Dental Public Health Activity Descriptive Report Submission Form

The Best Practices Committee requests that you complete the Descriptive Report Submission Form as follow-up to acceptance of your State Activity Submission as an example of a best practice.

Please provide a more detailed description of your **successful dental public health activity** by fully completing this form. Expand the submission form as needed but within any limitations noted.

ASTDD Best Practices: Strength of Evidence Supporting Best Practice Approaches
Systematic vs. Narrative Reviews: http://libguides.mssm.edu/c.php?g=168543&p=1107631

NOTE: Please use Verdana 9 font.

CONTACT PERSON PREPARING THE SUBMISSION AND TO ANSWER QUESTIONS

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PROVIDE CONTACT INFORMATION FOR ONE ADDITIONAL PERSON WHO COULD ANSWER QUESTIONS REGARDING THIS PROGRAM

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SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

Oral Health Surveillance

Public Health Functions*: Check one or more categories related to the activity.

"X"	**Assessment**
X	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
	8. Assure an adequate and competent public and private oral health workforce
	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2020 Objectives: Check one or more key objectives related to the activity. If appropriate, add other national or state HP 2020 Objectives, such as tobacco use or injury.

"X"	**Healthy People 2020 Oral Health Objectives**	
	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
	OH-9	Increase the proportion of school-based health centers with an oral health component
	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component
	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year

	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
X	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training

"X"	**Other national or state Healthy People 2020 Objectives: (list objective number and topic)**	

Provide 3-5 Key Words (e.g. fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:
oral health surveillance, oral health surveillance system, oral health data, acquiring oral health data

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

The National Oral Health Surveillance System (NOHSS) is a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the Association for State and Territorial Dental Directors (ASTDD), and is designed to monitor the burden of oral disease, use of the oral health care delivery, and the status of community water fluoridation. The New Hampshire Oral Health Surveillance System (NHOHSS) is modeled accordingly, and encompasses systematically collected data, analyses, interpretation, and dissemination of outcome-specific data for use in planning, implementation, and evaluation of public health programs. Review of NHOHSS data allows us to understand the burden of oral disease and injury in New Hampshire, and also the risk and protective factors that impact oral health status. We also know that different sectors of the population within New Hampshire have varying levels of access to oral health care and that they face the burden of disease disproportionately. Costs associated with the maintenance and analysis of the NHOHSS include a portion of the salaries for the evaluator and epidemiologist.

The NHOHSS centralizes the collection, maintenance, and reporting of NH oral health data as related to the oral health status of residents across the lifespan, oral health services provided to individuals and communities, public health program service delivery, and the capacity within the State to deliver the level of services appropriate for the population. Data captured through the NHOHSS are reported out approximately every 5 years in the New Hampshire Oral Health Data Report. The report is intended to provide details about the above noted indicators to oral health stakeholders, decision makers, and the general public. In addition to the Oral Health Data Report, data briefs and survey results are published and posted intermittently as relevant data becomes available. The data elements that make up the NHOHSS provide a comprehensive picture of oral health burden and assets in New Hampshire so that status and need can be understood and so that informed decisions can be made. The purpose of the NHOHSS is to document the magnitude of the public health problem, to monitor disease trends over time, to detect changes in health care practices, to evaluate prevention strategies, and to facilitate planning.

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Complete using **Verdana 9 font.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

   The New Hampshire Department of Health and Human Services, Oral Health Program was established in 1997. At that time, the state program consisted of a single staff person, the program manager who was a dental hygienist. While it was recognized that there was a need for oral health data collection, until the year 2000, the state health department did not have a chronic disease epidemiologist and the capacity for the collection of oral health data was limited. In 2000, a CDC epidemiologist was assigned to the New Hampshire Department of Health and Human Services. His expertise provided the opportunity to develop the New Hampshire Oral Health Surveillance System (NHOHSS).

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

   The Association of State and Territorial Dental Directors (ASTDD), the Council of State and Territorial Epidemiologists (CSTE), *Oral Health in America: a Report of the Surgeon* General (2000) and Healthy People 2020, have recommended that states develop and maintain a surveillance system for oral health. A surveillance system provides a reliable source of information for assessing the oral health status of the state's population. Surveillance data allows for the recognition and prioritization of needs, and informs program planning and policy development.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

   - 1997- NH Oral Health Program established
   - **2000- CDC epidemiologist was assigned to NH, allowing for the development of an oral health surveillance system**
   - 2012- NHOHSS was partially assessed during the surveillance and epidemiology evaluation funded by the Coordinated Chronic Disease (CCD) cooperative agreement. At this time, the Chronic Disease epidemiologist developed an Oral Health Program surveillance plan for the years 2013-2018.
   - 2013- An Oral Health cooperative agreement through the Centers for Disease Control and Prevention (CDC) allowed for expanded capacity, including financial support for a part-time evaluation specialist.
   - 2015- An Evaluation Specialist was hired. The Evaluation Specialist became responsible for the maintenance, analysis, and output development for the surveillance system.
   - 2016- The most recent version of the oral health burden report was written and published (New Hampshire Oral Health Data 2015).
   - 2016- An Oral Health cooperative agreement through the CDC allowed for further expanded capacity, including funding for an epidemiologist.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

   - Funding
   - Staffing
   - Data sources
   - Reported data
   - Technology (computer, database, analysis and word processing software,

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description of the key aspects of the activity, including the following aspects: administration, operations, and services.

- Identify measures: Core measures are consistent with the NOHSS; additional measures are identified by the Oral Health Program, with guidance from the evaluator and epidemiologist. New data sources are considered in the development of measures.
- Identify data sources, collect data, store/maintain data, analyze data: These steps are carried out by the evaluator and epidemiologist.
- Summarize and report data (Oral Health Data Report, issue briefs, etc…), share findings with stakeholders: The evaluator and epidemiologists are responsible for drafting data related reports. Distribution of reports depends on the intended audience; in general, reports are shared via the New Hampshire Department of Health and Human Services website.
- Decision making based on the NHOHSS: Output from the NHOHSS is used to inform decision making by the Oral Health Program as well as stakeholders such as the NH Oral Health Coalition.

INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3. What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

Indicators: Although new data is continuously reviewed, analyzed, and reported with each iteration of the Oral Health Data Report, there are a core set of eight indicators prescribed by the NOHSS that have historically been reported as part of the NHOHSS: dental visits, teeth cleaning, complete tooth loss, fluoridation status, caries experience, untreated caries, dental sealants, and cancer of the oral cavity and pharynx. The table below includes each of the eight indicators with details about the source of data.

Indicator	**Source***
Adults aged 18+ who have visited a dentist or dental clinic in the past year	CDC Behavioral Risk Factor Surveillance System
Adults aged 18+ who have had their teeth cleaned in the past year, among those with natural teeth who have visited a dentist or dental clinic	
Adults aged 65+ who have lost all of their natural teeth due to decay or gum disease	
Adults aged 65+ who have lost six or more teeth due to tooth decay or gum disease	
Percentage of third grade students with caries experience	Third Grade Baseline Screening Survey
Untreated caries in third grade students	
Percentage of third grade students with dental sealants on at least one permanent molar tooth	
Fluoridation of public water supplies	CDC Water Fluoridation Reporting System

In addition to the 8 core indicators, the most recent iteration of the New Hampshire Oral Health Data report (2015) included the indicators detailed in the table below.

Indicator	**Source***
Oral and Pharyngeal Cancer: Annual Incidence Rate over 5-year Rate Period (Males and Females, age-adjusted , rate per 100,000 population per year)	CDC & National Cancer Institute State Cancer Profiles
Oral and Pharyngeal Cancer: Annual Mortality Rate over 5-year Rate Period (Males and Females, age-adjusted, rate per 100,000 population per year)	
Women who had insurance to cover dental care during pregnancy	Pregnancy Risk Assessment Monitoring
Women who needed to see a dentist for a problem during pregnancy	

Women who went to see a dentist for a problem during pregnancy	System
Women who had their teeth cleaned by a dentist or dental hygienist during the 12 months prior to their pregnancy	
Proportion of patients who receive oral health services at Federally Qualified Health Centers	US DHHS, HRSA, BPHC Uniform Data System Report
Active dentists by specialty type	NH Board of Dental Examiners
Active registered dental hygienists and certified public health hygienists by county	
Designated dental health professional shortage areas (map)	State of NH, DHHS, DPHS, Rural Health and Primary Care Section
Population living in a designated dental health professional shortage area	US DHHS, HRSA, Data Warehouse
Percent of need met & Practitioners needed to remove dental health professional shortage area designations	

Publications: Numerous publications have been developed using data from the NHOHSS. The most comprehensive and most current publication is the New Hampshire Oral Health Data 2015 report (linked in tools and resources section). Using data from the surveillance system (indicators noted above), the report was organized to tell the story of oral health in New Hampshire. Background information and indicators were organized into sections as follows:

- Burden of Oral Disease and Injury in New Hampshire
- Risk and Protective Factors
- Dental Safety Net, Dental Workforce, and Capacity.

Where data was available, indicators were stratified by geography, demographic, and socioeconomic factors in order to highlight existing disparities to inform programmatic and policy decisions.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4. What outcomes did the program achieve? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:
    a. How outcomes are measured
    b. How often they are/were measured
    c. Data sources used
    d. Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years)

The outcome of maintaining and utilizing the NHOHSS is an increase in knowledge about the oral health status of the State of New Hampshire. The outputs of the system provide detail about the burden of oral disease in the State, the risk and protective factors impacting oral disease rates, and the capacity within the State to address the existing need. This information can be used by stakeholders, including the oral health program, the oral health coalition, and others throughout the State who have an interest in oral health, to make programmatic and policy related decisions.

Information from the NHOHSS has been disseminated and shared at the national, state and local levels. New Hampshire has contributed the oral health surveillance data to both the National Oral Health Surveillance System and the State Synopsis of State and Territorial Oral Health Programs. In addition, a Morbidity and Mortality Weekly Report (MMWR) article has been published on the results of the 2001 third grade survey. Summary articles have been included in the state Epidemiology newsletter and in the newsletter of the NH Dental Hygiene Association. Furthermore, information from the state surveillance system has been presented at three national meetings (Epidemic Intelligence Service, Chronic Diseases and Oral Health). The Oral Health Data report, which is a comprehensive summary of data available through the surveillance system, is published approximately every 5 years. The report is distributed directly to stakeholders and is posted on the website. While the Oral Health Program has heard feedback from stakeholders about the usefulness of the report, the system has not formally been evaluated.

The surveillance data are used extensively. Program performance measures developed from surveillance data are now used to manage the performance of programs receiving oral health funding from the state. Surveillance data is also used for prioritizing oral health program activities.

New Hampshire's state and local stakeholders have used the surveillance data for developing the state oral health action plan. The Coalition for New Hampshire Oral Health Action, broadly representative of the individuals and entities concerned with oral health, that developed the state action plan wanted information that only the surveillance system could provide. Without measures of the oral health status of the population, the discussion would have focused mainly on access to care issues. **Having population based data from the oral health surveillance system made the coalition look at issues more from a public health perspective.**

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

There is not a specific budget for this activity as it varies depending on staff time spent on surveillance system activities, data collection activities conducted throughout the year, and data needs and requests from stakeholders. It is estimated that the annual budget averages out to be approximately $45,000.

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

Cost Estimations:
Staff time (epidemiologist and evaluator): $35,000/year
Survey/Data collection costs: $10,000/year (these are estimations for a yearly average based on a variance in scope from year to year; some years the survey and data collections may be lower, some years, they may be higher.)

3. How is the activity funded?

Activity related to the oral health surveillance system is funded through a cooperative agreement with the Centers for Disease Control and Prevention.

4. What is the plan for sustainability?

Maintaining up to date oral health data is a core function that allows for informed decision making. As such, the activities associated with the NHOHSS will continue to be included as part of the job description/functions of the evaluator and epidemiologist, both of whom are funded in part by the Oral Health Program; the remainder of funding for their positions comes from other programs that they support within the Chronic Disease Section. As funding opportunities become available, the Program will continue to seek support for the evaluator and epidemiologist.

Lessons Learned and/or Plans for Addressing Challenges:

1. What important lessons were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

Developing the oral health surveillance system was made easier by the infrastructure for surveillance that has been developed by ASTDD and CDC. The existence of the National Oral Health Surveillance System, Behavioral Risk Factor Surveillance System, Basic Screening Surveys, and Water Fluoridation Reporting System made the work much easier. Leadership within the health department has supported oral health surveillance efforts, and assists with securing the needed resources.

2. What challenges did the activity encounter and how were those addressed?

Changes in staffing have posed a challenge to the Oral Health Program in regards to many activities, including those associated with the NHOHSS. Due to lack of evaluation and epidemiologic staffing, the Oral Health Program contracted with an external organization for the development of the 2015 Oral Health Data Report. There were challenges associated with the contract and associated deliverables; so when the Oral Health Program was able to secure a part-time evaluator for the program, they terminated the contract and completed the project internally. In July of 2016, the Oral Health Program evaluator accepted a position as an epidemiologist for the Chronic Disease Prevention and Screening Section. In this role, she will continue to support the Oral Health Program in activities relating to the

NHOHSS. The Program is currently in process of hiring an evaluator who will also help to maintain the system.

Related specifically to data collected by the Oral Health Program, in 2016 it was noted that the funded school based programs were not reporting decay measures consistently. The data definitions that were being used for treated decay and history of decay varied across programs; as a result, the data lacked uniformity. To address this issue, the Oral Health Program developed and conducted a webinar to ensure that all reporting entities were on the same page.

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.

New Hampshire Oral Health Data 2015 (Comprehensive data report, commonly referred to as the burden report)
Poster: Why is Data Important? (Poster prepared for and presented at a legislative breakfast)
Presentation: School Based Oral Health Programs- Annual Reporting (Presentation developed to ensure uniform reporting of school based program data)
Oral Health in New Hampshire (2014 data brief)
Oral Health Program Activities in New Hampshire (Summary of Program activities, updated in 2014)
Oral Health Survey of New Hampshire Older Adults (2014 data brief)

TO BE COMPLETED BY ASTDD	
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