A Best Practice Approach Report describes a public health strategy, assesses the strength of evidence on the effectiveness of the strategy, and uses practice examples to illustrate successful/innovative implementation.

I. Best Practice Approach

State Oral Health Plans and Collaborative Planning

Summary of Evidence Supporting State Oral Health Plans and Collaborative Planning

Research	+
Expert Opinion	+++
Field Lessons	++
Theoretical Rationale	+++

See **Attachment A** for details.

II. Description

A. Definition of a State Oral Health Plan

A State Oral Health Plan is a public health strategic plan to systematically address the burden of oral diseases and to enhance oral health of the citizens residing in the state. Ideally, the plan is based on appropriate oral health needs assessment and surveillance findings at the state and local levels and uses evidence-based interventions that have been shown effective through research (1). Such a plan is key to establishing a vision for improving the oral health and well-being of the citizens of a state and local communities, developing policies, and targeting actions.

A State Oral Health Plan can provide an overarching direction or roadmap. A state plan enables a state to design a comprehensive, integrated approach to meeting the oral health needs of the state's population through oral health promotion and disease prevention and control. In many states, localities have their own health improvement plans that may not be related to one another. A state plan can provide the linkage and coordination needed to set goals and objectives, integrate interventions, and efficiently use available resources.

B. Collaborative Planning

Public health professionals encourage planning to address complex issues such as chronic diseases and to achieve desired public health outcomes (2). When problems require long-term strategies and multiple approaches, planning is important at the state and community levels. Preventing oral disease and promoting oral health will be complex, involving significant social and cultural factors, and will require changes in policy, environment and individual behavior.

Planning involves both the planning process as well as the finished plan that is the outcome of the process. The process of planning and the success of a plan need the support of those who must make it happen. Therefore, a collaborative process should be used in developing a State Oral Health Plan and bringing together stakeholders. Collaborative planning includes pooling information from

state and community needs assessment studies and surveillance to identify needs, coordinating activities with the state dental director and the state oral health program, linking to appropriate state and community stakeholders including consumers, and working with partners in setting priorities and implementing intervention strategies. Jointly, stakeholders review information on the oral health status of the population, understand evidence-based practice and best practice information, specify goals, objectives, tasks and timelines, and identify the roles of agencies and organizations to fulfill the plan.

The development of a State Oral Health Plan should include the following, which will contribute to the successful implementation of intervention programs and achieving goals (3.4):

1. Provide a vision for the future to enhance oral health;

2. Identify and enlist stakeholders that will collaborate and contribute to the plan's implementation;

3. Acknowledge the different roles of stakeholders;

4. Identify key issues within selected priority population groups and for oral health across the life-span (e.g., tooth decay, periodontal disease, oral cancer, water fluoridation, dental sealants, infection control, etc.);

5. Identify existing oral health and general health plans and build upon these existing plans;

6. Assess and recognize existing and potential resources and develop strategies to leverage resources and obtain commitment of resources;

7. Establish long-term and short-term goals and measurable objectives based on needs identified through needs assessment studies or surveillance data and priorities determined through consensus of primary stakeholders;

8. Review current evidence-based strategies and best practice information that can be replicated or adapted;

9. Select/develop implementation strategies that integrate interventions, maximize oral health into general health programs, establish strong collaborations and partnerships, and incorporate aspects for success such as building social value for oral health and ensuring cultural sensitivity in the delivery of services;

10. Establish evaluation for monitoring of measurable outcomes and impacts of plan implementation;

11. Have the plan be flexible so it is able to be integrated and/or coordinated with other existing state and local health plans and policies, particularly the state's general health plan;

12. Have the plan be linked to national goals and objectives such as Healthy People 2010, Surgeon General's Report on Oral Health, and/or *A National Oral Health Call to Action to Promote Oral Health*;

13. Coordinate and identify additional resources needed to achieve objectives;

14. Establish accountability of the plan through monitoring of the plan, periodic assessment of progress made, appropriate evaluation of outcomes achieved, and regular reporting to partners;

15. Assign responsibilities to stakeholders for implementation, monitoring and reporting of the plan;

16. Disseminate the plan widely;

17. Periodically update the plan as new information becomes available and continuous feedback requires alignment of the plan to current environment and emerging issues.

Centers of Disease Control and Prevention (CDC), Division of Oral Health has developed a conceptual model for a comprehensive planning process of a state oral health plan (5). The model is provided on the CDC website at http://www.cdc.gov/OralHealth/state_programs/infrastructure/activity3.htm. (See **Attachment B**.) The conceptual model provides an overview of the process to develop a state oral health plan and illustrates outcomes of the planning process as well as outcomes resulting from implementation of the plan. In addition, the model highlights the need to review data and assess the burden of oral diseases for developing a plan and that a plan should address enhancing infrastructure, building partnership, developing evidence-based strategies, and evaluating process and outcomes.

The development of a State Oral Health Plan is only the beginning. Implementation of the plan is critical to the strategic planning process. All key players must be committed and dedicated to the implementation of the strategies for the plan to be effective. Furthermore, regular review and revision of the plan is recommended to monitor the progress of the plan's implementation, make mid-course adjustments, update the plan to address emergent issues, and recognize successes.

C. Current State Oral Health Plans

CDC, Division of Oral Health's communication in 2007 with state oral health programs showed (5):

- 25 states reported having a state oral health plan that is statewide in scope, developed collaboratively with stakeholders, a "stand-alone" document, and published for external use

- 10 states reported having a state plan that is a chapter of their state's Healthy People 2010 document or developed through other strategic planning

- 3 states reported that a state oral health plan is in development

The status of states with a state oral health plan and examples of the current state oral health plans are provided on the CDC website at http://www.cdc.gov/OralHealth/state_programs/OH_plans/index.htm. This website will be periodically updated as new plans are developed and existing plans are revised. CDC anticipates conducting another survey to analyze the content and format of current plans.

State oral health plans typically include specific, measurable, time-phrased objectives for future reductions in oral disease and related risk factors and objectives for the promotion of oral health. Although current state oral health plans have different formats and components, **collectively** these plans illustrate elements of a state plan that include:

- A vision statement

- A description of the state's oral health overview/assessment or identifying oral health problems of the state with supporting data

- References to the national Healthy People 2010 objectives as well as state plans developed previously

- A description of the oral health infrastructure including current resources and gaps in resources

- Priority issues and/or goals that reflect oral health across the lifespan

- Objectives including baseline information, targets and timeframe (e.g., addressing the need to reduce tooth decay rates in high risk populations and improve access to care for priority populations)

- Recommendations, strategies and/or actions to achieving goals/objectives (e.g., implement evidence-based practices, best practices and promising practices as well as to develop best practices that can be replicated/adapted)

- Responsible members for each objective or strategy and their roles and responsibilities in implementing the strategies

- Evaluation and measures of outcome and impact of the plan implementation

Various opportunities for collaborative planning to improve oral health have been observed among the states. These opportunities include:

- The development of a stand-alone statewide public health plan for oral health

- The development of a state's Healthy People 2010 plan

- The development of a strategic plan for the state health agency or the oral health program

- A statewide dental summit

- An action taken by a state oral health coalition

- A directive carried out by a commission, task force or advisory committee for oral health

- A national sponsored event such as the National Governors Association (NGA) Policy Academy for Children's Oral Health

- Grants supporting the building of oral health infrastructure through the development of a state plan, e.g., CDC cooperative agreement and HRSA State Oral Health Collaborative Systems (SOHCS) grant program

States reported that, on an average, a year is needed to develop a state oral health plan through a collaborative process. Having funding and a facilitator to support plan development made the process easier (5).

D. Evaluation of State Plans

Public health experts believe that quality planning will result in better health outcomes. Evaluation of the quality of the end product of planning (a written plan) is an important checkpoint. The overall purpose of the evaluation of state oral health plans is to provide information that will enable states to develop and implement plans as effectively and efficiently as possible. A state that creates and evaluates a plan can determine what worked and what did not work, and make mid-course adjustments. Evaluation results of state plans can build evidence for the effectiveness of state plans and expand the knowledge base for all states.

A generic logic model, that represents how state plans can, if successful, lead to changes in the oral health of a state's population, has been developed by CDC, Division of Oral Health (6). See **Attachment C**. States could adapt this model to fit their needs. The use of an evaluation consultant is recommended to guide and support the evaluation of a state plan.

The evaluation of the state plan will initially focus on the state plan development assessing *inputs*, *activities*, *outputs*, and *initial outcomes* of the state plan. Additional evaluations, once the plan is implemented, could then assess the effectiveness (immediate and longer-term) of programs, services, initiatives, or other efforts implemented because of the plan. These evaluations constitute assessments of the effectiveness of oral public health activities, rather than assessment of the state plan itself. Evaluation is needed to review, revise and improve the state plan.

Evaluation Questions

The evaluation of a state oral health plan may involve five sets of questions (6).

- About Process – Evaluation questions focus on the extent to which the activities to develop the plan occurred in ways likely to nurture the engagement of relevant stakeholders and in ways likely to receive official endorsement and informal acceptance from those who must approve and/or implement it.

- About Content – Evaluation questions focus on the extent to which the plan contains necessary and/or recommended elements.

- About Dissemination – Evaluation questions focus on the extent to which the plan's distribution activities bring it to all relevant stakeholders, decision-makers, users.

- About Awareness – Evaluation questions focus on the extent to which relevant stakeholders, decision-makers, and other users recognize and understand the plan after it has been disseminated.

- About Implementation – Evaluation questions focus on the extent to which those who are supposed to take action based on the plan actually do take action.

The extent to which specific questions can be addressed will depend upon the stage of the plan development process. All questions can be addressed after the plan has been developed and disseminated. However, it may be useful to obtain some information sooner and to use that information as part of a self-correcting mechanism to improve the plan development process.

- Process questions can be addressed at any time. It may be helpful to examine participation records and do a survey of stakeholders once or more prior to writing a first draft of the plan, in order to make sure that relevant individuals and organizations are participating.

- Content questions can be addressed any time after the first formal draft of the plan is developed.

- Dissemination questions can be addressed after the plan has been developed and efforts to bring it to relevant audiences have begun.

- Awareness questions should probably be addressed about three to six months after the major efforts to disseminate the plan have concluded.

- Implementation questions can be addressed after the plan has been disseminated.

These methods to collect evaluation information include using participation records, survey of stakeholders, expert informant survey, survey of key leaders and decision-makers, conversations with state oral health directors, annual inventory of significant documents related to organization, funding and delivery of oral health services, inventory of endorsements, and plan monitoring form.

Evaluation Instruments

To date, evaluation instruments have focused on assessment of the planning processes (7-9) and on methods to inventory or describe the content of the plans (10,11). Limited efforts have been made to develop evaluation instruments for assessing the quality of written plans regardless of the planning processes used.

One evaluation instrument for assessing a state plan is the **State Plan Index** (SPI). The SPI was developed as part of the evaluation of the CDC's Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases (12,13). The tool is available from http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/resources.htm. The SPI was developed through collaboration between CDC and more than 100 public health experts. The Index is used to guide and assess nutrition, physical activity, and obesity planning efforts in CDC-funded states as well as provide an evaluation tool that can be adapted to other chronic disease areas. The SPI draws on an array of public health planning models, tools, and resources, and is grounded in theory, public health practice, empirical field testing, and expert opinions. The quality of 60 items are scored with the SPI in order to rate a state plan. The SPI organizes these items into nine components:

1. Involvement of stakeholders
2. Presentation of data on disease burden and existing efforts to control obesity
3. Goals
4. Objectives
5. Selecting population(s) and strategies for intervention
6. Integration of strategies with other programs and implementation of plan
7. Resources for implementation of plan
8. Evaluation
9. Accessibility of plan

The SPI can be used to evaluate plans developed using different public health planning models and can be adapted to other chronic disease areas. In addition, the tool has been adapted by state staff for use as a self-assessment tool and to use as guidance for new planning efforts.

Another evaluation instrument, specific to assessing a state oral health, is the **CDC Oral Health State Plan Review Index**. This index was development by CDC, Division of Oral Health (6). The tool is provided as **Attachment D**. The index is a checklist used by CDC/DOH to review published state plans in order to assess national progress on oral health goals and objectives. States revising or developing their state plans as individual line items may find this index particularly useful. The index incorporates national goals and objectives as outlined in the 2000 Surgeon General's report, *Oral Health in America,* National Call to Action, and Healthy People 2010 in one document. Additionally, the document incorporates research from literature reviews regarding what makes an effective plan including S.M.A.R.T. objectives and evaluation. The Oral Health Plan Review Index includes items addressing stakeholder involvement, use of evidence-based information, plan framework, strategies and programs, partnership, implementation, and evaluation of the plan.

E. Initiatives and Coordinated Efforts

Several initiatives and coordinated efforts recognize that state oral health plans and collaborative planning are essential for improving oral health. The following describes three of such efforts.

CDC Cooperative Agreement

The CDC, Division of Oral Health provides cooperative agreement funding to 12 states and a U.S. territory. The cooperative agreement is designed to facilitate the development of core capacity infrastructure, which in turn leads to strengthening the state/territorial oral health programs and reducing oral health inequalities of the state/territorial residents. The 13 grantees include: Alaska, Arkansas, Colorado, Illinois, Michigan, Nevada, New York, North Dakota, Oregon, Rhode Island,

South Carolina, Texas, and the Republic of Palau. The CDC funding is renewable for up to five years and supports improvement of basic state oral health services (e.g., supporting program leadership, adding additional program staff, monitoring oral health risk factors, developing prevention programs, and evaluating programs).

Grantees have used CDC funding to support the development of their state/territorial oral health plans. The following grantees have developed oral health plans including Arkansas, Colorado, Illinois, Michigan, Nevada, New York, South Carolina, Texas and the Republic of Palau. Other grantees are in the process of developing their state plan.

State Oral Health Collaborative Systems (SOHCS) Grant

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), through its State Oral Health Collaborative Systems (SOHCS) grant program, awarded funds to state oral health programs. The purpose of the grants is three-fold:

1. Support states in developing, implementing or enhancing efforts to integrate oral health into state Maternal and Child Health programs;
2. Address Maternal and Child Health Bureau performance measures in oral health; and
3. Stimulate action toward implementation of the Surgeon General's "National Call to Act to Promote Oral Health" as it affects women and children.

States that have use the SOHCS funding to support the development of a state oral health plan include: Arizona, California, Connecticut, Florida, Maine, Maryland, Mississippi, Montana, and New York.

Head Start/Early Head Start Oral Health Forums and Action Plans

In 1999, a national Head Start Partners Oral Health Forum was convened by the Health Resources and Services Administration (HRSA), Head Start Bureau, Administration for Children and Families (ACF), the Health Care Financing Administration (HCFA) now known as the Center for Medicare and Medicaid, the Special Supplemental Nutrition Programs for Women, Infants and Children (WIC) to focus attention on early childhood oral health. Participants at the national Forum called for regional and state level Head Start Forums to address oral health issues. In 2001, the ACF, HSB and MCHB entered into an Intra-Agency Agreement to improve oral health for children in Early Head Start and Head Start programs. Two of the six activities in this agreement are Head Start Regional Oral Health Forums for Regions I-XII, and a Head Start Oral Health Project through the Association of State and Territorial Dental Directors (ASTDD) that includes support for state/territorial forums and action plans. A survey of state and territorial dental directors showed a wide range of collaborative relationships with Head Start programs, and highlighted the need to expand and strengthen these relationships.

Through the cooperative agreement with HRSA, ASTDD provided funding of initial Early Head Start/Head Start (EHS/HS) Oral Health Forums in states and territories from 2002-2006. The purpose of these forums is to solicit input from a multidisciplinary, multi-organizational group of stakeholders to develop an action plan to improve Head Start oral health components that includes enhancing prevention and oral health education as well as increasing access to oral health services. As of 2006, the opportunity provided by the HRSA and ASTDD grant program seeded efforts to conduct a Head Start oral health forum and to develop an action plan in all 50 states, District of Columbia, and 7 U.S. territories/jurisdictions participating in the program. State efforts in convening an EHS/HS forum and developing an action plan are illustrated by: Alaska, Arkansas, District of Columbia, Kansas, Minnesota, Montana, Oregon, Rhode Island, and Republic of Marshall Islands. The forums and action plans served as an impetus for collaboration and communication among stakeholders to address oral health issues in Head Start.

In their action plans, states and territories considered activities and outcomes related to improved leadership, collaborations and communication among stakeholders; increased access to regular and appropriate preventive and treatment services; expansion of evidence-based prevention in Head Start

programs; use of up-to-date, scientifically sound, developmentally and culturally appropriate health education/health promotion approaches and materials; assessment and evaluation of program components and outcomes; innovative leveraging of resources for technical assistance and funding. A follow-up assessment of the forums (an Executive Summary of the evaluation report is available) showed that 97% of the responding states said strategies were developed for implementing their HS/EHS action plan. These strategies included development of health screening approaches; integration of oral health screenings and fluoride varnish applications into medical exams; passage of legislation for expanded functions of Allied Dental professionals; development of educational materials targeting multi-cultural populations, implementation of oral health into the Head Start curriculum, development of advocacy activities and oral health coalitions; regular collaboration between dental professionals and HS/EHS for improving access and quality of care.

III. Guidelines & Recommendations from Authoritative Sources

A. Healthy People 2010

Healthy People 2010 provides a set of overall national health objectives (14). These objectives and their benchmark statistics enable the assessment of progress made towards improving the health of Americans. One of the HP 2010 objectives, Public Health Infrastructure Objective 23-12 supports the need of all states to have a state health improvement plan:

> *Increase the proportion of Tribes, States, and the District of Columbia that have a health improvement plan and increase the proportion of local jurisdictions that have a health improvement plan linked with their State plan.*

B. Surgeon General's Report on Oral Health and *National Call to Action to Promote Oral Health*

Oral Health in America: A Report of the Surgeon General was released in May 2000 (15). According to the report (available at http://www.surgeongeneral.gov/library/oralhealth/): All Americans can benefit from the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individual, health care providers, communities, and policy makers at all levels of society and by taking advantage of existing initiatives. Everyone has a role in improving and promoting oral health. The following are principal components of the plan:

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

- Ensure the development of a responsive, competent, diverse, and "elastic" workforce.

National Oral Health Call to Action to Promote Oral Health, a report released by the Office of the Surgeon General in April 2003, emphasized the need for action plans with monitoring and evaluation components to improve oral health (16). Planning and implementation at the state level will be needed to support the national *Call to Action*. The report is available at http://www.surgeongeneral.gov/topics/oralhealth/nationalcalltoaction.htm.

C. State and Territorial Dental Directors

State dental directors or state dental consultants from 43 states responded to an ASTDD survey in 1999 and identified ten essential elements that would build infrastructure and capacity to achieve HP 2010 Oral Health Objectives (17). Among the top ten elements is the development and maintenance of a state oral health improvement plan.

D. Oral Health America

Oral Health America, a national and independent organization dedicated to improving oral health, publishes a report card to call greater policy attention to areas of need in prevention, access to care, infrastructure, oral health status, and oral health policies across the country. The **2003 Oral Health Report Card** gives an "A" grade to a state oral health plan that is a long-term plan, developed through a collaborative process with a broad range of constituents, and is reviewed regularly. The report card can be accessed on http://www.oralhealthamerica.org/ (18).

IV. Research Evidence

There is a lack of reporting in the research literature on the effectiveness of state strategic plans or strategic planning to improve oral health. Even for the broader field of health care, limited evidence is available documenting that strategic planning is effective (19-21). However, extensive research has examined strategic planning and its relationship to performance in corporate settings. This body of research provided mixed support for an association between planning and performance (22). Several comprehensive reviews have summarized prior research on corporate strategic planning and the influences on performance (22-25). Most studies completed before 1975 report positive results with higher corporate performance in firms adopting formal strategic planning systems. Research findings since 1975 are somewhat inconsistent with some studies demonstrating positive association between planning and performance and some studies did not. Several factors have been suggested as possible contributors for the more recent mixed results supporting effectiveness of strategic planning. They include: simplistic conceptualization of planning, difficulty in operationalizing a plan, sampling bias, interactive effects of environments and strategy, narrow performance measures, and not controlling for the effects of different industries (26). Future studies, such as longitudinal research studies that track planning, performance and strategy over several years, could clarify the inconsistent results for the planning-performance relationship.

V. Best Practice Criteria

For the best practice approach of **State Oral Health Plans and Collaborative Planning**, the ASTDD Best Practices Committee has proposed the following **initial review standards** for five best practice criteria:

1. **Impact/Effectiveness**

   - State oral health plan is based on accepted assessment and elements of surveillance to establish goals and objectives and prioritize actions.
   - State plan is developed through a collaborative process that includes key state and local representation and/or obtain stakeholders' input.
   - State plan has identifiable and measurable outcomes (intermediate & distal outcomes) and their evaluation is incorporated in the state plan.

2. **Efficiency**

   - Stakeholders commit time and resources in supporting the development, implementation and maintenance of the state plan.

3. **Demonstrated Sustainability**

   - Accountability, monitoring, periodic review, and reporting of progress made are incorporated in the state plan.

4. **Collaboration/Integration**

   - Linkages with stakeholders, including local communities, are established for the development of state plan.
   - The state oral health plan contains a core set of objectives that is easily customized to meet local needs/objectives as well as other organizations.

5. **Objectives/Rationale**

   - The state oral health plan objectives reflect the broader vision for the state and are measurable in terms of oral health outcomes that can be linked to overall health outcomes where appropriate.

VI. State Practice Examples

The ASTDD Best Practices Committee has considered the variability in resources and infrastructure among states and recognizes that there are several conceptual frameworks by which a State Oral Health Plan can be developed. During the first phase of the ASTDD Best Practices Project, states submitted descriptions of their successful practices to share their experiences and implementation strategies. The following practice examples illustrate various elements or dimensions of the best practice approach for **State Oral Health Plans and Collaborative Planning**. These reported success stories should be viewed in the context of the state's and program's environment, infrastructure and resources. End-users

are encouraged to review the practice descriptions (click on the links of the practice names) and adapt ideas for a better fit to their states and programs.

A. Summary Listing of Practice Examples

See **Figure 1**. Each practice name is linked to a detailed description report.

FIGURE 1

State Practice Examples of
State Oral Health Plans and Collaborative Planning

Item	Practice Name	State	Practice #
1.	Developing a State Oral Health Plan	IL	16005
2.	Kansas Early Childhood Action Plan	KS	19010
3.	Louisiana's Oral Health Summit	LA	21002
4.	National Governors Association (NGA) Policy Academy on Oral Health Care for Children	MN	26001
5.	Montana Dental Summits	MT	29001
6.	Nevada's State Oral Health Plan	NV	31006
7.	Director of Health's Task Force on Access to Dental Care	OH	38003

B. Highlights of Practice Examples

IL Developing a State Oral Health Plan (Practice #16005)
Illinois' process in developing a state oral health plan included gathering local input through community meetings across the state, involving the IFLOSS state oral health coalition, using of the community oral health infrastructure development plan, and getting feedback from a statewide oral health summit. A steering committee oversees the design, refinement and implementation of the state plan.

KS Kansas Early Childhood Action Plan (Practice #19010)
The Kansas Head Start Association (KHSA) conducted the Kansas Early Childhood Oral Health Forum. Dentists, dental hygienists, pediatricians, Head Start staff, parents, policymakers and

funders from throughout Kansas identified priority strategies in the areas of (1) Access, (2) Policy and Financing, and (3) Prevention and Education. Based on input from the Forum, the Kansas Early Childhood Action Plan was developed. In response to the Action Plan, several grant-funded projects have been initiated to increase the number of children who remain cavity-free and to increase access to oral health services.

LA Louisiana's Oral Health Summit (Practice #21002)
Louisiana's Oral Health Summit assembled dental health leaders and policy makers to address access and barriers to dental care, infrastructure strengths and weaknesses, educational needs, and the financing of oral health care in the state. One outcome of the Oral Health Summit was the development of a state oral health plan. The Louisiana Oral Health Plan identifies the priorities to access dental care for the residents of Louisiana and includes recommendations to implement the priorities.

MN National Governors Association (NGA) Policy Academy on Oral Health Care for Children (Practice #26001)
The National Governors Association Policy Academy required a participating state to form a state team. Minnesota's NGA team represented major stakeholders of oral health. The Academy led the team to develop an action plan to improve children's oral health in the state addressing oral health care coverage and services.

MT Montana Dental Summits (Practice #29001)
The Montana Dental Summits resulted in the establishment of a state oral health coalition (which has evolved and gained a broader oral health focus beyond access to dental care) and the development of the *Montana Dental Action Plan* in 2006. The state plan reflects the coalition's vision, guiding principals, goals and priority strategies. The state plan will serve as a roadmap for promoting oral health, preventing oral diseases, and improving access to dental services.

NV Nevada's State Oral Health Plan (Practice #31006)
The first state oral health plan for Nevada was developed by the Governor's Maternal and Child Health Advisory Board in 1998. In 2002, an updated state oral health plan was released. In 2004, stakeholders were once again convened for an Oral Health Summit. The outcome of the 2004 Summit developed a comprehensive plan for oral health activities throughout Nevada, building upon the 2002 oral health plan. The 2004 Nevada State Oral Health Plan provided a set of goals and objectives to guide oral health promotion activities for the state. Six community-based coalitions representing all counties are implementing the state plan.

OH Director of Health's Task Force on Access to Dental Care (Practice #38003)
In 1999, Ohio's Director of Health appointed the Task Force on Access to Dental Care. More than 70 people with a broad range of expertise and experience contributed to the process of studying and making recommendations for improving access to dental care for vulnerable Ohioans. The Task Force formulated recommendations that included improving Medicaid and SCHIP, dental care delivery system, community action for oral health access, and public awareness of oral health. A state action plan was developed based on the task force recommendations.

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ATTACHMENT A

Strength of Evidence Supporting Best Practice Approaches

The ASTDD Best Practices Committee took a broader view of evidence to support best practice approaches for building effective state and community oral health programs. The Committee evaluated evidence in four categories: research, expert opinion, field lessons and theoretical rationale. Although all best practice approaches reported have a strong theoretical rationale, the strength of evidence from research, expert opinion and field lessons fall within a spectrum. On one end of the spectrum are promising best practice approaches, which may be supported by little research, a beginning of agreement in expert opinion, and very few field lessons evaluating effectiveness. On the other end of the spectrum are proven best practice approaches, ones that are supported by strong research, extensive expert opinion from multiple authoritative sources, and solid field lessons evaluating effectiveness.

Promising Best Practice Approaches			**Proven Best Practice Approaches**	
Research	+	⇨ ⇨	Research	+++
Expert Opinion	+		Expert Opinion	+++
Field Lessons	+		Field Lessons	+++
Theoretical Rationale	+++		Theoretical Rationale	+++

Research

+	A few studies in dental public health or other disciplines reporting effectiveness.
++	Descriptive review of scientific literature supporting effectiveness.
+++	Systematic review of scientific literature supporting effectiveness.

Expert Opinion

+	An expert group or general professional opinion supporting the practice.
++	One authoritative source (such as a national organization or agency) supporting the practice.
+++	Multiple authoritative sources (including national organizations, agencies or initiatives) supporting the practice.

Field Lessons

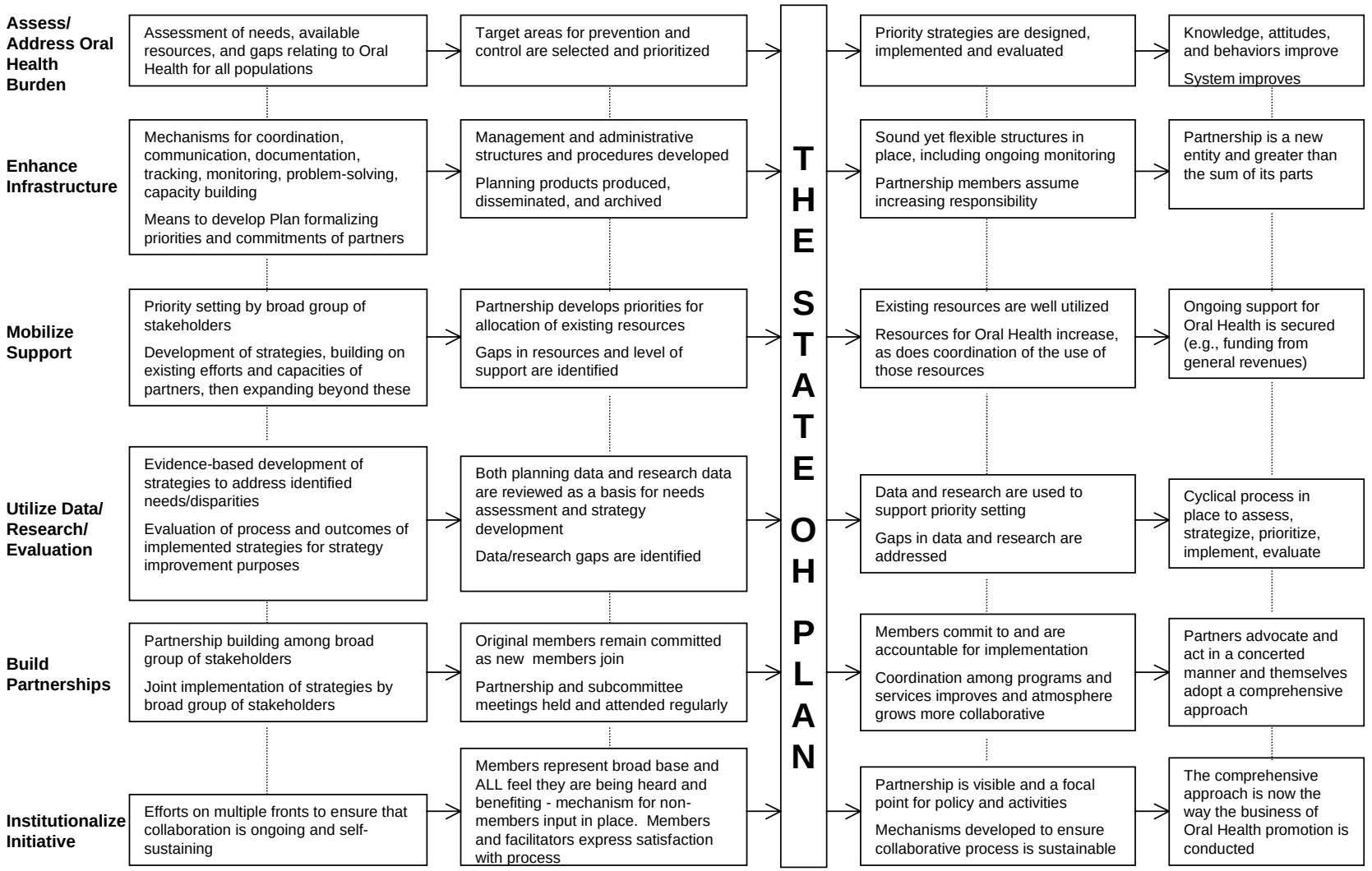
+	Successes in state practices reported without evaluation documenting effectiveness.
++	Evaluation by a few states separately documenting effectiveness.
+++	Cluster evaluation of several states (group evaluation) documenting effectiveness.

Theoretical Rationale

+++	Only practices which are linked by strong causal reasoning to the desired outcome of improving oral health and total well-being of priority populations will be reported on this website.

ATTACHMENT B

Conceptual Model of Comprehensive Oral Health State Plan Process

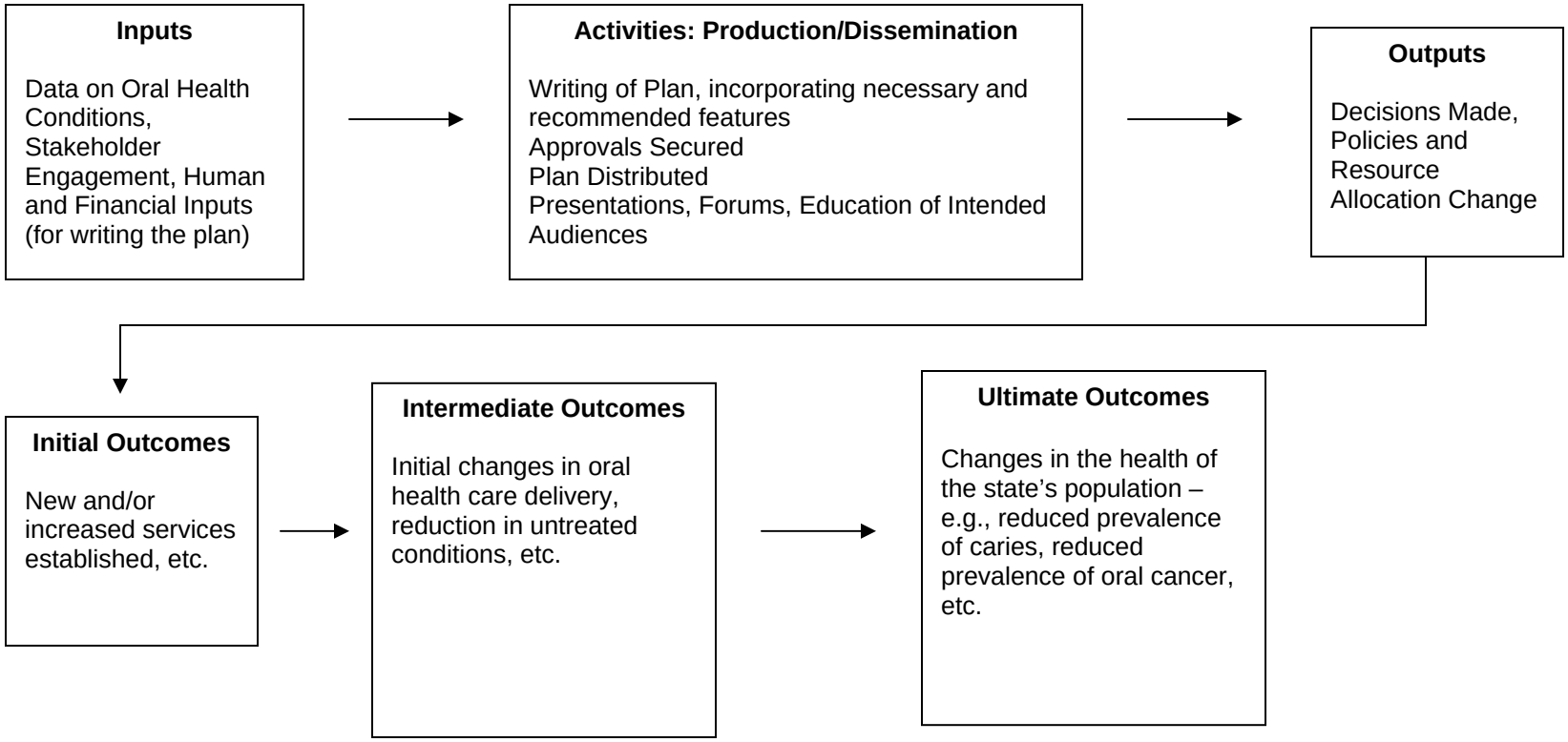


Source: CDC, Division of Oral Health, http://www.cdc.gov/OralHealth/state_programs/infrastructure/activity3.htm (accessed May 27, 2008)

ATTACHMENT C

Logic Model

For Evaluation of State Plans

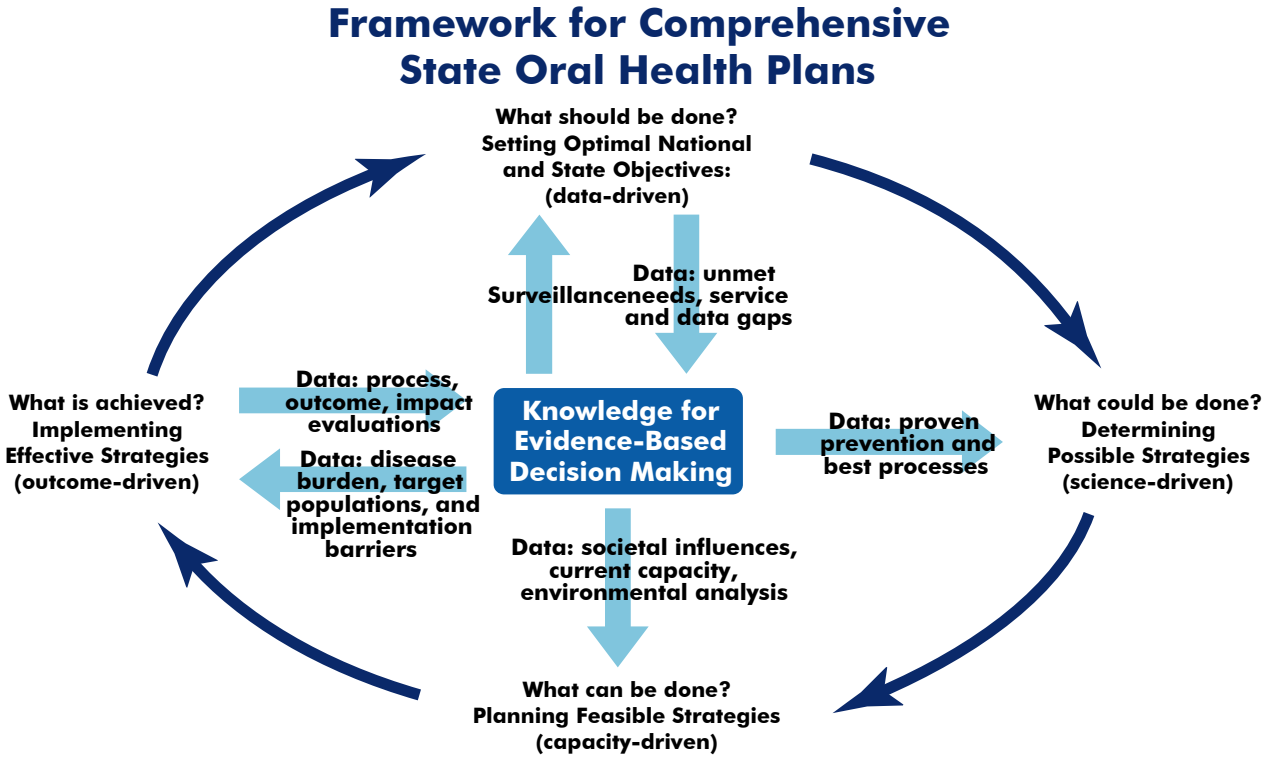


ATTACHMENT D

ORAL HEALTH STATE PLAN REVIEW INDEX

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Oral Health
April, 2003

Items for inclusion in this index were taken from National documents (the Surgeon General's Oral Health Report (2000), National Call to Action (2003), Healthy People 2010, Core Public Health Functions, and CDC PA 03022 Performance Measures) indicating National objectives or "what should be done". Additional items were gathered from proven prevention practice guidelines, literature review regarding what makes an effective plan, as well as from promising practice submissions – published state plans -- to reflect "what could be done". It is up to each state to review these documents in light of what data reveals about the context to reflect "what can be done." Use of this tool is intended to assist sites in a review of the above mentioned documents. Use of evaluation throughout the process of plan development, dissemination, and implementation will assist each site in understanding "what was done" as well as shed light on what should be done next. Additional information can be found at http://www.cdc.gov/OralHealth/state_programs/infrastructure/activity3.htm.



State:
[STATE]

Review Date:
[REVM]
[REVY]

Name of Plan:
[NAME]

Publication Date:
[PUBM]
[PUBYR]

Development start date:
[TIME]

_____ **State oral health plan**
[StatePlan]

_____ **2010 plan**
[HPPlan]

Funding source:
[Fund]

NGA Academy:
[nga] [NGAYr]

_____ **On state-DOH website**
[web]

ASTDD Program Report: Y / N
[ASTDDrep]

Reviewer:_____

SECTION I. Stakeholder Involvement

☐ 1. Key stakeholders were involved throughout the plan development process: [Stake]

- ☐ a. NGA team [s_nga]
- ☐ b. Government [s_gov]
- ☐ c. Coalition [s_coal]
- ☐ d. Community [s_comm.]
- ☐ e. Education [s_edu]
- ☐ f. Providers [s_prov]
- ☐ g. Public [s_pub]
- ☐ h. Third-party payers (including Medicaid) [s_third]
- ☐ i. Higher-education [s_high]
- ☐ j. Other chronic disease representation [s_chronic]
- ☐ k. Drinking water/EPA/Fluoridation [s_drink]
- ☐ l. 2010 teams [s_hp]
- ☐ m. Not able to identify [s_not]
- ☐ n. State Department of Health and Human Services [s_doh]
- ☐ o. Others specify: _____ [s_others]

NOTES:

SECTION II. Plan is Evidence Based

☐ 1. State-level burden of oral health disease describe and/or reference burden document [S2_1]
(If referenced, include copy and source information with plan)

☐ 2. Priority populations based on epidemiologic data [S2_2]

☐ 3. Priorities based upon assessment of existing infrastructure, resources, and gaps [S2_3]

☐ 4. Healthy People 2010 objectives [S2_4]

Oral Health Chapter

☐ 21-1 Dental caries experience [HP21_1]

☐ 21-2 Untreated dental decay [HP21_2]

☐ 21-3 No permanent tooth loss [HP21_3]

☐ 21-4 Complete tooth loss [HP21_4]

☐ 21-5 Periodontal diseases [HP21_5]

☐ 21-6 Early detection of oral and pharyngeal cancer [HP21_6]

☐ 21-7 Annual examinations for oral and pharyngeal cancer [HP21_7]

☐ 21-8 Dental sealants [HP21_8]

☐ 21-9 Community water fluoridation [HP21_9]

☐ 21-10 Use of oral health care system [HP21_10]

☐ 21-11 Use of oral health care system by residents in long-term care facilities [HP21_11]

☐ 21-12 Dental services for low-income children [HP21_12]

☐ 21-13 School based health centers with oral health component [HP21_13]

☐ 21-14 Health centers with oral health service components [HP21_14]

☐ 21-15 Referral for cleft lip or palate [HP21_15]

☐ 21-16 State-based surveillance system [HP21_16]

☐ 21-17 Tribal, state and local dental programs [HP21_17]

Oral Cancer Objective

☐ 3-6 Reduce the oropharyngeal cancer death rate [HP3_6]

Diabetes Chapter Objective

☐ 5-15 Increase the proportion of persons with diabetes who have at least an annual dental examination [HP5_15]

Public Health Infrastructure chapter

☐ 23-2 Made information available to public in the past year on leading health indicators [HP23_2]

☐ 23-4 Population-based HP 2010 objectives with national data for all population groups [HP23_4]

☐ 23-8 Specific competencies essential to public health services into personnel systems [HP23_8]

☐ 23-11 Meet national performance standards for public health services [HP23_11]

☐ 23-12 Local jurisdictions with health improvement plan linked to state plan [HP23_12]

☐ 23-14 Provide or assure comprehensive epidemiology services to support essential PHS [HP23_14]

☐ 23-15 Review and evaluate the extent to which statutes, ordinances, and bylaws assure deliver of essential PHS [HP23_15]

☐ 23-16 Documentation of public health expenditures, categorized by essential PHS [HP23_16]

☐ 5. Reference Surgeon General's report [SGRepor]

☐ 6. Address Core public health functions [S2_6]

- ☐ a. Assessment [Core_assess]
- ☐ b. Policy Development [Core_policy]
- ☐ c. Assurance [Core_assur]

☐ 7. Five-points of Call to Action [S2_7]

- ☐ a. Change perception of oral health [call_chg]
- ☐ b. Overcome barriers to implement what works [call_over]
- ☐ c. Build a balanced science base [call_build]

☐ d. Increase oral health workforce [call_inc]

☐ e. Join forces to fix problems [call_join]

SECTION III Plan Framework

☐ 1. Plan is based on state-wide goals and objectives [S3_1]

☐ 2. Plan reflects a solid "call-to-action" [S3_2]

☐ 3. Plan includes a summary statement [S3_3]

☐ 4. Plan is well-organized [S3_4]

☐ 5. Plan is easy to read [S3_5]

☐ 6. Plan has identified clear, definable, goals [S3_6]

- ☐ a. Goals project for at least a 5 year time frame [S3_6A]
- ☐ b. Goals emphasize infrastructure development for sustained achievements [S3_6B]
- ☐ c. Goals address system changes [S3_6C]
- ☐ d. Goals are realistic for the environment [S3_6D]
- ☐ e. Strategies are based upon environmental assessment [S3_6E]

☐ 7. Plan has identified clear, definable, objectives or action steps [S3_7]

- ☐ a. Objectives/action steps are realistic towards the accomplishment of goals [S3_7A]
- ☐ b. Objectives/action steps include identification of person(s)/organization(s) [S3_7B] responsible for implementation
- ☐ c. Objectives/action steps include identification of resources needed to accomplish [S3_7C]

☐ d. Objectives/action steps are defined in S.M.A.R.T. format [S3_7D]

- ☐ i. Specific [S2_7D1]
- ☐ ii. Measurable [S2_7D2]
- ☐ iii. Attainable [S2_7D3]
- ☐ iv. Results oriented [S2_7D4]
- ☐ v. Time-phased [S2_7D5]

☐ 8. Plan goals and objectives integrate with other chronic disease areas including strategies to partner and leverage resources [S3_8]

☐ 9. Plan is published for public consumption [S3_9]

☐ 10. Plan is posted on state website [S3_10]

SECTION IV. Strategies and Programs

☐ 1. Plan addresses access [S4_1]

☐ a. Provide approximate percentage of plan devoted to access issues [S4_1A]

Number of objectives or items discussed in plan _____
Number of objectives or items devoted to access _____
Number of objectives or items devoted to prevention _____

☐ b. Access for children [S4_1B]

☐ c. Access for adults [S4_1C]

☐ d. Access for seniors [S4_1D]

☐ e. Access for populations experiencing disparity [S4_1E]

☐ f. Access for low-income populations [S4_1F]

☐ g. Increase number of dental schools [S4_1G]

- ☐ h. Increase number of hygiene/technical schools [S4_1H]
- ☐ i. Loan repayment program [S4_1I]
- ☐ j. Increase workforce [S4_1J]
- ☐ k. Identification of alternative providers [S4_1K]
- ☐ l. Practice act/expanded duties [S4_1L]
- ☐ m. Mandates and/or policy change [S4_1M]
- ☐ n. Increase reimbursement issues (Medicaid/SCHP) [S4_1N]
- ☐ o. Equipment/buildings [S4_1O]
- ☐ p. Increase public health in existing schools [S4_1P]
- ☐ q. Increase pediatric dentistry and/or residency [S4_1Q]
- ☐ r. Licensure issues [S4_1R]
- ☐ s. Referral networks [S4_1S]
- ☐ t. Safety nets [S4_1T]
- ☐ u. Residency training, other training for working with high risk populations [S4_1U]
- ☐ v. Coordinate management or system of care[S4_1V]
- ☐ w. Private insurance [S4_1W]
- ☐ x. Increase number of students in dental school [S4_1X]
- ☐ y. Increase number of students in hygiene or technical school [S4_1Y]

NOTES:

☐ 2. Plan addresses proven prevention strategies [S4_2]

- ☐ a. Provide approximate percentage of plan devoted to prevention issues [S4_2A]
- ☐ b. Fluoridation [S4_2B]
  - ☐ i. Water fluoridation [S4_2B1]
  - ☐ ii. Mouthrinse and/or tablet program [S4_2B2]
  - ☐ iii. Awareness campaigns [S4_2B3]
  - ☐ iv. Legislative issues [S4_2B4]
  - ☐ v. Varnish programs [S4_2B5]
  - ☐ vi. Water testing [S4_2B6]
- ☐ c. School-based, school-linked sealant programs [S4_2C]
- ☐ d. Community-based sealant programs [S4_2D]

☐ 3. Plan addresses education and/or awareness programs [S4_3]

- ☐ a. Public awareness [S4_3A]
  - i. Provide name of program
- ☐ b. Policy maker outreach [S4_3B]
- ☐ c. In non-traditional settings [S4_3C]
- ☐ d. Provider training and/or awareness programs [S4_3D]
- ☐ e. School-based education [S4_3E]

☐ 4. Plan addresses state-wide summit (explain if other type meeting) [S4_4]

☐ 5. Plan addresses caries [S4_5]

- ☐ a. Experience [S4_5A]
- ☐ b. Untreated decay [S4_5B]
- ☐ c. ECC [S4_5C]
- ☐ d. In children [S4_5D]
- ☐ e. In youth [S4_5E]
- ☐ f. In adults [S4_5F]
- ☐ g. In seniors [S4_5G]

☐ 6. Plan addresses periodontal disease [S4_6]

☐ 7. Plan addresses oral cancer [S4_7]

- ☐ a. Early detection [S4_7A]
- ☐ b. Awareness/education programs [S4_7B]
- ☐ c. Coordination with tobacco/cancer programs [S4_7C]

☐ 8. Plan addresses infection control issues [S4_8]

☐ 9. Plan addresses policy and systems change [S4_9]

- ☐ a. Practice act [S4_9A]
- ☐ b. General policy issues [S4_9B]
- ☐ c. Mandatory screening [S4_9C]
- ☐ d. Increase in Medicaid reimbursement [S4_9D]
- ☐ e. Change in Medicaid filing requirements [S4_9E]

☐ 10. Plan addresses surveillance [S4_10]

- ☐ a. Plan specifies state data sources [S4_10A]
- ☐ b. Plan addresses expansion of surveillance efforts [S4_10B]
- ☐ c. Plan addresses infrastructure needed to support surveillance [S4_10C]
- ☐ d. Plan addresses fluoridation surveillance [S4_10D]
- ☐ e. Program surveillance [S4_10E]
- ☐ f. School or state needs assessment [S4_10F]

☐ 11. Plan addresses issues related to the integration of oral health with overall health [S4_11]

☐ 12. Plan addresses infrastructure development [S4_12]

☐ 13. Plan addresses issues of sustainability of program and/or infrastructure [S4_13]

☐ 14. Oral and facial injuries [S4_14]

- ☐ a. Face masks [S4_14A]
- ☐ b. Mouth guards [S4_14B]
- ☐ c. Awareness [S4_14C]

NOTES:

SECTION V. Partnerships

☐ 1. Plan addresses partnerships with other chronic disease areas: [S5_1]

- ☐ a. Diabetes [S5_1A]
- ☐ b. Tobacco [S5_1B]
- ☐ c. Violence/Injury [S5_1C]
- ☐ d. Early childhood [S5_1D]
- ☐ e. Maternal and child health [S5_1E]
- ☐ f. Cancer [S5_1F]
- ☐ g. Cardiovascular [S5_1G]
- ☐ h. Health promotion [S5_1H]
- ☐ i. Coordinated school health [S5_1I]

☐ 2. Plan addresses partnerships with other department of health and/or government agencies [S5_2]

- ☐ a. Board of education [S5_2A]
- ☐ b. Department of education [S5_2B]
- ☐ c. Medicaid [S5_2C]
- ☐ d. WIC [S5_2D]
- ☐ e. Head Start [S5_2E]
- ☐ f. Drinking water [S5_2F]
- ☐ g. EPA [S5_2G]
- ☐ h. Schools in general [S5_2H]
- ☐ i. Dental schools, research, hygiene schools [S5_2I]

☐ 3. Plan describes technical assistance to be provided to partners to assist in the implementation of the plan [S5_3]

☐ 4. Business, local industry [S5_4]

SECTION VI. Implementation

☐ 1. Plan identifies person(s) and organization(s) responsible for implementation of objectives/action steps [S6_1]

☐ 2. Plan identifies technical assistance to be provided to partners to assist in the implementation of the plan [S6_2]

☐ 3. Plan addresses sustainability of programs and health achievements [S6_3]

☐ 4. Plan addresses resources needed to implement the plan [S6_4]

☐ 5. Plan describes strategies for obtaining needed resources [S6_5]

☐ 6. Plan describes clear, realistic dissemination plan [S6-6]

SECTION VII. Evaluation

☐ 1. Plan has identified evaluation strategies for goals and objectives [S7_1]

☐ a. Evaluation strategies include measurable markers [S7_1A]

☐ 2. Plan identifies evaluation of dissemination strategies [S7_2]

☐ 3. Plan includes logic mode [S7_3]

☐ 4. Plan identifies potential outcomes and unintended effects [S7_4]

☐ 5. Plan includes system for using evaluation results to update plan strategies to promote great health gains [S7_5]

☐ 6. Plan identifies need for outside evaluation assistance [S7_6]

☐ 7. Describes need for monitoring implementation [S7_7]