiting the dentist. Opportunities to utilize an inter-professional model of oral health care should be considered for Texas, building upon the Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV) initiative.

3.4.4 Action Items

3.4.4.1 Community Water Fluoridation

- The Texas Oral Health Coalition recommends continued support through current DSHS administration to assist communities in the design and implementation of water fluoridation systems by qualified water fluoridation engineers so that the Healthy People 2020 goal can be reached and maintained in Texas.
- The Texas Oral Health Coalition supports optimal community water fluoridation as a primary preventive practice against dental caries with sufficient evidence and efficacy to justify the continuation and expansion of state fluoridation projects.

3.4.4.2 School-Based Dental Sealant Programs

- The State should support Medicaid reimbursement for children enrolled in Medicaid Managed Care Organizations who receive preventive services through school-based/school-linked dental sealant programs operated by local and state governmental entities, not-for-profit agencies, dental schools and dental hygiene programs. Also, this reimbursement for preventive services would include school-based sealant programs that are linked to school-based health centers. This reimbursement by Medicaid would be allowed for services provided outside of the

dental home for preventive services only for the specified non-profit entities. In addition, the OHP should also continue to support fluoride varnish applications in the First Dental Home program for both dentists and physicians who administer such preventive services through the first 35 months of life. However, an evaluation plan should be designed and executed to determine if these preventive attempts are efficacious in the current modalities in which they are performed in Texas.

- The Texas Oral Health Coalition should support DSHS and HHSC regulations prohibiting a provider from billing Medicaid for services that are also being offered to non-Medicaid clients for free or at a reduced cost.
- There are a variety of non-profit organizations, faith based organizations, school districts, and dental schools providing school-based dental sealants in the state. The Texas Oral Health Coalition recommends that HHSC support these efforts by providing information and technical assistance to organizations and communities who wish to plan, implement, and evaluate such programs in the future.
- The Texas Oral Health Coalition supports school-based dental sealant programs as a proven strategic prevention measure to reduce the dental caries burden in Texas.

3.4.4.3 Fluoride Varnish Programs

- Based on the Marinho *et al*. review (**Error! Bookmark not defined.**), the Texas Oral Health Coalition supports fluoride varnish programs for children enrolled in Head Start Programs, as well as children in school based dental sealant programs. These community based programs should provide linkage to comprehensive dental services in a dental home.

3.5 Infrastructure Development

3.5.1 Background

State infrastructure: *Build capacity and infrastructure for sustainable, effective, and efficient oral health programs* (8).

Oral Health in America: A Report of the Surgeon General states that *"The public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups, and the integration of oral and general health programs is lacking.*(2)"

3.5.2 Existing Activity at the State Level

The State of Texas employs dentists in several departments across the Health and Human Services Commission. More than 100 dentists work within the HHSC and have positions in the Department of Aging and Disability Services, the Department of State Health Services, the Texas Department of Criminal Justice (including correctional dentists in the University of Texas Medical Branch and Texas Tech correctional facilities programs) (39). Based on organizational charts for these departments, it is unclear who is in charge administratively of the dentists employed in state hospitals, and in state supported living centers. The State Dental Director for Medicaid and CHIP is located in the HHSC, Office of Health Policy and Clinical Services. The Oral Health Program has a Dental Director at headquarters in Austin and dentists and dental hygienists employed in regional locations (40).[12] The Health Program Preventive Dental Service Regional Teams functions are as follows (41):

1. *Provid*[ing] *and coordinat*[ing] *preventive dental services in border, rural, frontier, and other underserved areas of the state for school-aged children, Head Start centers, daycares, and other venues.*

2. *Coordinat*[ing] *with DSHS epidemiologists to maintain a statewide oral health surveillance system.*
3. *Support*[ing] *the dental home concept for children to enhance access to dental care and assist*[ing] *in identifying local dental home resources for children with limited or no access to dental care.*
4. *Develop*[ing] *and coordinat*[ing *collaborative partnerships to increase state capacity through linkages with academic institutions, local health departments, professional organizations, community health centers, tribal health centers, and community-based organizations.*
5. *Provid*[ing] *leadership and support for community-based solutions to address oral health needs.*
6. *Serv*[ing] *as technical advisors to Medicaid, CHIP, Title V, Children with Special Health Care Needs Services Program and other HHSC adult programs by participation on committees and special projects.*

[12] Dentist and dental hygienist positions in Regions 1/2 (Lubbock), 3/4/5N (Tyler), 5S/6/7 (Houston), 8/11 (San Antonio), and 9/10 (Midland). Regions 3/4 and 9/10 have a hygienist vacancy and Regions 5S/6/7 and 9/10 have a dentist vacancy at the time of this writing.

7. *Conduct*[ing] *dental utilization reviews of Medicaid Providers in the regions and provide staff and resources when directed by HHSC, Office of Inspection and Enforcement (OIE), for targeted utilization reviews.*

3.5.3 Gaps

- There is a lack of legislative appropriations for the authorized *Oral Health Improvement Act* programs.
- There is a lack of appropriately educated support staff to develop and monitor oral health programs, *i.e.*, dental public health statisticians and epidemiologists.
- There is a lack of dentists with advanced education in dental public health (MPH degreed, dental public health [DPH] certificate). The CDC recommends that "[t]o develop effective leadership within state oral health programs, a state will benefit by employing a full-time dental director who is an oral health professional with training in public health" (42).[13] Moreover, Healthy People 2020 goals include "Increas[ing] the proportion of States (including the District of Columbia) and local health agencies that serve jurisdictions of 250,000 or more persons with a dental public health program directed by a dental professional with public health training" (43).
- The Oral Health Program is submerged too deeply within the organizational structure of the Texas Department of State Health Services (DSHS)
- Dentists working in the Department of State Health Services (DSHS) have low salaries compared to dentists in positions within other state agencies (*e.g.*, Department of Aging and Disability Services, correctional care dentists) (30).
- There is no overarching dental administrative supervision and no surveillance systems or program evaluations existing currently for oral health related programs

[13] **"**Activity 1 further states that Strong program infrastructure is an essential component to a successful program. Infrastructure enables a program to increase capacity, enhance support, and build sustainability. In addition, the following staff is also important for developing effective oral health program infrastructure (minimum availability shown for each type of expertise): [1] Program coordinator (.5 full-time equivalent [FTE]), [2] Epidemiologist (.5 FTE), [3] Water fluoridation engineer/specialist or coordinator (.5 FTE), [4] Dental sealant program coordinator (.5 FTE), [5] Other appropriate staff, including: Program evaluator (.25 FTE), Health education/health communication specialist (.25 FTE), [and] [a]dequate support staff. States that have met the minimal staffing levels (shown above) may wish to employ FTEs at greater amounts or acquire additional capacity by sharing positions, such as those for a fiscal coordinator or a grant writer. If states have insufficient funding for dedicated staff, they may seek ways to build infrastructure by leveraging existing state resources and sharing staff time with other programs" (42).

funded by the Texas Department of Aging and Disability Services (DADS)[14], the Texas Department of State Health Services (DSHS), and the Texas Department of Criminal Justice (TDCJ).

3.5.4 Action Items

- The Texas Oral Health Coalition and other non-governmental stakeholders should educate key legislators about the importance of the oral health program and other initiatives identified in the oral health plan, so that funding may be restored or even increased for authorized oral health initiatives.
- In the event of decreased or continually inadequate funding, the HHSC should evaluate the potential of moving regional positions to headquarters and filling them with public health dentistry specialists, epidemiologists, statisticians, and experts in program evaluation. Regional Dentists should possess MPH degrees as do their counterpart physician Regional Medical Directors (44).
- The DSHS should amend the job description of the DSHS Oral Health Program Dental Director to require that in addition to being a Texas licensed dentist, the Program Director possess a graduate degree in public health and has completed a Dental Public Health Residency. Additional training in public health for the Oral Health Program Dental Director is advocated in Healthy People 2020 Oral Health Objectives (45)[15].
- The DSHS should amend the job descriptions for dentists working for DSHS to recommend a graduate degree in public health.
- The Legislature should appropriate funds to the OHP that are needed to collect, analyze and disseminate data on oral health, including but not limited to statewide surveys, needs assessments, and outcomes measurements (16).
- The DSHS should establish a Dental Public Health Residency Program within the DSHS Office of Academic Linkages to provide equal opportunity to dentists that physicians in the DSHS Preventive Medicine residencies have at the state level (46).

[14] The DADS dental emergency policy for nursing facilities does not have oversight.

[15] OH- 17.1. “Increase the proportion of States (including the District of Columbia) and local health agencies that serve jurisdictions of 250,000 or more persons with a dental public health program directed by a dental professional with public health training.”

Alternatively, partnerships with the state's dental schools should be explored to accomplish this goal.

- The Oral Health Program should partner with the DSHS Center for Health Statistics for conducting dental/oral health surveys and data analysis if statistical expertise is not otherwise available (47).[16] The Oral Health Program does partner with designated DSHS program areas and staff as deemed appropriate by the executive management of DSHS.

3.6 Evaluation

3.6.1 Background

Evaluation: *Evaluate programs to ensure successful implementation* (8)*.*

Evaluation is an element of two of the Oral Health Program's Core functions (9):

Core Function 1: Facilitate, monitor, and evaluate sealant program effectiveness.

Core Function 3: Evaluate the effectiveness of implemented oral health strategies through annual strategic planning and programmatic evaluation activities;

3.6.2 Existing Activity at the State Level

Programmatic evaluation of the Oral Health Program dental sealant and fluoride varnish program is limited to encounter data. A plan for future surveillance activities includes a Basic Screening Survey for third graders in FY 2012, and a Behavioral Risk Factor Surveillance System survey for adults in FY 2012. Medicaid, CHIP, Fluoridation Status (WFRS), and Cancer Registry data are planned to be supplied in all future fiscal years (Appendix 5).

3.6.3 Gaps

Currently there are limited data with which to evaluate the effectiveness of the state's oral health program (see surveillance/research sections). In addition to the paucity of data, there is no formal evaluation of the effectiveness of the state's oral health programs. Routine evaluation is critical to ensure the proper stewardship of the

[16] The Center for Health Statistics states that it is the "Portal for Comprehensive Health Data in Texas"; however, no oral health data are provided on its home page.

state's resources. Improving data quality and use is also recognized as an important action item for the Department of State Health Services in the Texas HHS System Strategic Plan (22; Section 8.4.3).

The *Frew v. Suehs* lawsuit (48) resulted in several dental-related initiatives, including the First Dental Home program and the Oral Evaluation and Application of Fluoride Varnish in the Medical Home. A recent evaluation of these initiatives has been performed (49); however, there is no methodologically sound evaluation of the effectiveness of either program's stated impact: "Changes in the number and proportion of class members 6-35 months of age requiring dental treatment in an Operating Room/Ambulatory Surgery Center setting."

A retrospective data analysis plan should be in place to measure any discernible change in the number of operating room cases occurring across the state over time. This will require the state to hire or contract with epidemiologists and dental public health educated specialists to design and conduct studies to evaluate the programs, in addition to having quality data available from Medicaid utilization reviews and hospital discharge data.

3.6.4 Action Items

- The State Dental Director for Texas Medicaid and CHIP programs should develop evaluation plans for all the oral health programs funded by Texas Medicaid and CHIP resources and establish a schedule for the evaluations. For each evaluation, the data required and the evaluation methodology shall be specified based on recognized research standards. Where data to support program are not available, the surveillance system should be modified to obtain the necessary data for ongoing systematic evaluation.
- An external review committee should be established to review all program evaluations, including Oral Health Program activities, and make formal recommendations as to whether the program should be retained unchanged, or modified to meet changing needs in Texas. This external committee should be composed of dental public health specialists and epidemiologists with education and credentials in dental bioinformatics and research study design.

- The Texas Department of State Health Services and Texas HHSC State Office of Health Policy and Clinical Services should support the review and evaluation of the First Dental Home program and the Oral Evaluation and Application of Fluoride Varnish in the Medical Home program. The information from the evaluation should be used to measure the effectiveness of the programs and modify the programs as needed to assure improvements in oral health status and outcomes in Texas.

3.7 Partnerships

3.7.1 Background

Partnerships: Identify and facilitate oral health partnerships to support CDC strategic priorities and enhance community efforts (8).

The Texas Oral Health Program Core Function that deals with partnerships states:

Develop[ing] *a collaborative network of community and professional partners to increase delivery systems for the implementation of preventive dental services programs* (9).

- The HHSC and Oral Health Program should develop and maintain liaison relationships with dental and medical professional organizations, professional schools, and individuals in organizations that are seeking to provide dental public health services.
- The Oral Health Program should work to involve the public, private, and non-profit local groups, agencies, and individuals interested in improving dental public health services in underserved areas and addressing the needs of vulnerable populations.
- The Oral Health Program should serve as an active collaborative partner with other public health, community, and statewide entities to promote improved oral health for all Texans.
- The Oral Health Program should serve as a referral liaison between Texans and regional public health programs and community partners.
- The HHSC and the Oral Health Program should promote oral health for the most vulnerable elderly by facilitating initiatives and communication with state and local aging agencies and organization which are involved with long term care facilities and other key aging services.

- The HHSC and the Oral Health Program should support mentoring opportunities in oral health across medical and social service disciplines and programs involved in long term care and other key aging services.

3.7.2 Existing Activity at the State Level

According to the Texas Department of State Health Services Oral Health Program, the OHP staff has worked to establish and maintain working relationships with all three Texas dental schools, several Texas dental hygiene programs, the Texas State Head Start Collaboration Office, Texas Dental Association, Texas Dental Hygienists' Association, Texas Academy of Pediatric Dentistry, Texas Academy of General Dentistry, Texas Maternal and Child Health Program, Texas Children with Special Health Care Needs Services Program, Texas Medicaid and CHIP Division, Texas Department of Aging and Disability Services, Texas Department of Family and Protective Services, Texas Diabetes Program, Texas Fluoridation Project, Texas Oral Health Coalition, Baylor College of Medicine, Texas A&M School of Medicine, Texas Tech School of Medicine, Texas Medical Association, Texas Pediatric Society, Association of State and Territorial Dental Directors, Medicaid-CHIP State Dental Association, American Dental Association, and the American Dental Hygienists' Association, as well as various local health departments operating in the cities of Houston, Laredo, San Antonio, and El Paso, community and faith based organizations such as Methodist Healthcare Ministries, and local hospital systems including Dell Children's Hospital (Austin), Cook Children's Hospital (Fort Worth), and Driscoll Children's Hospital (Corpus Christi).

3.7.3 Gaps

Collaborations between Head Start and the American Academy of Pediatric Dentistry (AAPD) have been successful in the initial efforts of matching dentists with children enrolled in Head Start Programs. This has been facilitated also by the Texas Dental Association. The national Office of Head Start discontinued its partnership with AAPD in November, 2010 (50). Moreover, there is no state level facilitation that promotes oral health at the end of the life span in coordination with state organizations involved with long term care.

3.7.4 Action Items

- Providing oral care to medically complicated elderly must overcome unique and complex logistical barriers that require multidisciplinary strategies. The Texas Oral Health Coalition should establish a Long Term Care Work Group that consists of representatives and key stakeholders from private, public, and nonprofit state and local organizations and agencies working on aging issues including long term care industry representatives.

3.8 Policy Development

3.8.1 Background

Policy development: *Develop and advocate sound public health policies* (8).

3.8.2 Existing Activity at the State Level

The CDC Division of Oral Health in cooperation with the Children's Dental Health Project (CDHP), the Department of State Health Services, and the Texas Oral Health Coalition conducted a Policy Workshop in spring, 2012. The workshop was designed to bring together oral health advocates to facilitate critical thinking about the state's oral health policies and systems. Fifty-two individuals participated in the Policy Workshop, representing dental and dental hygiene organizations, public health professionals, community health advocates, and other interested parties.

The Director of the Texas Oral Health Program welcomed participants to the half-day workshop. Two CDHP Facilitators introduced the Policy Tool and the agenda for the session. Participants were asked to introduce themselves and the organization or constituency they represented.

Participants were requested to suggest a policy or systems change priority for discussion, and to clarify how each might impact the oral health status of Texas communities. In addition to policy and systems change priorities, a number of programmatic suggestions were generated from which five priority issues were selected. Two of the issues identified as priorities at the Policy Workshop included community water fluoridation and oral health surveillance across the lifespan. These key issues have been described in detail in the Texas Oral Health Plan. Three other

issues are identified as gaps in the current oral health activities of the state and will be discussed in the next Gaps section (3.8.3).

3.8.3 Gaps

3.8.3.1 ElderCare

In Texas, Medicaid eligible residents in long term care with an incurred medical expense account (IME) may use the Medicaid IME process to access medically non contraindicated dental care. The reimbursement process is inconsistent among the 11 regions (51).

Federal requirements include the provision of dental care for nursing homes receiving Medicare and Medicaid funding (52). Subsequent amendments included dentistry (53). Each nursing home resident must undergo a Nursing Home Resident Assessment with an instrument called the Minimum Data Set (MDS), which includes sections on Oral/Nutritional Status and Oral/Dental Status (54). Nursing homes must assist residents in obtaining routine and emergency dental care (55). Routine care requires an annual exam (56). An emergency involves an episode of pain or other dental problem that requires immediate attention (56). Nursing homes can arrange services by hiring a local dentist or by having an agreement with a local dentist to treat residents (56). If a resident's dentures are lost or damaged, the nursing home is required to make a prompt referral to a dentist and to aggressively work at replacing the dentures (56).

Nursing facility residents continue to have significant oral health care needs. Katz *et al.* described an operational definition of oral neglect in institutionalized elderly in the United States (57).[17] Another gap is that despite the mandate that nursing facilities must make emergency dental care available for their residents, there is no well-defined process for obtaining reimbursement for residents who do not have an applied income.

3.8.3.2 Oral Health Literacy

[17] The clinical implication is stated as follows: *"Since federal legislation that funds payments to nursing homes for the care and housing of their residents requires that there shall be no oral neglect, this validated consensus ONiIE [Oral Neglect in Institutionalized Elderly] definition provides a utilitarian means to enforce that legislative expectation.".*

Health literacy in dentistry is "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions" (58). Nearly nine out of ten U.S. adults have difficulty understanding and using everyday health information that is generally available in health care facilities, retail outlets, media and communities. The average American reads at the 8th to 9th grade level; however, health information is usually written at a higher reading level (59). Texas Health and Human Services Commission should make health literacy, including oral health literacy, a part of the HHSC System Strategic Plan. Strategies should include: Simplifying and making written materials easier to understand[18]; **i**mproving providers' communication skills[19]; and **i**mproving patients' self-management skills[20] (60**).**

3.8.3.3 The Dental Home

The dental home in contrast to the First Dental Home initiative was a policy priority identified by the Texas Oral Health Coalition policy development workshop (¶ 2.2, *supra*). The dental home should be promoted through professional education according to the recommendations outlined by the attendees of the Policy Workshop. There is little funding through any government agency revenues or non-profit organizations for this initiative. Promotion of this concept by individual health care professionals and professional dental organizations is encouraged to promote dental homes for working adults and the elderly as well as children not included in the First Dental Home initiative.

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[18] Medication counseling using a plain language, pictogram-based intervention resulted in fewer medication-dosage errors (5.4 percent versus 47.8 percent) and greater adherence, compared to standard medication counseling (38 percent versus 9.3 percent).

[19] A study of rates of participation in colon cancer screening compared two groups of providers. One group received feedback on their patients' health literacy status and underwent subsequent training in communicating with patients who had limited literacy skills; the second group did not. The patients of the first group of providers had higher colon cancer screening rates than the patients of the second group of providers (41.3 percent versus 32.4 percent). Among patients with limited literacy, screening rates for patients of providers in the first group were almost twice as high as those for patients of providers in the second group (55.7 percent versus 30 percent).

[20] A congestive heart failure self-management program—featuring education on self-care, picture-based educational materials, and scheduled telephone follow-up to reinforce adherence to necessary medication regimens and daily weight measurement—reduced hospitalization rates and mortality by 35 percent, compared with patients in the control group. Similarly, patients with limited literacy who received a diabetes self-management program that used health literacy strategies were more likely to achieve program goals than people with diabetes who received usual care (42 percent versus 15 percent).

The Texas Oral Health Coalition should facilitate this concept through its communications and website presence in collaboration with the TDA, TDHA, Texas Academy of General Dentistry (TAGD) and other professional organizations.

3.8.4 Action Items

- The HHSC and DSHS should continue to support policies that allow for resources to support the provision of dental care to nursing home residents through coordination with the Texas Department of Aging and Disability Services (DADS), and residents of group homes through the Intermediate Care Facilities-Mental Retardation program, as well as the Children with Special Health Care Needs program (CSHCN) in DSHS.
- The HHSC should support reinstatement of the dentist loan repayment program which was discontinued by the Texas legislature. Loan repayment programs are vital in recruiting and retaining dentists in rural and other underserved areas of the state, in helping establish dental homes in those areas, and originally were funded as one of the initiatives of the *Frew v. Suehs* settlement (22; p 79).
- The TDCJ should support basic dental care[21] for all state prisoners, jailed adults, and juvenile detainees across the state, to be provided by qualified dental personnel. Collaboration with state oral epidemiologists and qualified public health dentists within the DSHS should be made possible with the TDCJ through interagency memoranda of understanding to design surveillance systems and quality assurance programs within these institutions.
- The State should support efforts to expand fluoride varnish programs in Head Start Centers, along with school based sealant programs as the evidence base continues to grow regarding the effectiveness of such programs. These programs should be supported by the reimbursement policies for enrolled recipients funded through the Medicaid and CHIP programs.
- The HHSC should support conducting needs assessments for elders in the state, particularly those residing in nursing homes, and support the appropriation of funds

[21] This includes dentures, basic restorative dentistry and extractions.

to provide preventive care to nursing home residents enrolled in Medicaid by qualified dental health personnel, as permitted by the *Texas Occupations Code*.

- The HHSC should support the concept of "dental home" for the elderly in long term care. A dental home must be available to provide diagnostic, preventive and comprehensive care and referrals when appropriate.
- The HHSC should ensure that oral health assessments are being monitored with improved auditing efforts of the Minimum Data Set.
- Since state and federal law[22] require nursing facilities (NFs) that receive Medicare and/or Medicaid funding be directly responsible for the dental care of their residents, the HHSC should promote the inclusion of a licensed dental professional on the multidisciplinary team (Nursing Facility Dental Program Director) which helps coordinate the individualized oral care plan for residents in long term care. The Nursing Facility Dental Program Director would help ensure that the NF is not in violation of any State and Federal Law regarding dental care; provide dental in-service training and assist in acquiring funding for dental care.
- The HHSC should embrace the "Health Literacy in Dentistry Action Plan 2010-2015" promoted by the American Dental Association.

3.9 Internal Advocacy

Policy for public programs should come from the Dental Public Health specialty area and a variety of knowledgeable and interested stakeholders. Though it is not possible for the Oral Health Program (OHP) or its employees to lobby the legislature, internal advocacy within the DSHS and HHSC is the responsibility and prerogative of the OHP Dental Director, and the HHSC Dental Director for Medicaid and CHIP, with the support of identified partners in this document. The HHSC and DSHS in partnership with the Texas dental schools should be the repository of dental public health expertise in the state. It should monitor and promote the oral health efforts of all state and local governmental entities and provide advice as to the scientific and programmatic validity of the programs, and be prepared to provide technical assistance to such programs.

[22] *The Omnibus Budget Reconciliation Act, 1987.*

3.9.1 Dental Medicaid

The changes to the Medicaid program that resulted from *Frew v. Suehs* (48) are a good example of how the Texas OHP and State Dental Director internally advocated for an increased profile of preventive services, including the coverage of fluoride varnish services which could be rendered by either dental providers or medical providers in the First Dental Home Program, and for increased fees for selected oral health services to increase provider participation in the Medicaid program.

Another example of interactions between the OHP State Dental Director and the HHSC occurred when the review of "non-routine" dental services for elders in nursing facilities by non-dental personnel was changed and reasonable increases in fees were enacted to increase access to care for these vulnerable populations.

3.9.2 Corrections

The Texas Department of Criminal Justice (TDCJ) incarcerates 171,249 (61) adults and 1,689 incarcerated juveniles (62), with 36,485 juveniles under some form of supervision (63). These individuals have a constitutional entitlement to health care which subsumes dental care (64). Since *Estelle v. Gamble* (64) was decided, the courts have held that health that demonstrates 'deliberate indifference'[23] (65) to 'serious medical needs'[24] falls below the constitutional threshold in violation of the *Eighth Amendment* (66).[25] Moreover, courts have held that dental conditions meeting the above criteria can be serious medical needs.

In Texas, health care to adult prison inmates is provided under contract to the TDCJ by the University of Texas Medical Branch at Galveston[26] and Texas Tech University Health Science Center. Dental care is provided pursuant to TDCJ policies and

[23] Deliberate indifference is subjective recklessness; that is "when a person has disregarded a risk of harm of which he was aware". (See *Farmer v. Brennan*, *supra*).

[24] Whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment, "whether the medical condition significantly affects daily activities, or the existence of chronic and substantial pain." *Brock v. Wright*, 315 F. 3d 158, 162. Additionally, courts will be likely to find a "serious medical need" if a condition "has been diagnosed by a physician as mandating treatment or … is so obvious that even a lay person would easily recognize the necessity of a doctor's attention. *Hill v. DeKalb Reg'l Youth Detention Ctr*., 40 F.3d 1176, 1187 (11thCir. 1994).

[25] "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted."

[26] The University of Texas has indicated that it will not continue to provide health care to the Texas prison system.

procedures. Since Oral Health Program responsibilities do not include review of clinical aspects of the TDCJ dental program, there is no opportunity to identify policies that are invalid from a public health and clinical perspective. For example, dentures are provided only for "medical necessity" – that is, only when the health of the patient would otherwise be affected adversely.[27] This policy is below the standard of dental care in the community. Policies such as this should be reviewed by the Director of the Oral Health Program and the Dental Director of HHSC, Office of Policy and Clinical Services as well as dental public health experts in dental schools and schools of public health and other oral health and public policy stakeholders.

3.9.3 Access to Care

Texas could see a substantial increase in access to oral health through the use of dentists and dental hygienists working together. The TDA, TAGD, and TDHA will collaborate in finding solutions to address increasing access to oral health care in Head Start programs, school-based clinics and public health facilities, ElderCare, long term care facilities, hospice, public health facilities and group homes. This could include exploring alternative means of delivering care and developing more productive and efficient relationships between providers.

[27] The policy instructs dentists to monitor the nutritional status of patients by tracking weight trends for those who may have compromised masticatory functions. As part of this monitoring, the Body Mass Index (BMI) is used as a tracking methodology. According to the policy, a BMI from 18.5 to 25 is considered normal and patients with a BMI of 25 or lower which is trending downward, or a patient who is 10 percent or more underweight relative to their ideal body weight, should be referred to the patient's treating physician for consultation. If the physician determines that the patient's nutritional status is compromised, special diets such as a mechanically blended diet may be considered. Dental prostheses for patients with compromised masticatory function should be considered following initiation and follow-up evaluation of the effectiveness of the special diet. CMC Policy E-36.5 provides for a dental utilization/quality review committee to address concerns about the dental care provided to inmates.

4.0 SUMMARY AND CONCLUSION

Like the report of the Surgeon General, Oral Health in America, the Oral Health Plan for the State of Texas serves as a call to action. Oral health is essential for overall health, but not all Texans are achieving the same level of oral health. While some people living in the state have seen an improvement in their oral health, there remain many individuals who suffer from dental pain and infection needlessly which negatively impacts their overall health and quality of life. It is to this end that the Oral Health Plan for the State of Texas seeks to identify gaps and develop action items to address these gaps based upon sound evidence-based public health science. Ultimately, the overarching goal is to improve the oral health of all Texans.

The Oral Health Plan for the State of Texas identifies the following five major findings.

1. Surveillance is a core public health function that can only be directed and funded by the State. While the Oral Health Program should have a critical mass of dental public health specialists, it should seek expertise, when needed from key stakeholders, especially the dental schools and schools of public health to accomplish a rigorous and continuous plan of oral disease surveillance.

2. The State should engage stakeholders and partners through an active communication strategy. The Texas Oral Health Coalition could serve as a clearinghouse for information that can be disseminated to a broader oral health audience. Other stakeholders can be identified to participate in this activity. The Oral Health Plan for the State of Texas encourages the use of webinars to improve meeting attendance and reach a broader audience and periodic newsletters to engage key stakeholders. This initiative should also include providing information at a literacy level appropriate for specific audiences using best practices that promote health literacy and cultural competence.

3. The State should actively support evidence-based, community-based prevention strategies. The Oral Health Plan for the State of Texas encourages the continued support of community water fluoridation initiatives across the state to achieve and maintain Healthy People 2020 objectives and the continued support of the state

fluoridation engineer. In addition, school-based dental sealant programs conducted by public health entities and dental schools should be supported through reimbursement from the Medicaid program. Other community-based prevention practices should be explored and evaluated, and when evidence supports their adoption, implemented widely.

4. The State should support the policy recommendation of the Texas Oral Health Coalition for a funded and sustained Oral Health Program Director who is a dentist and a specialist in dental public health. Continuous funding from the State for the Oral Health Program Director is essential to maintain a program that can develop both short-term and long-term goals and objectives and function effectively and efficiently. In addition, the Oral Health Program needs greater visibility within the organization of the DSHS.
5. The State should identify and facilitate oral health partnerships to support strategic priorities. The collaboration of public-private partners can enhance interprofessional and culturally competent community-based prevention strategies. Understanding that the oral health and overall health are linked, the promotion of tobacco control and cessation initiatives, eating health and better dietary choices, and improving sports gear and safety measures to reduce head and neck injuries are the purview of public health dental practitioners and dental professionals.

The Oral Health Plan for the State of Texas recognizes that improving the oral health of all Texans requires input and support from the public sector, private sector, nonprofit sector, and other key stakeholders. The plan provides a framework that allows that collaboration to occur in the future. It is paramount that all parties work together collaboratively to achieve our common goal, which is the optimal oral health for all Texans.

5.0 APPENDICES

Appendix 1. **Outline and Results of Listening Sessions**

Appendix 2. **Texas Oral Health Program Policy Tool Workshop**

Appendix 3. **Oral Health Program Summary**

Appendix 4. **Population Change between 2000 and 2010 Census: United States, Texas, California, Florida, North Carolina, and Arizona**

Appendix 5. **Texas' Ethnic Composition 2000 and 2010**

Appendix 6. **Texas Department of State Health Services Organizational Chart**

Appendix 7. **Division for Family and Community Health Services, Department of State Health Services**

Appendix 8. **Texas Oral Health Program, Department of State Health Services Surveillance Matrix, 2010-2018**

APPENDIX 1 – Outline and Results of Listening Sessions

Written Comments/Suggestions

from the

2011 Oral Health Listening Sessions

The following is a collection of written comments/suggestions to update the Collaborative Oral Health Plan in Texas (aka State Oral Health Plan), generated from the Six Oral Health Listening Sessions in the spring of 2011. Listening session sites and names are included when given on the submitted forms.

Number of Attendees at each Listening Session: 93 **Number of Responses: 16**

Dallas (Baylor)	**22**
San Antonio am	**21**
San Antonio pm	**8**
Austin	**19**
El Paso	**12**
Houston	**11**

Assessment

Goal 1: Support a Texas Oral Health Surveillance System to Assess Oral Health Burden and Trends

Objective: Support, enhance, and expand statewide, ongoing Oral Health Surveillance System with a common set of data, uniform collection and reporting methods. The Oral Health Surveillance System will have the capacity to define the scope of oral health needs and access to oral health services, to monitor community water fluoridation status, and to measure the utilization of oral health services by children and adults in Texas.

Strategy:

A. Collaborate with the Texas Department of State Health Services, Oral Health Program, to support, enhance, and expand a common statewide Oral Health Surveillance System.

Action Plan:

- Create a subcommittee within the Coalition that will work with TDSHS, Oral Health Program to work in collaboration to identify data gaps, discuss possible ways to address the surveillance needs, and analyze data that reflects the oral health needs of the State. This body should consider utilizing data collected at the local level and how it can be utilized as well as national data sources. - *San Antonio, Cappelli*
- Are you trying to gather information from private practice also? If so, need basic, easy-to-read forms that gather very essentials in a short amount of time. – *El Paso, Brown*

B. Identify potential primary and secondary sources of data that can be used to measure the oral health status of people living in Texas.

1) Basic Screening Survey (BSS) conducted in elementary schools in Texas

2) Basic Screening Survey (BSS) conducted in Head Start Centers in Texas

3) Behavioral Risk Factor Surveillance System (BRFSS) survey on the oral health of adults living in Texas

Action Plan:

- Expand data collection to include the elderly (nursing homes, homebound, and senior centers). Also, better understanding of the prevalence of periodontal disease is needed. – *San Antonio, Cappelli*

C. Develop a burden document that will describe the oral health status of people living in Texas.

Action Plan:

- Develop a burden document every five years that reflects the oral health of all people living in Texas. This document will also address workforce capacity and access to care issues. – *San Antonio, Cappelli*

What ways could we enhance and expand the State Oral Health Surveillance System?

- Department Oral Health Program at DHHS – Recommend that this be funded by the State of Texas. Require Medicaid/CHIP insurance providers to accumulate and report this information. Mandate oral health assessments by school nurses. – *Baylor, Hoffmann*
- Need to work closely with the TDSHS to identify gaps in data collection and analysis. Need to identify an epidemiologist with a statistical background that can develop appropriate sampling frames that comply with CDC guidelines for the NOHSS. – *San Antonio, Cappelli*
- No comment, as I have little information on the plan. – *San Antonio, Taylor*
- Based on above strategy utilize regional coalitions to identify all programs in demographic region which collect data ? oral health statistics; formulate regional way to get data then extend to state approach – *Houston, Barnes*
- Possibly getting school district needs involved in areas identified as underserved. – *Houston, Shirali*
- Surveillance data from ISD, Veterans hospitals, Nursing Homes, Head Start. – *Houston, no name*

- Leadership, ana?tic capacity, infrastructure, and partnerships are needed to enhance program efforts to fully utilize data collected and to expand a comprehensive surveillance system. – *faxed, Navarro*

What other primary and/or secondary sources of data should be used to measure the oral health status of people in Texas?

- SEER data, MCH Title V data, Title IXX data – *Baylor, no name*
- We are not collecting data to measure prevalence of periodontal disease and lack comprehensive data on the oral health of the elderly. We can use BRFSS data to measure the oral health status of adults, but should look to other national surveys (e.g. NHANES) to measure periodontal disease prevalence. Use SEER data for oral cancer incidence. We need to see how we can better utilize data that is collected locally to develop a statewide profile, including calibration and standardization of data collection methods. – *San Antonio, Cappelli*
- Unsure – *San Antonio, Taylor*
- Could send out questionnaire to each office in the state to report on the patients they've seen in past 6 months. Provide a chart that they can use to tabulate each day over the 6 month period. Monetary incentive to fill out form. – *El Paso, Brown*
- Colgate Bright Futures Van – does sweep throughout Houston and fills out screening tools. – *Houston, Barnes*
- Looking toward shelters (w/ many TX residents that are underserved) along w/ communication w/community health centers in identified areas. – *Houston, Shirali*
- See response to previous question. – *Houston, no name*
- Data on dental visits, teeth cleaning, complete tooth loss, fluoridation status, cancer of the oral cavity and pharynx, caries experience, untreated caries and dental sealants. – *faxed, Navarro*

What other data should be reported to the NOHSS?

- Nursing home survey data – edentulousness – *Baylor, no name*
- We should be reporting data in all categories to the NOHSS. – *San Antonio, Cappelli*
- Unsure – *San Antonio, Taylor*
- Compilation of data from each state – *Houston, no name*
- Listed above – Periodontal condition and Alarming, untreated Medical data collected during the physical history – *faxed, Navarro*

How can we develop a burden document that will describe the oral health status of people living in Texas?

- Need support from epidemiology and statistician from DSHS – *Baylor, no name*
- The burden document needs to reflect the oral health status of all people living in Texas. In the past, data collected reflected only people (primarily children) living in poverty (free and reduced lunch). We need to fill in the gaps noted above in describing the oral health of individuals living in Texas. – *San Antonio, Cappelli*
- Unsure – *San Antonio, Taylor*
- (?)Gather input from all surveillance entities and summary the findings. – *Houston, no name*
- The CDC division of Oral Health developed a tool to assist states with creating a comprehensive document that describes the state's burden of oral disease. This tool is available on the CC website at http://www.cdc.gov/oralhealth/poublications/library/burdenbook/index.htm. – *faxed, Navarro*

How could the Basic Screening Survey on selected pre-K and 3rd graders be performed and reported on to the NOHSS if the Department of State Health Services, Oral Health Program is abolished?

- Would require dedicated funds from DHHS to commission a survey – *Baylor, no name*
- It would be extremely difficult to provide this data if the Oral health Program is abolished. Assessment is a core public health function that is the purview of the Texas Department of State Health Services. We rely heavily on the manpower and expertise to make data reporting happen for the state. – *San Antonio, Cappelli*
- I do not believe it can be. – *San Antonio, Taylor*
- Utilize school-based dental programs to help collect data. Regional coalitions work with regional organized dentistry entities and disseminate everything to state coalition. – *Houston, Barnes*
- The possible link of area community centers and the public could be a means to still have access to that patient population. – *Houston, Shirali*
- Through grant funding and utilization Public Health Dental Residents - UTSA-Dental, Baylor and UT Dental Houston. One of (?) (?) would take the lead. – *Houston, no name*
- The State Oral Health collaborative Systems (SOHCS) grant program, awarded funds to state oral health programs. – *faxed, Navarro*

Additional Comments:

- I am sorry I am of no help with this section – *San Antonio, Taylor*
- Utilize partnerships with surrounding dental schools and departments of public health/community health dentistry to aid in collecting/reporting on the data**. –** *Houston, Barnes*

Policy Development

Goal 2: Support the expansion of the State Oral Health Infrastructure

Objective: Develop a strong oral health unit with a full-time state dental director and effective infrastructure within the Texas Department of State Health Services to provide state level oral health leadership and perform the essential public health functions to meet the oral health needs of all Texans.

Strategy:

A. Support the maintenance of a full-time State Dental Director with regional personnel to meet the dental public health need across the State.

Action Plan:

- Continued support for a full-time State Dental Director in Texas. Elevate the Oral Health Program to a more autonomous status within the TDSHS. – *San Antonio, Cappelli*

B. Request that the State Oral Health Program retain a full-time fluoridation engineer and sufficient infrastructure to oversee reporting of fluoridation levels.

Action Plan:

- Strongly endorse continued support for a full-time fluoridation engineer to oversee the infrastructure needed to adequately report fluoridation levels in the State of Texas. Continued support for enhancing community water fluoridation by the State of Texas for the prevention of dental caries across the lifespan. – *San Antonio, Cappelli*

C. Work in partnership with the Texas Department of State Health Services to enhance the oral health infrastructure

Action Plan:

- Continue collaboration with the TDSHS to strengthen the oral health infrastructure with a focus on early preventive services through Head Start and school-based prevention programs. – *San Antonio, Cappelli*

Questions:

What can we do to support funding the maintenance of a state dental director and appropriate staffing?

- Work with stakeholder representatives to issue letters of support on a regular basis. – *Baylor, no name*
- Support strategies. Do not contract current program and staffing. Send letter of support to maintain current staffing. – *Baylor, Hoffmann*
- The Coalition should develop a legislative agenda that explains the need for an intact and strong oral health program at the state level and educate legislators as to the role and responsibility of this agency. – *San Antonio, Cappelli*
- Educate legislators of the status of oral health in Texas, the consequences of poor dental health, and need to maintain a dental health director. We should network with other organizations to get their legislative support as well. – *San Antonio, Taylor*
- Grants – apply for. In burden document, provide literary review of states with one, benefits of having one w/disadvantages of not having one. Distribute to person responsible for appointment. – *Houston, Barnes*
- Lobbying at the state level, possible fund raising*…Houston,Shirali*
- Advocacy for the position of state Dental Director and appropriate staffing*. – Houston, no name*
- Cost effect approaches to reduce the amount of staff needed can be achieved by linking to existing surveillance systems for oral health data (e.g. Behavioral Risk factor Surveillance system (BRFSS) and Youth Risk Behavior Surveillance system (YRBSS) and adding new oral health questions to an existing surveyor surveillance system. – *faxed, Navarro*

In what ways can we support the retention of a full-time fluoridation engineer with sufficient infrastructure to oversee reporting of fluoridation levels?

- Emphasize importance of maintaining the submission of water fluoridation to the WAFERS program @CDC – *Baylor, no name*

- Currently, Texas is reporting fluoridation levels to WFRS. While the monthly reports are submitted to the fluoridation engineer by the water system operators, this person provided knowledge about costs and systems of startup and maintenance of fluoridation projects in cities in Texas. In addition, we should support a minimal staff to do random verification of the reporting done at the local level. – *San Antonio, Cappelli*
- Educate legislators of the status of oral health in Texas, the consequences of poor dental health. We should emphasize the benefits of water fluoridation to dental health and the need to maintain a fluoridation engineer to maintain safety and efficacy. We should network with other organizations to get their legislative support as well. – *San Antonio, Taylor*
- See above – *Houston, Shirali*
- Advocate the continuation of a F/T Fluoridation engineer; supported by data noting efficient and a cost effective (?) measure. – *Houston, no name*
- The state to continue its cooperative agreement with the Centers for Disease Control and Prevention allowing the hiring of a full time oral health epidemiologist. – *faxed, Navarro*

In what ways can we enhance the oral health infrastructure?

- Work to increase expansion of FQHCs locally and lobby school districts to create more school based health clinics which include dental services. – *Baylor, no name*
- The oral Health Program should focus on activities that are in line with the core public health functions (assessment, policy development, and assurance) and target projects based on those principles. Then, the Oral Health Program can develop roles and responsibilities based on these core values and justify expanding the program. – *San Antonio, Cappelli*
- We can work to reinstitute a public school education program such as the tattle tooth program of years ago and have regional dental health workers assist in implementing the program in local schools. – *San Antonio, Taylor*
- Until we get state dental director, continue to refine infrastructure/data collection from regional perspective. – *Houston, Barnes*
- Through possible partnership with the state government ?(if any) w/the influence of *the TDA – Houston, Shirali*
- Advocate to enhance the oral health infrastructure on a (?) of investment perspective. – *Houston, no name*
- By using the NOHSS model – *faxed, Navarro*

Additional Comments:

Goal 3: Mobilize Support for Oral Health

- Will get better buy-in with less paperwork- concise, efficient gathering and reporting. –*El Paso, Brown*

Objective: Change perceptions regarding oral health and oral disease so that oral health becomes an integral component of health policies and programs in Texas by informing, educating, and empowering community partners, public officials, policymakers, and the public.

Strategy:

A. Establish linkages and foster communication between the Texas Oral Health Coalition and the local and regional coalitions

Action Plan:

- The Summit should include a meeting between the Board of the TxOHC and the regional coalitions. Regional coalitions should be represented on the TxOHC Board. – *San Antonio, Cappelli*

B. Create a mechanism to sustain and grow the Texas Oral Health Coalition as an independent 501(c)(3)

Action Plan:

- Need sponsors with $ - *Baylor, no name*
- Develop a focus of action that defines the TxOHC as a unique entity. While we should engage key stakeholders in this activity, we need to define goals, objectives and purpose to exist. I would recommend identifying those areas where we can be a key leader and act on the objectives. A strategic planning process followed by action based on the plan is critical. The TxOHC can no longer afford to be hijacked by any special interests. – *San Antonio, Cappelli*

C. Advocate increasing support for oral health in Texas

Action Plan:

- We need to be a key leader as an advocate to expand the Oral Health Program and increase its visibility within TDSHS. Also, we need to address key oral health issues that face Texans and identify sound, evidence-based approaches to solving the problems. These problems and solutions need to be a focus of our advocacy activities. – *San Antonio, Cappelli*

D. Plan, organize, support, and host an annual Oral Health Summit

Action Plan:

- Conduct a meeting with CE that people want to come to every year – *Baylor, no name*
- Yes, in the process of developing this. – *Baylor, Hoffmann*
- Conduct an annual Oral Health Summit – *San Antonio, Cappelli*

E. Increase and diversify the membership of the Texas Oral Health Coalition

Action Plan:

- Recruit school nurse liaison, recruit rep from Texas Association of School Boards – *Baylor, no name*
- Identify key stakeholders (school nurses, FQHCs, CHIP organizations, WIC, Head Start, etc) and have them engaged in oral health issues. They need to be a voice at the Coalition table. – *San Antonio, Cappelli*

F. Support initiatives that foster community and oral health capacity

Action Plan:

- Target evidence-based population-based preventive programs that work, including community water fluoridation and school-based sealant programs. Unfortunately, a dental home, while an

admirable pursuit, is not recognized as a program with sufficient evidence to warrant its recommendation in prevention of disease. – *San Antonio, Cappelli*

Questions:

In what ways can we establish linkages and foster communication between the Texas Oral Health Coalition and the local and regional coalitions?

- Individuals in coalition networking with others in the community who share goals (community health centers) – *Baylor, no name*
- Engage the regional coalitions in state coalition activities. Conduct annual meeting with the regional coalitions and the TxOHC Board at the summit. – *San Antonio, Cappelli*
- Contact leaders of local and regional coalitions and review common goals and action plans. – *San Antonio, Taylor*
- Implement quarterly meetings among regional coalitions (webinars, hotel-based meetings) – *Houston, Barnes*
- Through networking, PR/advertisement,,, word of mouth… - *Houston, Shirali*
- Use of technology, e.g. teleconferencing, Skype, face to face (?) meeting annually. – *Houston, no name*
- Establishing linkages and fostering communication can be accomplished through the Internet and the preparation of fact sheets and other materials. – *faxed, Navarro*

What kind of mechanism can be created to sustain and grow the Texas Oral Health Coalition?

- Make 501 (c) (3) more known – *San Antonio, Kerr*
- Emphasize the goals common to other organizations and work with these organization's committees to achieve the common goals. – *San Antonio, Taylor*
- Solid leadership with increased membership – *Houston, Shirali*
- Increase membership; assess dues; summit registration; corporate sponsors. – *Houston, no name*
- The implementation of an oral health surveillance system plan with a collaborative effort between the Texas Oral Health coalition and the Texas Department of State Health Services. – *faxed, Navarro*

How can we increase support for oral health in Texas?

- Education, health promotion, PSAs. – *Baylor, no name*
- I think that the better question is how can the TxOHC become a relevant organization? – *San Antonio, Cappelli*
- Educate others – *San Antonio, Taylor*
- Become more visible in the community – the more people know us and what we are doing, we can solicit support. – *Houston, Barnes*
- Making dental students aware as early as possible of such as organizations to increase support. – *Houston, Shirali*
- By promotion and awareness; publicize successes e.g. First Dental Home. Oral Health champions to advocate for oral health. – *Houston, no name.*
- We can increase support for oral health in Texas through education and by providing community-specific data to support communities in raising awareness of oral health needs, planning and

developing solutions to meet the need of their residents, and/or justifying resources. – *faxed, Navarro*

How can we increase multidisciplinary collaboration and coordination between systems including medical, dental, mental health, social services, academia and education, non-profit, professional organizations, and government at the state and local levels?

- This has to start at the academic training level – *Baylor, no name*
- Engage these groups in Coalition activities. – *San Antonio, Cappelli*
- Networking and education – *San Antonio, Taylor*
- Have roundtable discussions: 1) Attend meetings that some of these other systems have – Medical, ADEA, etc… 2) Focus group discussions 3) With oral health program (TX) when medical providers sign up for First Dental Home visits – have session for them and dentists to meet/greet. – Houston, Barnes
- Communication, visibility – *Houston, no name*
- We can increase multidisciplinary collaboration by conducting oral health screenings with height and weight measurements and through oral health questionnaires that include questions on soda and milk consumption. – *faxed, Navarro*

Since the Texas Oral Health Coalition offers CE's at the Oral Health Summit and this year's theme is "Total Health through Oral Health" what topics are you most interested in attending?

- Effects of nutrition and diet on oral health and general health efforts dealing with diabetes & obesity could be joined with oral health issues. – *Baylor, no name*
- The use of motivational interviewing in the public health setting, I would suggest Dr. Phillip Weinstein from the University of Washington. – *San Antonio, Taylor*
- Mouth-Body Connection – Target medical providers and discuss various systemic diseases impacting oral health. – *Houston, Barnes*
- Surveillance; coalition building; success shown in oral health coalition – *Houston, no name*
- The impact of Oral Health on Physical and Mental Health. – *faxed, Navarro*

Additional Comments:

Assurance

Goal 4: Support Collaborative Partnerships that Implement Population-Based Oral Health Programs

Objective: Plan, implement, and evaluate population-based programs through collaborative partnerships to increase the utilization of evidence-based primary and secondary prevention and reduce the oral health burden in Texas.

Strategy: Support initiatives that foster community-based initiatives to reduce the burden of oral disease in Texas.

1) These initiatives include, but are not limited to, school-based sealant programs, Texas water fluoridation project, oral cancer prevention programs, and WIC/Early Head Start/Head Start Oral Disease Prevention Programs.

Action Plan:

- Work with TDSHS and the regional coalitions to encourage community-based initiatives. – *San Antonio, Cappelli*

Strategy: Serve as a clearinghouse to support ongoing population-based prevention programs throughout the State.

Action Plan:

- Develop an expert panel within the Coalition that can serve as a resource for ongoing population-based prevention programs. – *San Antonio, Cappelli*

Questions:

In what ways can we increase communication at the state and local level among partners in the public, private, and non-profit sectors?

- Funding at state level is too low to be effective oral health needs to be a division or larger branch at DSHS – *Baylor, no name*
- Unsure how but it needs to be done. – *San Antonio, Taylor*
- 1) Create TxOHC commercials – DVD's for distribution; 2) Participate in health fairs.- *Houston, Barnes*
- Websites – *Houston, no name*
- Increased communication can be accomplished through the Internet and the preparation of fact sheets and other materials. – *faxed, Navarro*

How can we increase the number of counties and cities that do not have dental directors or public health clinics with dental personnel?

- This is lobbied at county and city level. Very difficult to do in the financial climate we currently have. – *Baylor, no name*
- The Coalition can advocate and educate about these issues. – *San Antonio, Cappelli*
- Educate county and city officials on the benefits to the community to support these positions. – *San Antonio, Taylor*
- If they are FQHC's, work with TACHC (Texas Association of Community Health Centers) to state our vision – they can advocate and send this message to all TX FQHC's. – *Houston, Barnes*
- Increase incentives - - salary, loan repayment *etc.* – *Houston, Shirali*
- Establish task forces within different counties/city – *Houston, no name*
- Through education and the recruiting process - *faxed, Navarro*

How can we increase dental public health training and information sharing related to contemporary dental public health principles and practices?

- At federal level there have been grants given for incorporating dental public health at predoctural level. CE courses for private practitioners across the health delivery system are needed. (M.Ds, R.Ns, P.As) – *Baylor, no name*
- Encourage inclusion of dental public health in all health education programs including nursing, medicine, etc. – *San Antonio, Taylor*
- Target dental schools – set up opportunities to speak to Junior/senior dental students (Lunch-n-Learn, etc) – *Houston, Barnes*
- Webinars etc. – conferences (statewide*) - Houston, Shirali*
- Through the 3 dental schools in TX; restore UT-Houston Dept of Public Health Dentistry. This can be done with all the dental schools in the USA. – *Houston, no name*
- Through education and marketing via the Internet, multi-media etc. – *faxed, Navarro*

Should we maintain community water fluoridation and technical support and how can we expand it?

- Yes, we are meeting HP2010 goals – *Baylor, no name*
- Absolutely. – *San Antonio, Cappelli*
- We should definitely maintain this support and expand it by seeking funding on the national level through the CDC as was present in the 1970-1980's, also work for state support in lieu of federal support – *San Antonio, Taylor*
- Yes, could use media via internet. Make it easy to find information on website*. – El Paso, Brown*
- Yes – *Houston, Barnes*
- Yes through education – *Houston, Shirali*
- Yes, expand through data and advocacy – *Houston, no name*
- Yes, and expand it through education and marketing*. – faxed, Navarro*

Should we maintain school-based sealant/fluoride varnish programs and how can we expand them?

- Repealing the parental accompaniment rule would help allow these services to be reimbursable through 3rd parties. – *Baylor, no name*
- Absolutely – *San Antonio, Cappelli*
- School based sealant programs must be administered with care as poorly done sealants are of no benefit. Fluoride varnish programs could benefit many but the most important preventive procedure is a thorough examination by a dentist. –*San Antonio, Taylor*
- Yes – *El Paso, Brown*
- Yes – *Houston, Barnes*
- Yes through increased communication with districts outside HISD (for ex in Houston*)- Houston, Shirali*
- Yes, through grant funding or reimbursement offered *(?) – Houston, no name*
- Yes, and expand it through education and marketing*. – faxed, Navarro*

Should we examine other preventive programs, and if so, what?

- Prevention during WIC visits – *Baylor, no name*
- School-based dental programs and school-based prevention programs. – *San Antonio, Cappelli*
- Motivational Interviewing programs for WIC families, and other low income groups. Utilizing community volunteers to help others is key to one of these type programs (see Journal of the American Dental Association June 2004) – *San Antonio, Taylor*
- I think at this time fluoridation and sealants are enough. – *Houston, Shirali*
- Examine programs that are successful and sustainable. – *Houston, no name*
- No – *faxed, Navarro*

In what ways can we promote healthy behaviors and dietary choices in schools?

- Local action at school board level, state level if we have liaisons with Tx Assoc. of school board – *Baylor, no name*
- Support initiatives that promote the link between oral health and overall health, including dietary programs and oral health education programs. – *San Antonio, Cappelli*
- Institute educational programs such as the "Tattle Tooth" program, and encourage schools to utilize the programs. In addition get schools to remove sport and soft drinks from their campuses. – *San Antonio, Taylor*
- Legislative pressure to remove coke machines from schools. Check out "Stop the Pop" – *El Paso, Brown*
- If school board meetings are open to the public, participate in them; write letters to school board advocating for healthy behaviors/dietary choices. – *Houston, Barnes*
- Open communication with school boards. – *Houston, Shirali*
- Through the ISD's management and Nutrition Department. – *Houston, no name*
- Education and marketing – *faxed, Navarro*

How can we expand Early Head Start/Head Start/WIC preventive oral health programs?

- Dependent on federal funding – *Baylor, no name*
- This is already being done in many areas. Children in SA Head Start have an annual dental visit and preventive services. They are referred if problems are identified. – *San Antonio, Cappelli*
- Educate the WIC workers with evidenced based material and consider motivational interviewing programs as mentioned above. – *San Antonio, Taylor*
- Increased education to women prior to pregnancy/education in high school possibly – seminars in identified schools with high risk of pregnancy.- *Houston, Shirali*
- By incorporating First Dental Home opportunities within Head Start/WIC Program. – *Houston, no name*
- Education and marketing – *faxed, Navarro*

In what ways can we promote early detection and prevention of oral cancer?

- Promote CE courses dealing with that subject – *Baylor, no name*
- Identify those individuals at greatest risk. Education about behaviors associated with this disease are important. Also, emphasizing oral health screenings to colleagues is critical. – *San Antonio, Cappelli*
- Encourage all adults to seek screenings. Educate junior high and high school students on the dangers of spit tobacco, ban the use of spit tobacco on campuses and ag barns. – *San Antonio, Taylor*
- Continue to promote oral health cancer screenings at each dental visit – *Houston, Barnes*
- More patient friendly literature in Spanish and English. – *Houston, Shirali*
- Through thorough head and neck (?) exams. – *Houston, no name*

- Education and marketing – *faxed, Navarro*

How can we expand the First Dental Home training for Dental and Medical Providers?

- Not certain why Dental/Dental Hygiene Schools can't provide this training. – *San Antonio, Cappelli*
- This year the American Academy of Pediatrics will be mailing each of their member's information on caries risk assessment including protective factors and important clinical findings. Contacting pediatricians after this mailing should help increase the number of pediatric providers that are First Dental Home providers. The TDA and TAPD have done a lot to help get dentist to participate, perhaps having staff training in the form of accredited CE would help get more dental offices to participate. – *San Antonio, Taylor*
- My training in Austin has amazing/beneficial – *El Paso, Brown*
- Exposure/Marketing, branding – *Houston, no name*
- Education – *faxed, Navarro*

How can we maintain and enhance the Dental Oncology Education Program?

- DOEP I believe has been defunded and absorbed in CIPRIT – *Baylor, no name*
- Unsure – *San Antonio, Taylor*
- Unfamiliar with this program – *Houston, no name*
- Education and marketing – *faxed, Navarro*

How can oral health education be implemented or increased into elementary school educational programs?

- Through local school health committees. Legislation? – *Baylor, no name*
- Should this be an initiative for the Coalition? There is very little evidence that these programs are effective. – *San Antonio, Cappelli*
- Have simple to implement programs developed such as the "Tattle Tooth" program. – *San Antonio, Taylor*
- Target school board and advocate for the importance of oral health education being year of curriculum for elementary schools; possible have books/DVD's that can be recommended for inclusion in school curriculum – *Houston, Barnes*
- Increase it in the students' curriculum e.g. science – *Houston, no name*
- Education (surveys) and marketing (posters, pamphlets, multi-media*) – faxed, Navarro*

Are there any other programs that exist that need to be maintained like oral health education, oral health surveys for surveillance, oral health programs for pregnant women, a Youth Risk Behavior Survey program , Mouthguard/Injury Prevention Programs, Access to Care, Abuse/Neglect or PANDA program, and/or a program designed to maintain Hospital Discharge Data?

- The Coalition needs to focus and not attempt too much. – *San Antonio, Cappelli*
- All of the above should be maintained – *Houston, Barnes*
- These are way too many programs to sustain – *Houston, no name*

- Orthodontic care to address and correct handicapping malocclusion that improves oral functions (such as masticatory or speech), which avoids the deterioration of the masticatory apparatus, digestive system and bone loss due to occlusal trauma bringing as consequence an overall improvement on teenagers performance (academic, athletic, social, etc) – *faxed, Navarro*

How can oral health assessments incorporate into the elementary school health assessments school nurses administer to identify, refer, and report for surveillance oral health disease?

- School screening assessments promoted by ADA and school nurses association should be joined and participated in at state level. TxOHC could publicize and promote this program joint effort. – *Baylor, no name*
- BSS is the perfect tool since it was designed for implementation by non-dental professionals. – *San Antonio, Cappelli*
- Make dental exams required for school entry. – *San Antonio, Taylor*
- Target City of Houston programs which work directly with schools. – *Houston, Barnes*
- Yes! This is very worthwhile; If the school could do vision, hearing, oral health, scoliosis; Acanthosis nigricans screenings within the course of the school year In so doing the (?.....)for other health follow up. – *Houston, no name*

Additional Comments:

- Community based funding of local dental student or scholarship –(suggestion in case the physician's loan repayment program does not get funded) – *San Antonio, Kerr*

Goal 5: Build collaborative partnerships to increase access to and quality of the oral health care system.

Objective: Remove barriers between people and the oral health care system by enhancing oral health system capacity, including directly supporting or providing oral health services when necessary.

Strategy:

A. Advocate to maintain and enhance current levels of CHIP and Medicaid funding

Action Plan:

B. Identify potential partners and foster relationships with public and private agencies that can help to advance the awareness of oral health

Action Plan:

- Implement strategy – *San Antonio, Cappelli*

Questions:

- These questions and the ones in the previous section describe an expanded role for the Coalition. I think that the Coalition should identify one key area and focus on it. It should be a program that is evidence-based and will focus on disease prevention rather than disease treatment. It should be an item that the Coalition can accomplish and can be identified as a key leader. I would avoid issues where we are not the key leader or that we cannot have a profound influence (e.g. treatment). **–** *San Antonio, Cappelli*

How can we maintain and enhance current levels of CHIP and Medicaid funding?

- This is largely out of our hands. State level/federal level funding. – *Baylor, no name*
- Support current levels of funding. Do not reduce reimbursements for dentists under Medicaid and CHIP. – *Baylor, Hoffmann*
- Partner with the FREW initiative to maintain funding for oral health care. – *San Antonio, Cappelli*
- Raise taxes, sorry it appears this is a lost cause in the current political environment. – *San Antonio, Taylor*
- Through patient education of opportunities – this starts at the level of front office and provider. – *Houston, Shirali*
- Put a big cap on Medicaid funding – Reevaluate and restructure to include preventive and restorative services, oral surgery only. – *Houston, no name*
- Addressing waste, abuse and fraud – *faxed, Navarro*

How can we maintain and expand community based training programs in higher education institutions?

- Again, the federal govt. sponsors these programs – *Baylor, no name*
- ? – *San Antonio, Taylor*
- Possible funding via ADA & TDA – *Houston, Shirali*
- *?? – Houston, no name*
- Education and marketing – *faxed, Navarro*

Should we continue to support the Texas loan repayment program for dentists in underserved areas, and if so, how can we enhance it?

- Yes, again this is a state legislative budget issue. – *Baylor, no name*
- Yes, don't let them take it away – *San Antonio, Kerr*
- We should support it, it would be good to give special incentives to those that practice in remote locations. – *San Antonio, Taylor*
- Increase amount of money that goes towards loan repayment to that of other programs like National Health Service Corps Have conferences for loan repayment providers – *Houston, Barnes*
- Absolutely, it is a big trade off for a dentist working in an underserved area, esp. the first year out of school with extremely high interest on loan rates- - there needs to be a form of incentive to allow the dentist to work without the stresses of do I have money to pay my loans and have to ? light as well. – *Houston, Shirali*
- Yes – *Houston, no name*

- Yes, through education and possible incentives. – *faxed, Navarro*

Should we continue the First Dental Home program with dentists and physicians and how can we expand it?

- Yes, move funds from orthodontics in Medicaid over to first dental home reimbursements – *Baylor, no name*
- Yes, allow more dentists to access the FDH program. – *San Antonio, Kerr*
- I believe the first dental home program helps dentist and physicians incorporate preventive dentistry into their practices. We can expand it by the methods discussed earlier. – *San Antonio, Taylor*
- Yes, Market it better – *Houston, no name*
- Yes, increasing the participation level through education, marketing and possible incentives.- *faxed, Navarro*

In what ways can we promote and expand School-based dental programs?

- Local level – *Baylor, no name*
- Allow parents to sign waiver for Medicaid services to be billed – *San Antonio, Kerr*
- School based sealant programs are not a substitute for having a dental home, and in some instances may make parents think a dental home is not important by the parents assuming the program is a substitute. All children seen in a school sealant program should have information sent to parents to inform them a thorough dental examination and in office dental procedures may still be necessary. – *San Antonio, Taylor*
- Education and marketing – *faxed, Navarro*

In what areas should we allow provisions for oral health assessments and preventive services by Registered Dental Hygienists under appropriate supervision?

- Lobby for changes in state practice act, or use current act to its greatest extent legally allowed. – *Baylor, no name*
- Assessment and prevention should be performed by hygienists under general supervision. – *San Antonio, Cappelli*
- Nursing home/rural hospital/school settings – *San Antonio, Kerr*
- Dental hygienists are only qualified to give limited assessments of oral health so this should be done only on a temporary basis until a dentist can do a thorough examination. – *San Antonio, Taylor*
- By (?) the successful and sustainable existing programs – *Houston, no name*
- Not applicable to Orthodontists – *faxed, Navarro*

How can we promote and expand Nursing home-based dental programs?

- Scholarships to dental students
- Find funding to pay dentist, set up loan repayment programs for nursing home providers, and give grants for portable equipment. – *San Antonio, Taylor*
- Better training(include it in curriculums/(?) program) and better reimbursement; more awareness – *Houston, no name*
- Not applicable to Orthodontists. – *faxed, Navarro*

Should we incorporate oral health as part of a student's total health assessment provided in elementary schools to help identify, refer, and report data into a state-wide surveillance system, and if so, how?

- Yes it should be added to vision, immunizations, etc. – *Baylor, no name*
- Yes, mandate it from (?) (author could not read it either) (looks like schools) – *San Antonio, Kerr*
- Require a dental exam for school entry and send home educational material to parents every year on the importance of regular dental examinations. – *San Antonio, Taylor*
- Yes – *Houston, Barnes*
- Yes! – *Houston, no name*
- Yes - *faxed, Navarro*

Should we require mandatory dental examinations for all students entering school by a Texas licensed dentist?

- No, dentist exam should not be mandated. An assessment by school nurse is appropriate. – *Baylor, no name*
- Yes – *San Antonio, Kerr*
- Yes – *San Antonio, Taylor*
- Yes – *Houston, Shirali*
- No – should be oral screenings and referrals done by school nurse, RDH or DDS – *Houston, no name*
- Yes – *faxed, Navarro*

If so, how are dental examinations funded for the non-insured?

- Corporate donations, private charity, church based, faith based – *Baylor, no name*
- Write-offs for dentists – *San Antonio, Kerr*
- Parents pay, the cost should be under $100 if no other services are provided. There is Medicaid for indigent, dental care is just another cost of having children just as clothing and food. – *San Antonio, Taylor*
- Through philanthropic organizations – *Houston, Shirali*
- FREE – *Houston, no name*
- Establish a quick screening process to determine if non-insured qualify for CHIP or Medicaid insurance. – *faxed, Navarro*

Should dentists be required to participate in data submission to retain information for a state-wide surveillance system if mandatory dental examinations are required for school entry?

- If the system were put in place by DSHS then yes they should report – *Baylor, no name*
- Yes – *San Antonio, Kerr*
- I think an easy reporting system would be nice, if it is required. – *San Antonio, Taylor*
- Yes – Houston, Shirali
- Yes – But do not support dental exam requirements for school admission. – *Houston, no name*
- Not applicable to Orthodontists – *faxed, Navarro*

How will required dental examinations be enforced? What are the consequences for non-compliance?

- 100% compliance not realistic. Waivers will need to be granted. – *Baylor, no name*
- Withhold billing – *San Antonio, Kerr*
- The same way and same consequences as for immunizations. – *San Antonio, Taylor*

- Through the "statewide" dental director's office if ?(formed). Non-compliance could lend to inability to register at the school. – *Houston, Shirali*
- N/A – do not recommend the required dental exams – *Houston, no name*
- Not applicable to Orthodontists – *faxed, Navarro*

What do you see as the largest barrier to oral health services in Texas?

- Money and ignorance – *Baylor, no name*
- I see the problem as a very diverse and multifaceted issue. The greatest problem with professionals is the readiness to blame the patient without a clear understanding of the transportation, financial, and other barriers that prevent them from seeking care. – *San Antonio, Cappelli*
- Education – *San Antonio, Kerr*
- Funding for educational programs. – *San Antonio, Taylor*
- Money – *El Paso, Brown*
- Access to care via the language barrier and the fact that patients don't know about a great deal of (501 (c)(3)'s) out there (?) greater care at such a low cost. – *Houston, Shirali*
- Lack of education of parents; lack of perceived need. – *Houston, no name*
- Education and marketing – *faxed, Navarro*

Additional Comments:

Overall Session Comments:

- I feel that the best way to enhance the State Oral Health Surveillance system would be to increase the use of auxiliaries and teledentistry. Regional dental directors would have staffs of hygienists and assistants who routinely visit schools and long-term nursing facilities. The hygienist would perform a health history, screening exam, take radiographs as well as intraoral and extraoral photos. The number and types if images would be at the discretion of the hygienist. If appropriate, a fluoride varnish, prophy, ultrasonic denture cleaning, OHI, etc. would be done at this time. This data is uploaded into a secure central database which can be accessed by the dental Directors, Staff Hygienists, Treating Doctors and Officials from the State Dept. of Health. After reviewing the information, the dental director makes the appropriate referral for routine care. Once the referral is made the treating dentist documents the specific diagnosis and treatment rendered in the central database. Officials from the Health Dept periodically run reports from the database to be certain that patients who were referred for treatment actually received the treatment needed, and in a timely fashion. Patients who have not been see are flagged for intensive follow up.
  Having been involved in Nursing home dentistry for 25 years has led me to the realization that there is a serious lack of knowledge regarding proper oral hygiene and the etiology of oral disease. Hygienists should be utilized to perform mandatory on-site oral hygiene instruction and oral disease education for both nursing home staffs and elementary school children at least once a year. – *Baylor, Oliver*

- Thanks for a very informative presentation. Your organization has collected a lot of data. To focus your efforts, I would consider what single aspect of dental care would make the best impact on Texas oral health.
  As an oral surgeon, that is extractions. Forget about the concept of mid-level providers or DTAs doing this – they can't and no one would see their complications and there would be many. Go to

the legislators and lobby for Texas Dental School student slots – free schooling for 4 years of care in underprivileged areas. That is the biggest band for the buck. Please let me know if I can help you in any way. – *San Antonio, Schmitz*

- Please contact me by email and let me know how I can help. – *San Antonio, Kerr*

- I just returned from the 23 Congress of the International Association of Pediatric Dentistry where pediatric dentist from all over the world discussed dental health problems. In many countries there is socialized dentistry for children and one thing I heard loud and clear is no country has the resources to fund surgical care of dental disease in their society, our country is no exception. The only answer seems to be through prevention. There are hard questions to answer when considering what are the rights of an individual to dental care, should everyone have the right to cosmetic procedures such as tooth whitening? I think we can all agree this should not be a right but at most an option. I personally think in an ideal world people would have the right to educational material that will help achieve and maintain health, and to water fluoridation as that is the most cost effective way to deliver fluoride. I believe perhaps everyone should also have access to extraction as a remedy for pain as no one should have to live in pain. If we are really going to improve the public's health we need to provide education. Some studies show only about 38% of people brush their teeth twice a day and considering another study reports 43% of people actually brush less than they report this number may be high. Our efforts should be to encourage the use of a dental home for routine examinations by a dentist, and encourage behaviors we know help prevent disease such as brushing twice a day with a fluoride toothpaste, flossing, and sealants. In Greece a program has been implemented called "brush day and night". The program is funded by Aim toothpaste; Colgate has similar programs in other countries. Efforts should be made to seek corporate funding for similar programs here. Brushing twice a day reduces decay by 50% versus brushing once a day. Perhaps in small communities public service announcements on radio and TV could get aired, bill boards could be donated, or at least fliers could be displayed around town for dental health messages. In large cities this free public support would be unlikely. There is the issue of dental manpower for underserved areas, getting loan repayment for new dentists, and funding of practice cost may help attract dentist to these underserved areas, but a lower standard of care by midlevel providers is not the answer. That would be worse than going to Mexico for dental care and every dentist near the border can tell you about the nightmares they have seen from Mexico. The answer to dental manpower is not easy, but certainly increased funding for dental schools would be a good start. Thank you for this opportunity to give my opinion. – *San Antonio, Taylor*

- Email response listing 10 bullets:

1. I am glad we are going to be discussing TxOHC dues at the next Board meeting. It seems like so much of what we want to do is going to cost money and the Coalition has very little. TDHA has just joined the Texas Society of Allied Health Professionals. Membership costs $300/year and includes individual membership for one person. Other individuals can join for $35. Certainly TDA, TAGD, TDHA, and other groups would be willing to pay dues to be a part of the Coalition.
2. And, along that line, maybe the Coalition needs to have a membership drive....for publicity as well as for new members. The Coalition really is not very well known, even in dental circles.
3. I liked the idea of TxOHC developing a business plan that young, new dentists could take to a rural community to help them survive financially when setting up practice in a rural area.
4. After the listening sessions are complete, maybe we need to have another strategic planning session for the Coalition. I think it helps to have one or two goals that we are working toward. We can look at our two goals from the last planning session and see if they are still important to us, given what has happened since the last strategic planning.
5. How can we reach families of nursing home residents? As suggested, they are the ones that really need to be making noise in the Legislature about lack of dental care in nursing homes and the Coalition should be supporting them.
6. Who makes the decision on what is included in public school curriculum? How can we get oral health in the curriculum each year, K - 12?

7. We need to work with legislators that want to improve school lunches and control vending machines in schools.
8. Is there a dentist in the Legislature now? If so, can we let him/her know about the goals of the Coalition?
9. Should the Coalition be testifying in favor of water fluoridation in communities (like Austin!) where the anti-fluoridation folks are trying to get it taken out?
10. Maybe a topic for a future summit could be dental public health training related to contemporary dental public health principles and practices. (Of course, we would have to make the title a little more glamorous!) – *Austin, Cline*

- Email response – Dental Hygienist and the Children
  All of us know how important dental education must be for the children. It must start at a young age and be reiterated over the years. This is the Hygienist's forte: education.
  There could be a position created for a school district Hygienist who would then be responsible for: creating a age appropriate curriculum for grades 2, 5, 7, 11, (every year would be ideal) and teach this curriculum in adjunct when the students are being taught health. The Hygienist can also organize dental health clinics for screening the children and helping them find a dental home. The Hygienist can be "on call" as far as pay goes for the different schools. Not be a full time paid employee. It would be difficult, with as many schools there are in a district.
  If this is not feasible, then cut down on the times when the Hygienist goes into the classrooms.
  If this is not feasible, have the dental Community come up with an age appropriate curriculum that can be taught by the current health teachers. And maybe when the dental section is being taught, have a Hygienist as a "guest speaker".
  Dental education is sorely lacking in our schools, we must be assertive and provide the tools and personnel to achieve our goals. No child should suffer with dental pain while trying to concentrate in school. Utilize the Hygienist in what he/she was best trained to do- educate! – *Austin, Tarver*
  Email response – Dental Hygienists and Nursing Homes
  The geriatric population especially in nursing homes is sadly neglected. This proposal should make it favorable to this population as well as the dental population.
  Nursing home Hygienist – a Hygienist would be employed by the nursing home as a "on call" person. This person would:
    1. Be responsible for all new residents and their initial assessment. This could be done monthly. The Hygienist would assess the needs of these residents, find them a dental home and perform an oral cancer exam.
    2. Be responsible to all residents to perform an oral cancer screening and visual exam every six months.
    3. Provide training for the staff of the nursing home in oral hygiene, denture care and train them to recognize obvious possible lesions.
    4. If a dental problem occurs, the Hygienist would be first to go out to the nursing home to assess the problem then make arrangements for dental care.

  By utilizing the Hygienist this way you cut down on dental costs, the residents are still taken care of and the Dentist is included in the loop. Hygienists would be the front line per se of the battle to provide care for the geriatric patient.
  This is a win-win scenario; the dentist would still see the residents on an as needed basis therefore being able to bill the resident or Medicare accordingly. The resident is receiving quality care and the nursing home only need to pay the Hygienist o an as needed basis. A Hygienist would be able to cover three to four nursing homes comfortably. – *Austin, Tarver*

- You asked how can we see more people in the public health setting?
  - More $ can be spent on dental personnel…pay for more numbers of dentists in a clinic. May need federal assistance on this. It seems a lot of $ in these clinics goes to administrative costs… to those supervising the dental personnel.
  - Expanded functions for assistants/hygienists.
  - If we had expanded duties for hygienists, we may have a niche of employment for them.

- ❖ Legislation would need to be passed protecting schools (liability) prior to having a dental clinic in the school
- ❖ Target population for a sealant program uninsured/indigent (In El Paso)
- ❖ Texas health Steps is hugely beneficial to our state
  I have seen a surge of pediatricians examining and referring patients < 1 year age
  Therefore, parents are much more savvy about appointment compliance and oral health education.
- ❖ Please continue to advocate for nitrous oxide, enteral and iv sedation
  We work with so many children that have already been traumatized because there were not options in their past dental experience.
- ❖ Education for pediatricians – refer at 6 months. They will need short presentation, data, images, 5 minutes. – *El Paso, Brown*

- This survey is way too long and laborious. – *Houston, no name*

Email Response:

- Partner with Texas Society of Allied health Professions – September 15-16, 2011 in Dallas
- Grassroots networking – have TxOHC members pledge to make a guest appearance at various local and regional coalition meetings
- AAP district VII or Texas Chapter: www.txpeds.org contact info. for Mary Greene-Noble
- Contact organizations such as the Oral cancer foundation, and set up local screenings for a way to get started with educating people
- Corporate sponsorship or federal grants for outreach projects
- Monitor development of new workforce models such as dental Therapists – *emailed, Schreiner*

Email Response:

-----Original Message-----
From: Babb, Joe <jbabb@mhm.org>
To: rlaw829273 <rlaw829273@aol.com>
Sent: Fri, Jul 29, 2011 3:26 pm
Subject: San Antonio Listening Session

Dr. Law

RE: Listening Session in San Antonio

After listening to the results of the Medicaid report – there is great concern that while some measures addressing dental care for children covered by Medicaid looked good, the report failed to address the lack of dental care for 30% of the children that are uninsured.

The lack of access to care for both children and adults is a real problem for much of Texas - especially non-urban areas, and organized dentistry in Texas is not doing enough to address the oral health problems of the State. This is especially alarming knowing that the number one childhood disease is dental caries.

It is a personal opinion that providing some care is better than no care. The requirement that only a dentist perform procedures that could be delegated to other qualified dental professionals is counterproductive and is a major contributing factor to the lack of access to care.

While TDA believes that the use of dental therapists is a quality of care issue, there is no formal study showing that dentists in Texas provide a level of care that is of any better quality than what a dental therapist provides. In fact TDA cannot produce any legitimate scientific study showing the level of quality care being provided by dentists in Texas.

TDA also espouses that a dental home is the answer to the access to dental care problems. This may be true for a majority of insured patients, but the dental home does little to address the needs of a large number of Medicaid patients, patients in rural communities without a dentist, patients on fixed incomes, or uninsured patients. With very few dentists accepting Medicaid (and even fewer once the State implements the Medicaid changes) there are an inadequate number of dentists serving Medicaid patients. Too many counties in Texas do not have a dentist. It is understandable that these sparsely populated counties cannot support a dentist, but they may very well support a dental therapist. Access to a dental therapist for basic dental procedures, fillings, cleanings, etc would go a long way to addressing the oral health needs of many individuals throughout Texas. But the use of dental therapists would have the greatest impact on those individuals who are uninsured with limited income and unable to afford the high cost of dental care. With 40% of the population having household incomes below 200% of the Federal Poverty Level leaves too many people without funds to access needed medical and dental services. Thus the position that some care is better than no care is based on the tremendous needs of the population.

While TDA does not support the position that some care is better than no care, they however do in fact subscribe to this belief with their Smiles program, in which dentists volunteer to provide services over a weekend to people in need at no charge. While this is an admirable effort, unfortunately, the Smiles program does not address all of the patient's needs during that weekend, so the patient is left trying to figure out how to get the rest of their needed care once the dentist leaves. Further, after the weekend is over, the dentist in essence abandons the patient (the dentist comes to the community for two days, provides some service then leaves) hoping someone else will pick up behind them. At least a dental therapist will remain in the community to provide appropriate services, then if necessary, makes arrangements with a dentist for services the dental therapist cannot provide. Then the patient returns to the therapist for ongoing and follow up care.

Not all avenues are being explored to provide dental care at some level for the least served in Texas by organized dentistry- its failure to support policies that improve access to care is unacceptable, especially with regard to taking care of those in need.

Serious thought should be given to the passage of legislation allowing Dental Therapists to practice in non-urban communities of Texas, and also to serve those Texas residents that are uninsured.

Thank you *San Antonio, Babb*

****

P**lease Circle Yes or No**

Prior to this meeting were you aware of the Texas Oral Health Coalition? Yes No

- Yes – *Baylor, no name*
- Yes – *San Antonio, Cappelli*
- No – *San Antonio, Kerr*
- Yes – *San Antonio, Taylor*
- No – *El Paso, Brown*
- Yes – *Houston, Barnes*
- Yes – *Houston, Shirali*
- Yes – *Houston, no name*

Prior to this meeting were you aware of the "*State Oral Health Plan?"* Yes No

- Yes – *Baylor, no name*
- Yes – *San Antonio, Cappelli*
- No – *San Antonio, Kerr*
- No – *San Antonio, Taylor*
- No – *El Paso, Brown*
- Yes – *Houston, Barnes*
- Yes – *Houston, Shirali*
- Yes – *Houston, no name*

I am a member of the Texas Oral Health Coalition Yes No

- Yes – *Baylor, no name*
- Yes – *San Antonio, Cappelli*
- No – *San Antonio, Kerr*
- Yes – *San Antonio, Taylor* (was not on our membership roster)
- No – *El Paso, Brown*
- Yes – *Houston, Barnes*
- Yes – *Houston, Shirali*

- Yes – *Houston, no name*

I would like to join the Texas Oral Health Coalition Yes No

- Yes – *San Antonio, Kerr*
- Yes – *San Antonio, Taylor*
- Potentially at a later time. My time is already dedicated to community projects. – *El Paso, Brown*

I am a member of these other Coalition/s:

- TxOHC Board of Directors – *San Antonio, Cappelli*
- San Antonio Oral Health Coalition – *Taylor*
- AGD – *El Paso, Brown*
- Houston OHC – *Houston, Barnes*
- TxOHC – *Houston, Shirali*

Did you find this listening session productive? Yes No

- Yes – *Baylor, no name*
- Yes – *San Antonio, Cappelli*
- Yes – *San Antonio, Kerr*
- Yes – *San Antonio, Taylor*
- Yes – *El Paso, Brown*
- Yes – *Houston, Barnes*
- N/A –*Houston, Shirali*
- Yes – *Houston, no name*

Additional Comments:

- Please send me info on how to join – *San Antonio, Kerr*
- Thank you so much! Very important information. – *El Paso, Brown*
- Listening Sessions have been very helpful and good approach on TxOHC to be forerunner in providing solutions to many challenges for promoting oral health in TX and providing infrastructure to state. Thanks to all TxOHC executive staff and board for relentless efforts. – *Houston, Barnes*
- This survey is too long. The TxOHC-Houston Regional report Re (?) using input was informative and well done. The reading of the TDA letter at the Houston session came like whip lash. – *Houston, no name*

TxOHC
TEXAS ORAL HEALTH COALITION

Appendix 2. Texas Oral Health Program Policy Tool Workshop

Texas Oral Health Program Policy Tool Workshop

March 23, 2012, Austin, Texas

A Report of Activities and Outcomes Utilizing a Policy Development Tool Developed by the Children's Dental Health Project in Cooperation with the CDC Division of Oral Health - Excerpts

The workshop held in Austin, Texas on March 23, 2012 was designed to bring together oral health advocates to facilitate critical thinking about the state's oral health policies and systems. Sixty individuals, representing organized dentistry and dental hygiene, public health professionals, community health advocates, and others pre-registered for the workshop, although actual attendance included only fifty-two registrants.

Dr. Linda Altenhoff, Director of the Texas Oral Health Program welcomed participants to the half-day workshop. Lori Cofano and Wendy Frosh, CDHP Facilitators, introduced the Policy Tool and the agenda for the session. Each participant was asked to introduce him/herself and the organization or constituency he/she represented.

Each of the participants was asked to suggest a policy or systems change priority for discussion, and to clarify how each might impact the oral health status of Texas communities. In addition to policy and systems change priorities, the list generated included a number of programmatic suggestions. Those identified issues included:

- Improve oral health literacy across Texas
- Integrate oral health into all elder-care services and facilities
- Support the development of the Dental Home through professional education
- Integrate oral health into electronic communications/health records
- Increase collaboration between dentists and physicians
- Provide prevention and early intervention services for all children ages 0 to 3
- Improve access to care for all underserved populations
- Develop oral health education for all early childhood providers
- Implement the BSS for the senior population
- Build and train an oral health team to address the needs of seniors
- Build collaboration with Texas school systems to implement oral health screenings and oral health curricula
- Establish tooth brushing programs in all Texas elementary schools
- Train dentists to address the needs of young children and their mothers

- Develop and finance care coordination systems, particularly for young children
- Develop and provide integrated oral health education for pregnant women
- Create policy to ensure the delivery of oral health care for the incarcerated
- Develop and disseminate quality of care standards to all dental providers
- Provide legislators with information regarding the importance of oral health to overall health
- Ensure that Texas residents have access to an integrated Health Home
- Provide oral health services children with major medical and special needs
- Create incentives for dentists to practice in underserved areas
- Implement mandatory dental screenings for all children entering kindergarten
- Require oral health training for all nursing home aides
- Structure public assistance programs to encourage dental provider participation
- Create and implement an integrated care model to address oral cancers
- Implement a common comprehensive health assessment tool for all publicly- funded programs
- Increase access to evidence-based prevention services
- Incorporate oral health in hospital discharge instructions for maternity patients
- Increase the enrollment window for Medicaid from 6 months to 12 months
- Implement integrated/"one-stop" care models to improve access for the underserved
- Ensure that both medical and dental providers can be reimbursed for providing basic oral health services
- Ensure that all long term care and assisted living facilities provide routine oral health care to residents
- Include oral health in all school-based "healthy lifestyle" programs
- Increase the number of school-based health centers and ensure that they provide preventive services focused on oral health
- Ensure that oral health benefits are included in the 'essential health benefit' under the [Affordable Care Act] ACA
- Fluoridate all community water systems
- Create and implement a comprehensive oral health surveillance system for use across the lifespan
- Ensure that dentists are trained to address the needs of children with special needs and developmental disabilities
- Create best practices and quality improvement systems to generate outcomes data to support policy development

The list was reviewed and edited, prior to the next exercise, in which participants were asked to select and vote on their top five priorities. The five policy/systems change suggestions that received the most number of votes were as follows:

- Support the development of the Dental Home through professional education (28 votes)

- Create a statewide Oral Health Surveillance System to collect oral health data across the lifespan (27 votes)
- Improve oral health literacy across Texas (25 votes)
- Integrate oral health into all elder-care services and facilities (22 votes)
- Fluoridate all community water systems (19 votes)

Appendix 3. Oral Health Program Summary

ORAL HEALTH PROGRAM

Vision Statement:

Our vision is a healthy Texas, where all individuals enjoy the benefits of good oral health as an integral part of overall health.

Mission Statement:

Promoting oral health through leadership in public health practices, policy development, education, and population-based preventive services.

Oral Health Program (OHP) Five Core Functions:

1. ***Promote effective evidence-based strategies and preventive oral health practices through population-based services.***
   - Screen and identify populations needing dental services.
   - Provide preventive dental services and treatment referrals.
   - Develop and promote evidence-based strategies and interventions to prevent and control oral diseases.
   - Provide dental sealant and fluoride varnish programs through a school-based delivery model.
   - Provide oversight and coordination of public health dental functions.
   - Educate Texans regarding good oral health and how it relates to overall health.
   - Address disparities in oral health.
   - Facilitate, monitor, and evaluate sealant program effectiveness.
2. ***Serve as an oral health subject matter expert and provide support for internal and external partners.***
   - Develop sound oral health policy.
   - Increase capacity by increasing infrastructure partners to leverage resources at the local, regional, and state levels.
   - Assist regional programs in providing community-based solutions to oral health problems.
   - Collaborate with school nurses to increase awareness of dental resources for students and the establishment of a dental home.
   - Work with dental and medical schools and other academic institutions to promote oral health.
   - Conduct educational activities geared at promoting optimal oral health with emphasis on the concept that oral health is a vital part total body health and well-being.
3. ***Gather, provide, and maintain oral health data required by local, state, and federal policy makers for decision making, support, and documentation of oral health trends.***
   - Collect oral health data that is statistically valid by calibrated dentists.
   - Evaluate the effectiveness of implemented oral health strategies through annual strategic planning and programmatic evaluation activities.
   - Implement statistically valid Basic Screening Surveys (BSS) for targeted populations.
   - Submit data reports to management per program reporting requirements.
   - Collect convenience data for preventive dental services clinics.
   - Establish an oral health surveillance system that utilizes various data sources (BRFSS, YRBS, Birth Defects, Cancer Registry, etc.) that describe oral health status.
   - Coordinate and conduct routine utilization reviews on randomly selected Medicaid dental providers.
4. ***Develop a collaborative network of community and professional partners to increase delivery systems for the implementation of preventive dental services programs.***
   - Develop and maintain liaison relationships with dental and medical professional organizations, schools, and individuals that are seeking to provide dental public health services.
   - Work to involve private local groups, agencies, and individuals interested in improving dental public health services in underserved areas.
   - Serve as an active collaborative partner with other public health, community, and statewide entities to promote improved oral health for Texas citizens.
   - Serve as a referral liaison between Texas citizens and regional public health programs and community partners.
5. ***Serve as support for disaster related response teams.***
   - Actively participate and/or serve in a supporting role to meet the agency's obligations for disaster response and/or recovery or Continuity of Operations (COOP) activation.

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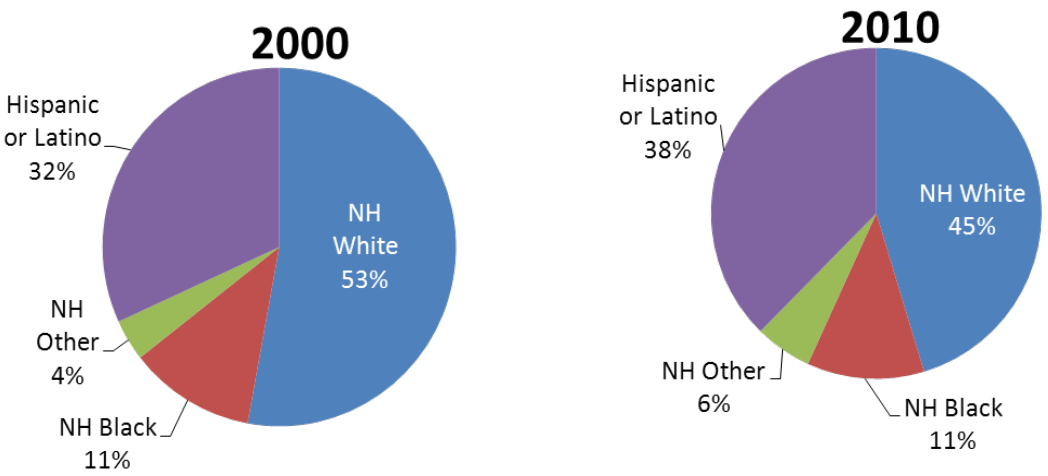
Appendix 4. Population Change between 2000 and 2010 Census: United States, Texas, California, Florida, Georgia, North Carolina, and Arizona

AREA	2000 Population	2010 Population	Numerical Change 2000-2010	Percent Change 2000-2010
United States	281,421,906	308,745,538	27,323,632	9.7%
Texas	**20,851,820**	**25,145,561**	**4,293,741**	**20.6%**
California	33,871,648	37,253,956	3,382,308	10.0%
Florida	15,982,378	18,801,310	2,818,932	17.6%
Georgia	8,186,453	9,687,653	1,501,200	18.3%
North Carolina	8,049,313	9,535,483	1,486,170	18.5%
Arizona	5,130,632	6,392,017	1,261,385	24.6%

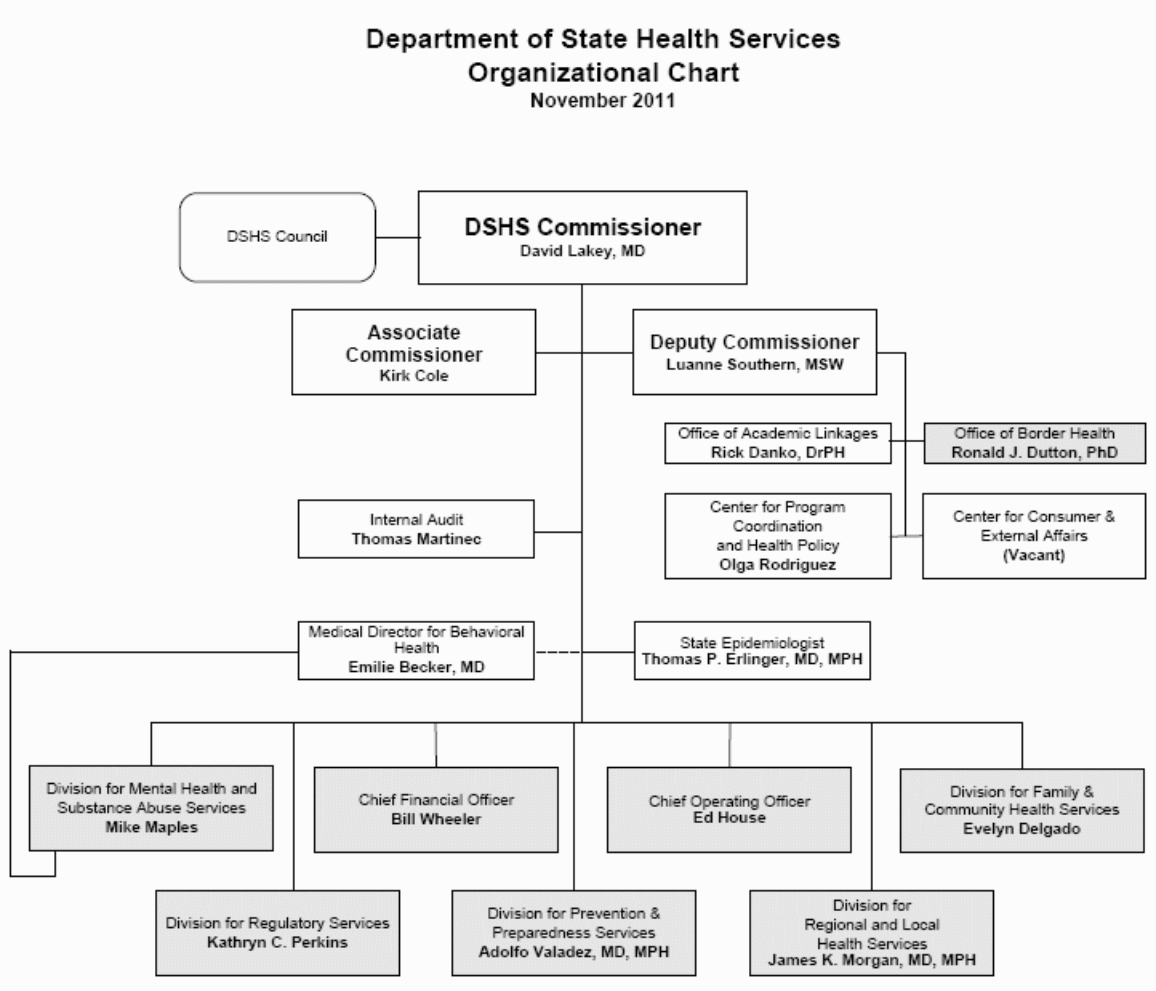
Source: Office of the State Demographer, Update of Texas Demographic Characteristics and Trends (67).

Appendix 5. Texas' Ethnic Composition 2000 and 2010

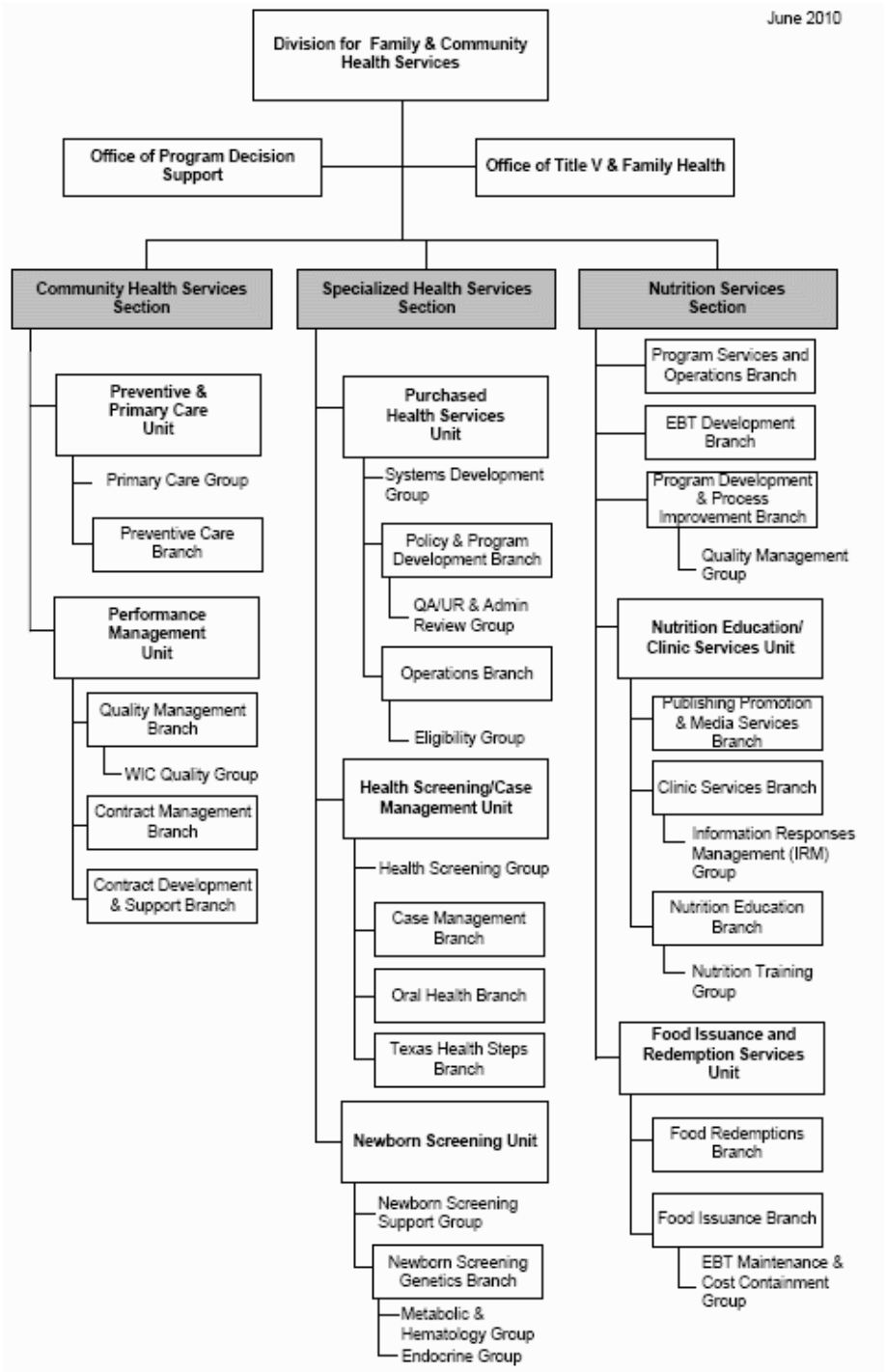


Source: Office of the State Demographer, Update of Texas Demographic Characteristics and Trends (67).

Appendix 6. Department of Health Services Organizational Chart (68)



Appendix 7. Division for Family & Community Health Services (69)



Appendix 8. Oral Health Program / Department of State Health Services Surveillance Matrix, 2010-2018

Texas Oral Health Data Source Grid

Topic	Source	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Pre-Schoolers										
Decay Experience	Basic Screening Survey (BSS)					X				X
Untreated Decay						X				X
Sealant Prevalence						X				X
Urgent Need						X				X
Third Graders										
Decay Experience	Basic Screening Survey (BSS)				X				X	
Untreated Decay					X				X	
Sealant Prevalence					X				X	
Urgent Need					X				X	
Adolescents										
Decay Experience	Youth Risk Behavior Survey (YRBS)				X		X		X	
Untreated Decay					X		X		X	
Sealant Prevalence					X		X		X	
Urgency Need					X		X		X	
Adults										
Length of time since last dental visit	Behavioral Risk Factor Surveillance Survey (BRFSS)	X		X		X		X		X
Length of time since last teeth cleaning		X		X		X		X		X
Number of teeth removed due to tooth decay or gum disease		X		X		X		X		X
Seniors										
Length of time since last dental visit	Behavioral Risk Factor Surveillance Survey (BRFSS)							X		X
Length of time since last teeth cleaning								X		X
Number of teeth removed due to tooth decay or gum disease								X		X

Updated October 2011-OPDS

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