



## Dental Public Health Activities & Practices

**Practice Number:** 12001  
**Submitted By:** Oral Health Section, Georgia Department of Human Resources  
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<b>SECTION I: PRACTICE OVERVIEW</b>		
<b>Name of the Practice:</b> Saving the Dental Program: Georgia's Experience and Support of the Oral Health Coalition		
<b>Public Health Functions:</b> Policy Development – Oral Health Program Organizational Structure and Resources		
<b>HP 2010 Objectives:</b> 21-17 Increase the number of State & local dental programs with public health trained director.		
<b>State:</b> Georgia	<b>Region:</b> South Region IV	<b>Key Words:</b> State oral health program, coalition, partners, infrastructure
<b>Abstract:</b> <p>The Georgia State Oral Health Program has twice in the last seven years (1996 and 2000) faced the threat of elimination with severe budget cuts of state funding for oral health. In response to the threat in 1996, the Georgia Oral Health Coalition (GOHC) was established to build and support state oral health infrastructure. The Coalition worked diligently in 1996 and 2000 to represent the need for the state's oral health program and necessary dental services. The Coalition, along with the Georgia Department of Audits (GDOA) Report, recommended that the state's oral health program remains intact and that the state expands oral health services. A one-page fact sheet was developed to promote retaining the state dental program, referring to the GDOA Report's recommendation to maintain and expand state oral health services, the oral health needs of the state, and the recommendation to maintain the state funding for the oral health program at the present funding level. All organizations/individuals of the Coalition utilized the fact sheet. In addition, consumers, city and county politicians, local boards of health, private dentists, professional health organizations and advocacy groups sent letters and made calls to the Governor and the Department of Human Resources Commissioner. All work performed was by voluntary members and associations, and there were no direct costs. As a result of this effort, the state oral health program was retained and funding reinstated both in 1997 and 2001. The efforts of the GOHC in raising the importance of the state's oral health infrastructure has also led to other benefits including developing a state oral health plan, funding the school-based Georgia Oral Health Prevention Program, and significant increases in dental Medicaid fees.</p>		
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## SECTION II: PRACTICE DESCRIPTION

### History of the Practice:

The state oral health program in Georgia has been at risk of elimination due to severe budget cuts twice within the last seven years:

(1) In August 1996, the Georgia Division of Public Health recommended to cut all state funding (\$1.2 million) for oral health. Since the state oral health program was not a statewide program, it was felt that the program had “essentially little impact.” The Georgia Department of Human Resources (DHR) and the Governor agreed to cut all state funding for oral health.

(2) In September 2000, the Georgia Department of Human Resources requested that the oral health program funds of \$1.4 million be “redirected” to the statewide school-based Georgia Oral Health Prevention Program (GOHPP). The Governor’s budget dropped the oral health program’s funding of \$1.4 million, but the funding was not redirected or added to the GOHPP. This eliminated all state funding for oral health.

### Justification of the Practice:

One of the Healthy People 2010 oral health objectives calls for an increase in the number of Tribal, State, and local health agencies that serve jurisdictions of 250,000 or more persons that have in place an effective public dental health program directed by a dental professional with public health training. In addition, a publication released by the Association of State and Territorial Dental Directors in April 2000, *Building Infrastructure & Capacity in State and Territorial Oral Health Programs*, cited the importance of providing leadership to address oral health problems with a full-time dental director and an adequately staffed oral health unit with competence to perform public health functions. The leadership that is provided in a state oral health program is essential in determining priorities, setting agendas, developing plans, making funding decisions, and establishing policies. Also, leadership is important in increasing awareness and raising priorities for oral health among a broad constituency.

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

In 1996, the following actions were taken to retain the state oral health program in Georgia:

(a) A Georgia Department of Audits (GDOA) Report in October of 1996 stated that state funding for the oral health program should be maintained, and that the program’s services needed to be expanded statewide. The Georgia Dental Association provided pertinent information to key members of the Budgetary Responsibility Oversight Committee (BROC). The Department of Human Resources (DHR) response to BROC essentially agreed with the GDOA Report. The report’s recommendation was used to provide strong support for the state oral health program.

(b) The Georgia Oral Health Coalition (GOHC) was formed in July 1996 to build and support state infrastructure. The coalition’s public-private partnerships members included Oral Health America, the Deputy Director of Centers for Disease Control and Prevention’s (CDC) Division of Oral Health, American Academy of Pediatrics: Georgia Chapter, Health Districts, Delta Dental Insurance, County Health Departments, Georgia Academy of Pediatric Dentistry, Georgia Association for Primary Health Care, Georgia Dental Association, Georgia Dental Hygienists’ Association, Georgia Dental Society, the Georgia Department of Community Health, the Georgia Department of Human Resources, Georgia Hospital Association, Georgia Nurses Association, Georgia Congress of Parents and Teachers, Healthy Mothers, Healthy Babies Coalition of Georgia, consumer advocates and private practicing dentists. The GOHC worked diligently to support the state oral health program.

(c) A one-page fact sheet was developed to promote retaining the state dental program, referring to the GDOA Report’s recommendation to maintain and expand state oral health services, the oral health needs of the state, and the recommendation to maintain the state funding for the oral health program at the present funding level. All organizations/individuals of the coalition utilized the fact sheet.

(d) Consumers, city and county politicians, local boards of health, private dentists, professional health organizations and advocacy groups sent letters and made calls to the Governor and the DHR Commissioner.

As a result of the Georgia Oral Health Coalition's support and the raising of awareness regarding oral health needs, all the state oral health funds were reinstated in July 1997. Another outcome was the development of the Georgia Oral Health Plan in 1997. Further, DHR requested an increase of oral health funding to \$3.5 million for the statewide, school-based Georgia Oral Health Prevention Program piloted in two Health Districts.

The strategy was used again when the oral health funding of \$1.4 million was eliminated in 2001. From the 1995-1997 experience, the Georgia Oral Health Coalition continued their support for the state's oral health infrastructure. The following factors contributed to preserving the state's oral health program: a new 1-page fact sheet was developed and disseminated, the GDOA Report's recommendation of maintaining and expanding the state oral health services, the state Oral Health Plan developed in 1997, letters and calls for support to the Governor and DHR Commissioner, and the House Study Committee on dental Medicaid. The result was that state FY 2001 budget for oral health funds totaled \$2.4 million (an increase of \$1 million to expand GOHHP statewide). Also, the support increased access for Medicaid/PeachCare (SCHIP) by increasing dental Medicaid fees significantly.

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

Essentially all work performed was by voluntary members and associations, and there were no direct costs.

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

The strategy implemented to retain the oral health infrastructure (state oral health program and its funding) illustrates the John Kingdon Model: Open Window of Opportunity –

**Problem** – Sense among those in power to act, that a legitimate problem exists and needs to be addressed (e.g., Define the problem and having key players accept serious problem.)

**Politics** – Sense among those in power to act, that timing for action is right to public sentiment & consistency with other policy objectives (e.g., Who was trying to get what from whom?)

**Policies** – existence of implementable policy that fits the scope of the problem, is understandable, and can attain sufficient support (e.g., Policy to address problem: any changes necessary to win approval - if so how?)

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

- 1999 Fact Sheet: *Recommendations of Georgia Oral Health Coalition: January 1999* (see page 5)

## 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 strategy in defining a legitimate problem exists, that timing for action is right to public sentiment and consistent with other policy objectives, and the implementable policy that fits the scope of the problem was successful in reinstating state funding to the oral health program in 1997 and in 2001. In addition, the strategy raised the priority of oral health, which resulted in developing a state oral health plan, funding the statewide school-based Georgia Oral Health Prevention Program, and led to a significant increase in dental Medicaid fees.

### **Efficiency**

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

The in-kind contribution of agencies and organization as well as donated time of individuals in the Georgia Oral Health Coalition resulted in major changes that retained and expanded state oral health infrastructure.

### **Demonstrated Sustainability**

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

The Georgia Oral Health Coalition was formed in 1996 and remains instrumental in addressing oral health infrastructure for the state. The state oral health program in Georgia was established in 1928 and will celebrate its 75<sup>th</sup> anniversary in 2003.

### **Collaboration/Integration**

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

The Georgia Oral Health Coalition established private public partnerships that included The Georgia Oral Health Coalition (GOHC) formed in July 1996 to build and support state infrastructure. The coalition public-private partnerships members included Oral Health America, the Deputy Director of CDC's Division of Oral Health, American Academy of Pediatrics, Georgia Chapter, Health Districts, Delta Dental Insurance, County Health Departments, Georgia Academy of Pediatric Dentistry, Georgia Association for Primary Health Care, Georgia Dental Association, Georgia Dental Hygienists' Association, Georgia Dental Society, the Georgia Department of Community Health, the Georgia Department of Human Resources, Georgia Hospital Association, Georgia Nurses Association, Georgia Congress of Parents and Teachers, Healthy Mothers, Healthy Babies Coalition of Georgia, consumer advocates and private practicing dentists.

### **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 efforts of the Georgia Oral Health Coalition and the strategy to retain the state dental program in the state made advances toward the Healthy People 2010 objective calling for an increase in the number of Tribal, State, and local health agencies that serve jurisdictions of 250,000 or more persons that have in place an effective public dental health program directed by a dental professional with public health training. In addition, the Surgeon General's Report on Oral Health also cited the need to strengthen the oral health infrastructure for improving oral health of Americans.

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

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

The risk of budget cuts and program elimination has been reported by other states at various periods of time. State oral health coalitions are also growing in number among other states. The extent of state oral health coalitions' efforts in retaining the state oral health program and sharing a similar experience, such as that found in Georgia, is not known.

## Recommendations of Georgia Oral Health Coalition: January 1999

### RETAIN THE STATE DENTAL PUBLIC HEALTH PROGRAM

**Issue:** Retain the State Dental Program, and restore the \$1.4 million in the FY2000 budget for the Dental Public Health Program.

**Why is this important:** Georgia Dental Public Health (GDPH) Program's focus is providing school-based dental prevention services to low-income high-risk children, who do not have access to dental services, especially in rural areas. A 1996 Department of Audits evaluation of the State Dental Health Program overall conclusion: "***The state dental program should not only be maintained, but should be expanded and staff increased with a more centralized direction.***" The *Georgia Dental Prevention Program* is the only safety net for many of Georgia's low income and working poor families.

#### The Facts:

1. The GDPH, *Georgia Dental Prevention Program*, focus is school-based prevention services, and does not duplicate Dental Medicaid and PeachCare for Kids that focus on obtaining dental treatment for eligible children by dentists in private dental offices.
2. Since FY1998, two Pilot Dental Prevention Programs in the Dublin and Augusta Health Districts have been providing school-based dental prevention services. The Programs concentrate in rural counties where there are few if any dentists, and there is little or no access to any dental services. Children benefit from school fluoride mouthrinses, dental education, screenings, and dental sealants provided with portable dental equipment in the schools. Referrals for basic emergency dental services are made to private dentists, Community Health Centers when available, or centrally located public health facilities.
3. Low-income children are 80% more likely to have dental disease, and 30% of the tooth decay among poor children in Georgia remains untreated. GDPH affects approximately 66,000 children in at least 55 counties.
4. Children with dental disease and tooth pain have high absenteeism in school thereby impacting their education. Georgia teachers indicate that dental and vision problems are the most cited reasons children miss school.
5. As of January 1999, 67% of the Powerline's child health calls are related to dental health. The Powerline is a statewide access to health care service managed by the Healthy Mothers, Healthy Babies Coalition of Georgia.
6. In a 1997 survey by the Healthy Mothers, Healthy Babies Coalition of Georgia, only 259 of 3,800 practicing Georgia dentists indicated they would accept new Medicaid patients. A recent update indicated only 300 dentists will now accept new Medicaid/PeachCare for Kids patients.
7. \$100 -\$150 expense results from one visit to a hospital emergency room to temporarily treat pain and infection until a dentist can be located. **(If state funds are eliminated, county and local funds will be used for emergency care.)**
8. Although dental disease can be easily prevented and controlled at a reasonable cost, the impact of not obtaining preventive dental care can be substantial. **Every \$1 invested in preventive dentistry saves as much as \$147 of future expenses.** (California Dental Association)

#### Key Action Steps:

**Support at a minimum the maintenance of the State Dental Program** at the present \$1.4 million level, **and ensure that future funding will support statewide expansion of the *Georgia Dental Prevention Program*.**