



## Dental Public Health Activities & Practices

**Practice Number:** 37001  
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### SECTION I: PRACTICE OVERVIEW

**Name of the Practice:**  
 North Dakota's Oral Health Surveillance System

**Public Health Functions:**  
 Assessment – Acquiring Data  
 Assessment – Use of Data

**HP 2010 Objectives:**  
 21-16 Increase the number of states with State-based surveillance system.

<b>State:</b> North Dakota	<b>Region:</b> North Central Region VIII	<b>Key Words:</b> Surveillance system, needs assessment, oral health data
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**Abstract:**  
 North Dakota Department of Health, Oral Health Program began building its oral health surveillance system in 1993. Since the program had limited staff and resources for surveillance, strategies to collect data for surveillance included paying for primary data collection, bargaining/bartering with partners to collect the data, integrating oral health into existing surveillances/surveys, and enlisting the support of stakeholders to collect the data. In 2007, the Oral Health Program acquired the services of epidemiology staff equal to a 0.5 full time equivalent position. With dedicated epidemiology staff, the program was able to update and publish a five year surveillance plan in March of 2008. A broad-based twenty-one member advisory committee assists the program in identifying data sources and gaps, providing data for the system, defining the indicators, reviewing data collection methods and processes, interpreting trends and making recommendations for data communication activities. A surveillance logic model was developed to guide the program in development of the surveillance plan and system. Currently, the North Dakota oral health surveillance system includes 44 indicators in the areas of oral health status and treatment need, utilization of dental services, oral health behaviors, tobacco use, oral cancer, cleft lip and cleft palate, dental workforce, and fluoridation. Sources of the data include Head Start Program Information Report (PIR), Basic Screening Survey, Medicaid, Vital Records, Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), Water Fluoridation Reporting System (WFRS), State Cancer Registry, Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey, workforce surveys, the state Data Centers and the U.S. Bureau of the Census. The purpose of the North Dakota Oral Health Surveillance System is to monitor oral health status and trends and use the information to guide program actions to improve the oral health of North Dakota's citizens. The data is used for program planning and implementation, assessing program effectiveness, guiding policy planning and advocacy and improving program accountability. This resulted in the implementation of oral health components in local maternal and child health programs; targeted fluoride mouthrinse, fluoride varnish and dental sealant programs to high risk children; establishment of a dental loan repayment program to expand the dental workforce; and expanding the scope of practice to allow medical professionals to apply fluoride varnish to high-risk children. The Surveillance Plan includes a timetable for data collection, a question matrix, a data indicator grid to track trends, and a data communication plan. Program integration and collaboration and strong partnerships assure the sustainability of the system by leveraging resources.

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## SECTION II: PRACTICE DESCRIPTION

### History of the Practice:

The North Dakota Department of Health, Oral Health Program began developing its oral health surveillance system in 1993. At the time, the Oral Health Program had no staff or program funding dedicated specifically for surveillance activities. Incremental steps were taken to gather and build oral health data for surveillance by identifying existing primary and secondary data sources. In the mid 1980s and early 1990s, many of the national and state surveillances and surveys (e.g., Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey) did not include oral health questions.

Initially there was resistance to adding oral health questions to the national surveillance systems. The state dental director negotiated the inclusion of oral health components in these existing data sources as state added questions by justifying the need for the data and cost-effective methods of collecting it. At the same time, the state dental director together with key partners identified gaps in data needs and methods of collecting the data.

In the early years, data was gathered for program planning purposes, but currently data collection is focused for policy development and surveillance. The surveillance system made significant progress when ASTDD and CDC collaborated on the development of oral health modules for the BRFSS and PRAMS surveys and with the development of the Water Fluoridation Reporting System where indicators were standardized and comparable to other states.

By the year 2000, the surveillance system included 27 indicators and 9 key data sources. In 2007, the Oral Health Program acquired the services of a .5 full time equivalent epidemiologist. A 21 member oral health data advisory committee was developed to guide the development of the updated five-year Oral Health Surveillance Plan. The system has been expanded to include 44 indicators and 13 data sources. The program now has a written [five-year surveillance plan](#) which includes a data communication plan, a [question matrix](#) defining selected surveillance indicators, and a [data grid](#) reporting the surveillance indicators. The updated system will provide additional capability to identify disparities and provide local, county and regional data. Enhancements to the system are ongoing with adaptations and changes to meet the needs of the program.

### Justification of the Practice:

One of the HP 2010 objectives calls for each state to establish an oral and craniofacial health surveillance system. The Centers for Disease Control and Prevention (CDC) defines public health surveillance as “the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know.” A state-based oral health surveillance system should monitor oral disease status, determine trends, and identify groups that bear the greatest burden of oral diseases. Such a system needs to analyze, interpret and integrate primary and secondary oral health data, and provide timely communication of findings to responsible parties, policymakers, the professional community, and the public. Program planning and policy development should be based on valid and reliable data collected on an ongoing basis. Oral health data and surveillance information remain the “keys” to developing appropriate public policy to improve oral health. Without good, reliable data, it is difficult to justify resource needs to policy makers.

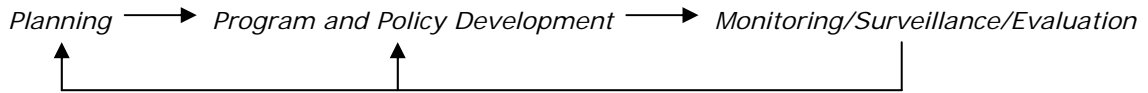
### Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:

The North Dakota Department of Health, Oral Health Program administers a state-based oral health surveillance system. The oral health program epidemiologist is responsible for gathering, analyzing, and reporting the findings. A network of seven regional oral health consultants assists in gathering the data for the statewide epidemiological surveys and other dental volunteers (dentists, hygienists, assistants) are included as necessary. The senior epidemiologist and staff with expertise in surveillance are used to verify conclusions. Program integration and collaboration and partnerships

with other divisions and agencies allow for leveraging of resources to gather oral health data from a variety of surveys. The addition of dedicated epidemiology staff has enhanced the ability of the program to analyze and report the data in a timely manner.

### The Framework

North Dakota uses the following framework in establishing the need for an oral health surveillance system:



In establishing a surveillance system, North Dakota considered the following questions:

- (1) What is needed from the surveillance system to determine oral health status?
- (2) What is needed from the surveillance system to make policy recommendations?
- (3) What kind of data and analyses are needed?
- (4) Is the data out there and if not, where and how to get it?

Two issues are important in establishing surveillance systems: the data that will be collected and how they will be collected. A collaborative process should be used to select which oral diseases, conditions, risk factors, services, quality of life measures, and outcomes should be under surveillance. The need for national surveillance data should also be considered.

### Existing Data

In addressing the data collection for the oral health surveillance system, the Oral Health Program recognized that the surveillance system should be dynamic and use simple, valid and reliable methods to collect data on an ongoing basis. The surveillance system should seek, collaborate and coordinate opportunities to collect oral health data by integrating into existing surveys conducted by state agencies and other organizations. Further, the system should also access secondary oral health data including national and state data sources. In building the surveillance system from scratch, the North Dakota Oral Health Program first looked for existing data and found the following sources:

- The Behavioral Risk Factor Surveillance Systems (BRFSS includes questions on dental visits, teeth cleaning, and loss of natural teeth.)
- New Mothers' Survey/Pregnancy Risk Assessment Monitoring System PRAMS provides data on maternal attitudes and experiences prior to, during, and immediately following pregnancy)
- Water Fluoridation Reporting System (WFRS provides water fluoridation status)
- ASTDD State Synopsis (provides state demographic data and oral health program administrative/service information)
- Vital Records (provides data for cleft lip/cleft palate births and oral and pharyngeal cancer deaths)
- State Cancer Registry (provides oral cancer data)
- Medicaid (provides dental utilization data)
- Head Start Program Information Report (PIR)

Yet the Oral Health Program wanted more data and added the following data sources to the surveillance system:

- Youth Risk Behavioral Survey (YRBS)
- Youth Tobacco Survey
- Basic Screening Surveys (BSS)
- Workforce Surveys

With limited program resources, North Dakota used a combination of the following strategies to get the data for the oral health surveillance system: (1) pay for it, (2) bargain/barter for it, (3) integrate it, and (4) use stakeholders and partners to help obtain it.

## Indicators for the Oral Health Surveillance System

The North Dakota oral health surveillance system currently uses 44 indicators to monitor/track oral health trends, justify program resources, maintain current program efforts and secure resources for new services. These indicators and their data sources include the following:

### *Children and Youth:*

#### *Head Start Program Information Report (PIR) – 4 indicators*

1. Percentage of Head Start children who had a dental examination in the past year
2. Percentage of Head Start children examined who need dental treatment
3. Percentage of Head Start children examined and needing dental treatment who received treatment
4. Percentage of Head Start children examined who received preventive care

#### *Basic Screening Survey (BSS) – 5 indicators*

5. Percentage of third-grade students with dental sealants on at least one permanent molar
6. Percentage of third-grade students with caries experience (treated or untreated)
7. Percentage of third-grade students with untreated tooth decay
8. Percentage of third-grade students in need of urgent care
9. Percentage of third-grade students who have had a previous dental visit

#### *Medicaid Claims – 1 indicator*

10. Percentage of Medicaid-enrolled children who had a dental visit during the year

#### *Vital Records – 2 indicators*

11. Number of babies born with cleft lip/cleft palate
12. Rate of babies born with cleft lip/cleft palate per 1,000 live births

#### *Youth Risk Behavior Survey (YRBS) – 6 indicators*

##### Grades 9-12

13. Percentage of youth reporting a dental visit in the last year
14. Percentage of youth reporting no cavities
15. Percentage of youth reporting one or more cavities
16. Percentage of youth reporting use of chewing tobacco, snuff or dip in the past 30 days

##### Grades 7-8

17. Percentage of youth reporting a dental visit in the last year
18. Percentage of youth reporting use of chewing tobacco, snuff or dip in the past 30 days

#### *Youth Tobacco Survey (YTS) – 2 indicators*

##### Grades 9-12

19. Percentage of youth who have ever used chewing tobacco, snuff or dip
20. Percentage of youth who have used chewing tobacco, snuff or dip in the past 30 days

##### Grades 7-8

21. Percentage of youth who have ever used chewing tobacco, snuff or dip
22. Percentage of youth who have used chewing tobacco, snuff or dip in the past 30 days

### *Adults and Elderly:*

#### *Medicaid Claims – 1 indicator*

23. Percentage of Medicaid-enrolled adults who had a dental visit during the year

#### *Behavioral Risk Factor Surveillance System (BRFSS) – 6 indicators*

24. Percentage of adults 18 and older who have visited a dentist or dental clinic in the past year
25. Percentage of adults 18 and older who have had their teeth cleaned in the past year (among adults with natural teeth who have ever visited a dentist or dental clinic)
26. Percentage of adults 65 and older who have lost all of their natural teeth due to tooth decay or gum disease

27. Percentage of adults 65 and older who have lost six or more teeth due to tooth decay or gum disease
28. Percentage of dentate adults 18 and older with diabetes who have visited a dentist or dental clinic in the past year
29. Percentage of adults 18 and older who currently use spit tobacco

*New Mothers' Survey/Pregnancy Risk Assessment Monitoring System (PRAMS) – 3 indicators*

30. Percentage of women who had a dental visit during their pregnancy
31. Percentage of pregnant women who received information from a health-care provider on importance of dental care during and after pregnancy
32. Percentage of pregnant women (new mothers) who had teeth cleaned within the last year

*Cancer Registry – 1 indicator*

33. Age-adjusted incidence rate per 100,000 population of new cases of oral and pharyngeal cancer

*Vital Records – 2 indicators*

34. Number of oral and pharyngeal cancer deaths
35. Age-adjusted mortality rate per 100,000 population caused by oral and pharyngeal cancers

*Licensure Workforce Survey – 4 indicators*

36. Number of full-time equivalent (FTE) licensed practicing dentists
37. Rate of practicing dentists per 100,000 population
38. Number of full-time equivalent (FTE) licensed dental hygienists
39. Number of full-time equivalent (FTE) certified dental assistants

*Dental Workforce Survey – 3 indicators*

40. Percentage of practicing dentists who work part-time
41. Percentage of practicing dentists who plan to retire in one to five years
42. Percentage of practicing dentists who accept any and all Medicaid patients

*Water Fluoridation Reporting System (WRFS) – 2 indicators*

43. Percentage of population served by public water systems who received fluoridated water
44. Percentage of public water systems that maintain optimal fluoride levels

### Data Collection Intervals

To efficiently use resources, the Oral Health Program and its partners collect oral health data for surveillance at periodic but regular intervals. For example, data from the BRFSS, YRBS and workforce studies is now collected every other year. Statewide screening surveys are planned every five (5) years. Medicaid, Vital Records, Fluoridation and Cancer Registry data are collected yearly. PRAMS data are collected as point-in-time surveys. By rotating the data collection cycles, the data collection is affordable for a small state with limited resources.

### Partners

Many internal and external partners collaborate with the Oral Health Program in collecting data for the oral health surveillance system. The partners include: Coordinated School Health Interagency Team (YRBS); Division of Tobacco Prevention and Control (chewing tobacco data); BRFSS Working Group (BRFSS); Department of Human Services (Medicaid data); Cancer Registry (cancer data); Vital Records Division (cleft lip/cleft palate and cancer data); Head Start Programs (PIR); EPSDT Programs, schools, state dental associations (state epidemiological surveys); Division of Family Health (PRAMS data); State Board of Dentistry and University of North Dakota Center for Rural Health - Primary Care Agency (workforce studies) and the Division of Water Quality (WFRS data).

### Use of Surveillance Data

Surveillance data can demonstrate oral health needs to local health departments and communities and help tailor strategies. Intervention program planning, management, and evaluation activities are also guided by surveillance information. Consequently, surveillance data needs to be reliable, valid, continued to be available over time, and provide a snapshot of children and adults of the state.

North Dakota uses the surveillance system data to direct programs. Data is used for (1) program planning – determining what programs are needed, (2) implementing programs – examining the operation, services and target populations, (3) assessing program effectiveness – measuring the success of strategies and needs for modifications, and (4) improving program accountability – to ensure and demonstrate effective approaches and efficient use of resources to stakeholders and policy makers.

Data from statewide epidemiological and screening surveys has led to the phasing out of school fluoride programs in many areas of the state, the addition of fluoride varnish and dental sealant programs targeted to high-risk children, the addition of oral health components in local health departments serving areas where oral health knowledge was limited and high disease rates were found, and the integration of oral health components in local MCH grant applications. The surveillance data allows the Oral Health Program to target its efforts to areas of greatest need and has led to the development of special initiatives in oral health education in which earned and free media are used to assist in reaching program objectives. The periodic surveys will allow the state to track trends to evaluate program efforts.

North Dakota also uses the surveillance data to drive policy development. Data from the workforce studies resulted in the establishment of a dental loan repayment program to increase the dental workforce to ultimately improve access to dental providers. In addition, the expanded scope of practice for medical professionals to apply fluoride varnish increases the availability of preventive services for high risk children. The WIC, Home Visiting and Optimal Pregnancy Outcome Programs established protocols for oral health education of pregnant women. Including basic oral health education in public health programs will aid the prevention efforts of the Program.

#### Tools for the Surveillance System

Several tools have been recently developed to guide the implementation and expansion of the North Dakota Oral Health Surveillance System (NDOHSS):

1. A written five-year [North Dakota Oral Health Surveillance Plan](#) (2007-2013) describes the historical perspective of oral health surveillance for the state, objectives/rationale of NDOHSS, structure of the system which includes a logic model and selected indicators, sustainability that address integration/collaboration and resource utilization/efficiency, and dissemination of surveillance information. Notably, an oral health communication plan is included in the surveillance plan.
2. A [Question Matrix](#) provides the specific question(s) for each surveillance indicator selected for the NDOHSS. In addition, the numerator and denominator are defined for each indicator.
3. A [Data Grid for Surveillance Indicators](#) has been set up to report the NDOHSS indicators and track trends for the period from 1999 through 2007.

#### **Budget Estimates and Formulas of the Practice:**

BRFSS oral health questions are a component of the rotating core questionnaire and do not require extra state resources. The Division of Family Health supports the inclusion of three to four oral health questions on the YRBS. Costs for the oral health questions on the YRBS average \$2,000-\$3,000 per survey based on the number of questions included. Workforce studies average around \$2,000. Statewide screening and epidemiological surveys average \$17,000-\$20,000 per survey. Medicaid, Vital Records, Cancer Registry, PRAMS and Fluoridation data reporting costs are absorbed by the partnering programs and agencies. Costs for the surveillance system range from \$2,000 to \$20,000 per year depending on the rotation pattern of the surveys. In order for a small state with limited resources to accommodate these surveys, the surveys are conducted on a periodic rotating basis. An example of the current rotation pattern and related costs is shown below.

<u>Yearly:</u>	Medicaid, Vital Records, Cancer Registry, Head Start and Fluoridation data – no cost to program	
<u>Point in time:</u>	PRAMS – costs paid by Family Health Division	
<u>Year 1:</u>	BRFSS	\$ 0
<u>Year 2:</u>	YTS, YRBS and Workforce Survey	\$ 2,000
<u>Year 3:</u>	BRFSS, BSS Third Grade Survey	\$20,000

<u>Year 4:</u>	YTS, YRBS, Workforce Survey	\$ 2,000
<u>Year 5:</u>	BRFSS	\$ 0
<u>Year 6:</u>	YTS, YRBS, Workforce Survey	\$ 2,000

**Lessons Learned and/or Plans for Improvement:**

- In building a comprehensive state oral health surveillance system, each state should: (1) define the data you need, (2) think innovatively, and (3) think of systems.
- Use data/surveillance to drive decision making, programming, and policy action.
- Open mouth surveys are recognized as the “gold standard” in assessing oral health status and treatment needs; however, such surveys are resource intense. Consequently, states must think of innovative ways for building surveillance systems and collecting the data needed.
- Additional analysis of the data is providing information on disparities and local, county and regional estimates.
- Reporting and communicating the findings to “tell a story” to the public and policy makers through web-based summaries and GIS mapping is the next phase. The addition of a part-time epidemiologist to the Oral Health Program staff will facilitate this action.

**Available Resources - Models, Tools and Guidelines Relevant to the Practice:**

- North Dakota Surveillance Plan 2007-2013  
<http://www.astdd.org/docs/SubmissionFileNDOHSurveillancePlan.pdf>
- North Dakota Oral Health Program Surveillance System Indicators – Question Matrix (question, numerator and denominator for each indicator)  
<http://www.astdd.org/docs/SubmissionFileNDSurveillanceQuestionMatrix.pdf>
- North Dakota Oral Health Program Surveillance System Indicators – A Data Grid for Reporting Indicators from 1992 to 2007  
<http://www.astdd.org/docs/SubmissionFileNDSurveillanceIndicators.pdf>
- Centers for Disease Control and Prevention. Framework for Program Evaluation in Public Health. MMWR 1999; 48 (No. RR-1): 1-40.
- Centers for Disease Control and Prevention. Updated Guidelines for Evaluating Public Health Surveillance Systems: Recommendations from the Guidelines Working Group. MMWR 2001; 50 (No.RR-13): 1-35.

## SECTION III: PRACTICE EVALUATION INFORMATION

### Impact/Effectiveness

*Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?*

The surveillance system provides information to identify disparate populations and communities. The information is used for program planning to most effectively target resources to areas of greatest need. Monitoring the implementation of evidence-based approaches allows for the evaluation of those approaches among selected populations and communities. Trend data provides information on long-term outcomes to assess program accountability and effectiveness.

Surveillance data from statewide epidemiological and screening surveys has led to the phasing out of school fluoride programs in many areas of the state, the addition of dental sealant and fluoride varnish programs in high caries areas, the addition of oral health components in local health departments serving areas where oral health knowledge was limited and high disease rates were found, and the integration of oral health components in local MCH grant applications. Data from the workforce studies resulted in the establishment of a dental loan repayment program to increase the dental workforce to ultimately improve access to dental providers. The surveillance data also resulted in WIC, Home Visiting and Optimal Pregnancy Outcome Programs having established protocols for oral health education of pregnant women.

### Efficiency

*Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?*

A statewide surveillance system that uses existing ongoing data sources, is integrated with other programs, and partners with other agencies and organizations maximizes use of resources, avoids duplication, is time efficient by avoiding multiple interruptions of survey participants, and shares costs among the users. A surveillance system should be simple in structure and in operation while meeting the objectives of the end user. Systems which are simple in nature are efficient to operate and manage.

In order for North Dakota, a small state with limited resources, to accommodate multiple surveys for surveillance, the surveys are conducted on a periodic rotating basis. Costs for the surveillance system range from \$2,000 to \$20,000 per year depending on the rotation pattern of the surveys. An example of the current rotation pattern and related costs is shown below.

<u>Yearly:</u>	Medicaid, Vital Records, Cancer Registry, Head Start and Fluoridation data – no cost to program	
<u>Point in time:</u>	PRAMS – costs paid by Family Health Division	
<u>Year 1:</u>	BRFSS	\$ 0
<u>Year 2:</u>	YTS, YRBS and Workforce Survey	\$ 2,000
<u>Year 3:</u>	BRFSS, BSS Third Grade Survey	\$20,000
<u>Year 4:</u>	YTS, YRBS, Workforce Survey	\$ 2,000
<u>Year 5:</u>	BRFSS	\$ 0
<u>Year 6:</u>	YTS, YRBS, Workforce Survey	\$ 2,000

### Demonstrated Sustainability

*Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?*

A statewide surveillance system that is integrated is easier to sustain over the long term because multiple users support the maintenance of the system. Using standardized questions allows for comparability among communities and states. Open mouth surveys continue to be resource intense, but can be integrated at longer time intervals to leverage funds for other surveillance efforts. Maximizing the use of existing, ongoing data sources enhances the sustainability of the surveillance system.

The North Dakota Department of Health, Oral Health Program began developing its oral health surveillance system in 1993. By the year 2000, the surveillance system included 27 indicators and 9 key data sources. By 2008, the surveillance system expanded to include 44 indicators and 13 key data sources. Surveillance system development efforts are ongoing with adaptations and changes to meet the needs of the program.

### **Collaboration / Integration**

*Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?*

Building a statewide surveillance system is an exercise in collaboration and integration. Both are necessary for the sustainability of the system. For surveillance systems to operate effectively, they must be acceptable both by participants and the end users. Collaboration increases awareness of oral health issues, identifies new opportunities for integration, and increases commitment of resources for oral health from other agencies and organizations. The impact of oral health on systemic health creates multiple opportunities for collaboration with a wide variety of maternal and child health and chronic disease programs.

North Dakota's oral health surveillance partners include: Coordinated School Health Interagency Team (YRBS); Division of Tobacco Prevention and Control (chewing tobacco data); BRFSS Working Group (BRFSS); Department of Human Services (Medicaid data); Cancer Registry (cancer data); Vital Records Division (cleft lip/cleft palate and cancer data); Head Start Programs (PIR); EPSDT Programs, schools, state dental associations (state epidemiological surveys); Division of Family Health (PRAMS data); State Board of Dentistry and University of North Dakota Center for Rural Health - Primary Care Agency (workforce studies) and the Division of Water Quality (WFRS data).

### **Objectives / Rationale**

*Does the practice address HP 2010 objectives, the Surgeon General's Report on Oral Health, and/or build basic infrastructure and capacity for state/territorial oral health programs?*

The statewide surveillance system provides for the collection of data on a majority of the HP 2010 objectives, provides information to address the recommendations from the Surgeon General's report on Oral Health by tracking the status of oral health, and provides justification for building the capacity and infrastructure of the program. Valid and reliable data justify the need for enhanced resources for oral health programs. The data can be used to educate the public and policy makers on effective preventive measures, enhance the transfer of science into practice, and build effective oral health programs and infrastructure that can meet the needs of all residents of the state. Communication of findings is a key component of a successful surveillance system.

### **Extent of Use Among States**

*Is the practice or aspects of the practice used in other states?*

There is a growing concern for valid and reliable data in state oral health programs. While few states have well-developed surveillance systems, most states are using some components of a surveillance system. This model can be used in other states, as the majority of the data is readily available in most states.