With the most recent funding award announcements, several states have faced uncertainty. Some state oral health programs have been forced to reduce the number of staff members and others have completely lost programs. The curtailing of one state oral health program has a negative impact on other programs as we are dependent upon one another for guidance and resources. In shaping the future of all state oral health programs, we call upon our oral health leaders. Our leaders create an inspiring vision that motivates and encourages others to engage with that vision. They build a strong team and coach that team to achieve the vision’s goals. Sometimes that means they must go down untraveled paths, facing uncertainty. Remember during these uncertain times, that you are never alone because optimal oral health is not achieved through one person or program, but through the supportive efforts of all.

As the ASTDD president, I feel that we need to work together to build a sustainable plan for every state oral health program. “A strong and effective governmental oral health presence in states and territories to assure optimal oral health” is our vision. With ASTDD’s vision in mind, I want to build upon past success and continue to increase oral health awareness as part of overall health. I feel that we have a strong team and I am certain that we can achieve our vision’s goals of assuring optimal oral health for all As we work together, I ask for your ideas and support to achieve our goal.
Executive Director’s Message

I hope you had a relaxing Thanksgiving and are ready to charge into winter energized and enthused! At ASTDD, we certainly are, especially with the start of a new five-year cooperative agreement with the Division of Oral Health at the Centers for Disease Control and Prevention. Later in the newsletter, our Cooperative Agreements Manager, Bev Isman, will provide you with an update on changes that have taken place with committees and consultants and plans for the coming year.

Along with all of that activity, the joint ASTDD/American Association of Public Health Dentistry (AAPHD) National Oral Health Conference (NOHC) Planning Committee has been busy getting everything in place for the 2019 NOHC in Memphis next April. This will be the 20th joint meeting of ASTDD and AAPHD; to celebrate, we are exploring some new events including a New Attendee reception and orientation, a social hour to kick off your Monday evening activities, and a new session format, the Five Minute Masterpiece. In addition, we may offer some longer workshops opposite the 60- and 90-minute concurrent sessions on Monday through Wednesday. And finally, our friends at the Oral Health 2020 Network will host a Network convening on Wednesday afternoon. There is so much to look forward to as we celebrate “Building on 20 Years of Oral Health!”

Debony Hughes, DDS

A native of Lynchburg, Virginia, Debony Hughes attended Lynchburg Public Schools and then attended the University of Richmond, receiving an undergraduate degree in Chemistry. Dr. Hughes then received her Doctor of Dental Surgery and a Certificate in Advanced General Dentistry from Howard University College of Dentistry.

Her public health career began in Vermont, where Debony was able to work with providers across the state to provide access to the underserved Medicaid population. For the last 22 years, she served the Prince George’s County Health Department, beginning as a staff dentist and ascending to Program Manager. During her tenure there, she implemented numerous programs and established community collaborations to educate and increase access for the residents of Prince George’s County.

Debony has experience in legislative testimony and has been recognized for her service to the community and the science of dentistry by numerous organizations. She currently serves as the Maryland Department of Health, Director of the Office of Oral Health.

Debony is married to Leroy Nesbitt, Jr., Esq. and has two children, Nina and Malayna. A lover of the arts, she grew up playing the piano and violin. Debony loves attending performances of all genres at the Kennedy Center and other venues across the City. She loves to travel and enjoyed visiting her youngest daughter in Barcelona this summer. Her favorite hobby is shopping. Family is extremely important, and one of her favorite quotes is “Having somewhere to go is home. Having someone to love is family. Having both is a blessing.” Author Unknown.
THE NATIONAL INTERPROFESSIONAL INITIATIVE ON ORAL HEALTH:
Improving Health Through Integrated Oral Health Care
By Anita Glicken

In 2007 when newspapers carried the story of the death of 12-year-old Deamonte Driver, if you were a physician, PA, or NP you might have read this story and said, “how unfortunate the family couldn’t find a dentist,” “too bad there was nothing we could do.” Their words reflected siloed education, practice and payment systems that had separated the mouth from the body and medical providers from oral health care. Ten years later those same providers are redefining the access problem through the lens of an integrated care delivery system and consider themselves a part of the oral health solution.

Working Smarter…. Integrating Oral Health Through Interprofessional Practice

Although many factors contribute to poor oral health, a historic lack of attention to oral health by primary care professionals continues to perpetuate a care system fraught with inequities. The non-dental healthcare workforce consists of more than 4,000,000 nurses, 1,000,000 physicians, 250,000 nurse practitioners and 123,000 physician assistants who each can play a role in improving the oral health of the public. These professions are uniquely positioned to:
• assess risk factors for oral disease,
• provide patient oral health education and preventive services, and
• refer patients to dental professionals.

Primary care clinicians also partner with public health, social work and community health workers, extending their reach into the community to address key social determinants of health including living and working environments and economic, social and welfare policies that create common risk factors for poor oral health.

Recognized as the national voice for the integration of oral health into overall health, The National Interprofessional Initiative on Oral Health (NIIOH) serves as the backbone of medical-dental integration efforts and the expansion of interprofessional oral health workforce capacity. NIIOH helps partners strategically select activities that leverage their capacity, both individually and organizationally, to increase awareness and access to oral health services. Using a collective impact approach, we align activities across professions to maximize impact.

NIIOH activities are organized using core strategies to:
• Cultivate oral health champions and leaders,
• Facilitate interprofessional learning and agreement,
• Develop tools and resources to enable the primary care workforce to acquire core oral health clinical competencies, and
• Support and connect partner efforts to integrate oral health into education and practice.
The goal is to equip the health workforce with the knowledge and skills needed to incorporate oral health into whole person care. Primary care clinicians including physicians, PAs, NPs, nurses, midwives, pharmacists, social workers, and public health professionals now embed oral health and interprofessional practice competencies in education programs and translate knowledge and skills into practice.

NIIOH partners are building new programs, bringing existing programs to scale, and piloting new projects to establish proof of concept. NIIOH connects these teams with the information, tools, and partners required to achieve their oral health goals. The following resources, supported by NIIOH, effect change across education and practice.

- **Smiles for Life (SFL)** is a free online curriculum of 11 independent modules that teach oral health across the lifespan. Modules can be completed online or downloaded and used as education coursework. Many health professionals receive free CE and new modules support frontline and community health workers. The curriculum can be used to educate all staff in a common oral health language and provides specific instruction on team-based, interprofessional care. Twenty professional organizations, including ASTDD, and seven health professions endorse SFL. Research documents that SFL positively influences the delivery of oral health care...
THE NATIONAL INTERPROFESSIONAL INITIATIVE ON ORAL HEALTH:
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Oral health is an essential component of overall health. Our ability to care for the health of the population is stronger when we join together to create high impact education and delivery models that capitalize on the strengths of the entire health care team. Interprofessional practice begins with key conversations to align our workforce around shared goals; ASTDD members are uniquely positioned to promote these discussions. We welcome opportunities to partner in these efforts, to learn more about your work and support activities that create optimal health for all.

To share your experience with oral health integration or learn more about our work, please contact Anita Glicken@niioh.org.

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5 actions primary care teams can take to protect and promote their patients’ oral health.

- Ask about oral health risk factors and symptoms of oral disease
- Look for signs that indicate oral health risk or active oral disease
- Decide on the most appropriate response
- Act offer preventive interventions and/or referral for treatment
- Document as structured data for decision support and population management
Wow, the winter holidays already are here and I'm still in "beach mode." Where does the time go? Chris mentioned in her ED column that we were awarded a new CDC cooperative agreement from the Division of Oral Health (DOH) to provide TA to states. See the separate article in this newsletter. We also submitted an application to the CDC Office for State, Tribal, Local and Territorial Support (OSTLTS) that was approved but not funded at this time; they will retain it for two years and fund it if suitable funding becomes available. Many thanks to the 21 individuals and groups who helped us develop the concepts and wrote letters of support for the OSTLTS application and the 22 who wrote letters for the DOH application. During the summer, the Year 01 contract we have as a partner on the National Maternal and Child Center for Oral Health Systems Integration and Improvement (COHSII) project that includes the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) grantees, ended and we are now in Year 02. Year 03 of our contract to coordinate the Dental Hygienist Liaison portion of the National Center on Early Childhood Health and Wellness (NCECHW) ended on September 29 so now we are in Year 04.

It is becoming increasingly difficult to keep all these start and end dates straight! There also is a heavy report writing/workplan and evaluation time commitment we face as well, including writing our five-year final report for our previous CDC cooperative agreement. We empathize with all the states in the same situation. In this column I’m going to provide an overview of activities and the many changes that have occurred since the last OHM issue. All committees have updated workplans and logic models posted on their ASTDD committee webpages.

**Healthy Aging Committee (HAC)**
The HAC sponsored a webinar, *Chronic Disease and Older Adult Oral Health*, that is now posted on the website in case you missed it. They also promoted an Oral Health America Twitter storm on August 22. This summer the HAC conducted a survey with the American Dental Education Association (ADEA) of dental and dental hygiene programs to determine if and how they are providing student experiences with older adults. Results will be shared when they are finalized. This committee also provides technical assistance (TA)/mentoring to states that plan to conduct an older adult Basic Screening Survey (BSS).

**School and Adolescent Oral Health Committee (SAOHC)**
Kathy Geurink has stepped down as the consultant to this committee to focus more on the COHSII project and her grandchildren. We thank Kathy for her many contributions to this committee, especially numerous hours and her expertise creating linkages with the School Based Health Alliance (SBHA) and promoting oral health integration into CDC's Whole School, Whole Community, Whole Child
Committees, Consultant Activities and Resources

continued

(WSCC) model. Donna Behrens, a member of the SAOHC and former staff of the SBHA, is now the SAOHC consultant. A big welcome to Donna! Sandy Tesch will continue her work with the committee as the Dental Sealant consultant, increasing her time to manage the focus for the newly funded CDC states on school-based sealant programs. Sandy is tracking sealant listserv inquiries and providing TA to states. Kudos to Sandy for her recent appointment to the Dental Quality Alliance (DQA) sealant measures ad hoc committee representing ASTDD. Lynn Bethel Short presented for ASTDD on the WSCC Model at the SBHA conference in June. She noted that school-based health center personnel are interested in offering dental services and incorporating the WSCC model but want guidance on how to do this at the local level. Attendees to the session weren’t knowledgeable about resources available from their state oral health program (SOHP). ASTDD and SOHP will need to continue to provide regular contributions of oral health information and resources to SBHA members through a newsletter and other media sources.

Perinatal Oral Health Committee (POHC) The POHC supports the PIOHQI project but is not duplicative of any COHSII committees. One recent activity was reviewing and updating the ASTDD Perinatal Oral Health Policy Statement, which was originally adopted in July 2012. Look for it to be posted sometime soon. Another POHC task was to update the POHC webpage on ASTDD’s website. This was completed, including streamlining, reorganizing and listing resources in a more systematic way. Check it out!

Fluorides Committee (FC) LeeAnn Hoaglin-Cooper, who has been our wonderful consultant to the FC forever, has decided to devote more time to her grandchildren (this seems to be a trend among our consultants) and only do limited projects for ASTDD. She will continue tracking the Fluoridation Rollback attempts for our database. Thanks so much to LeeAnn for her creativity around the annual Fluoridation Awards photo shows, her many state surveys to document use of fluorides and her national advocacy. We at ASTDD are glad she is still staying engaged with us and willing to work on special projects. Judy Feinstein will assume her duties as consultant to the committee, which she used to chair, in addition to staffing the Dental Public Health Resources Committee. LeeAnn and Judy recently reviewed materials for a reference guide for the American Academy of Pediatrics (AAP) to post on their new webpage for water operators on the I Like My Teeth website. We will be working with AAP’s Campaign for Dental Health this year on water fluoridation messaging for primary care providers. The FC has created an inventory of state and territorial fluoridation plans to use as a baseline for CDC grant work and as a resource to all states and territories. Examples of some plans are posted on the Members Only section of the website.

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Committees, Consultant Activities and Resources

continued

The Best Practice Approach Report (BPAR) on Use of Fluoride in Schools was updated July 2018. This new BPAR contains updated information on K-12 school-based fluoride mouthrinse or fluoride supplement programs. In addition, the report reviews information on the use of other fluoride products in school settings including fluoride varnish, silver diamine fluoride, school water fluoridation and fluoride toothpaste/brushing. States, communities and territories have submitted State Activity Submissions as examples of success stories and lessons learned to serve as models of implementation strategies for best practices or promising practices.

Oral Cancer/Tobacco Resources
Christine Veschusio has served on ASTHO’s Tobacco Forum for the past few years and also helped assemble and post resources on our website related to oral cancer and smoking and tobacco use. Chris recently went back to work full-time and has resigned from the Forum and cut back on her work with ASTDD. Kimberlie Yineman, past ASTDD president, was appointed to the ASTHO Forum to take Chris’s place. Carissa Beatty attends CDC’s Office of Smoking and Health Tobacco Control Partner calls and will share information with us.

Chronic Disease and Oral Health Integration
For the past two years ASTDD has had an MOU with the National Association of Chronic Disease Directors (NACDD) to support Barbara Park’s time to serve as a consultant on oral health (OH) and chronic disease (CD) integration to ASTDD and to SOHP. During that time Barb assembled a Chronic Disease Collaboration Workgroup that developed Examples of How Oral Health Promotion and Risk Reduction Strategies Align with the Chronic Disease Four Domains, an NACDD impact brief on OH and CD, and updated the CD webpage on the ASTDD website. She coordinated two webinars, one for NACDD members on integration of oral health into the WSCC model and the recent HAC webinar on chronic disease and older adults. In addition to providing TA to the six pilot project states funded by CDC for CD/OH collaboration for the previous two years, she coordinated a panel at the 2018 NOHC on chronic disease/ oral health collaboration in seven states. All these activities and resources have strengthened states’ abilities to foster collaboration and enabled closer ASTDD/NACDD ties. CDC just funded NACDD to continue to support state CD/OH collaboration, and five states to pursue medical/dental collaboration around diabetes and hypertension.

Dental Public Health Resource Committee (DPHRC)
Look at the new white paper, Opportunities for Improving Oral Health and Chronic Disease Program Collaboration and Medical-Dental Integration. The paper focuses on the Four Chronic Disease Domains framework. Although the primary audience is state oral health and chronic disease programs, the issues apply to any program hoping for better medical-dental integration.
Other white paper topics are in various stages of development based on priorities noted by members in recent surveys. The DPHRC also has updated an ASTHO Oral Health Policy Statement and sent it back to ASTHO’s Access Policy Committee to finalize. Also, Judy Feinstein was appointed to the ASTHO Population Health and Informatics Policy Committee and attended an ASTHO Policy Summit in Alexandria, VA on September 25. The purpose of the meeting was to a) engage federal partners in “conversations” about state, territorial, and federal programs, priorities, and partnerships, in several roundtable sessions; and b) review and shape ASTHO’s policy agenda around the identified Three Pillar Framework for Population Health, and the work of the newly configured Population Health and Informatics: clinical to community connections, addressing health equity and the social determinants of health, and data analytics and public health informatics. Judy noted that there was no other oral health presence.

Best Practices Committee (BPC)
The ASTDD State Activity Submission Form has been revised and posted to BP State Activities webpage. In case you aren’t familiar with that webpage, it serves as a resource for dental public health activities that state and territorial oral health programs lead, administer, partner, facilitate or support to improve the oral health of that state’s or territory’s citizens. States and territories have reported these activities as successful within the context of their experiences, environments, and resources (such as existing local infrastructure, practice laws and program funding). The activities are searchable by topic or by state. Submissions are accepted at any time.

Judy Feinstein, with the assistance of the American Network of Oral Health Coalitions, is in the process of developing a Best Practice Approach Report on Collaborative Partnerships. The Role of Oral Health Workforce Development in Access to Care BPAR also is complete. They have issued a call for longer state submissions for both BPARs. Contact Lori Cofano at lkcofano@gmail.com if you are interested in submitting and she will send you the form. Jennifer Sukalski, who was a Master’s degree student at the time and the primary author of the Workforce BPAR, presented a poster on it at the American Public Health Meeting in San Diego in November.

Data Committee (DC)
Beth Anderson recently stepped down as Chair of the DC because of changing workloads in the MI program. Thanks so much to Beth for her leadership! Moving forward, Mona Van Kanegan from IL has agreed to chair the committee. So, welcome Mona! Mike Manz and Kathy Phipps continue to provide TA to states on the BSS and Oral Health Surveillance issues; they have provided TA to 14 states since June. Bev Isman and Kathy are co-authors on an oral presentation, Progress in State Oral Health Surveillance: 1990s – 2017, which was presented at the APHA conference in November.
Communications Committee (CC)
The CC didn’t meet over the summer but had a lively call in September. ASTDD’s new CDC funding is allowing us to contract with the AAP around messaging for fluoridation and for primary care providers (as noted under the Fluorides Committee update), and with Matt Jacobs Strategies to create a “message matrix” as a format that SOHP can use during various types of presentations to stakeholder groups to pull together content, then structure and tailor messages. Tips will be given on how to deliver the information to increase people’s comfort in creating effective messages. We plan to do a workshop on this topic at the NOHC.

State Development and Enhancement Committee (SDEC)
This committee has had responsibilities for many documents and programs throughout the years and has primarily functioned through workgroups, with quarterly committee calls. Cathy Taylor Osborne has just resigned as the chair, so we have decided to only use workgroups and not have an overall committee. Thanks to Cathy, the previous chairs and committee members for their hard work. Many will still remain on workgroups.

Workgroups will include:
1. Peer Support and New Membership,
2. Technical Assistance and Program Reviews,
3. Leadership and Professional Development, and
4. Tools and Resources with Partners.

All workgroups will report their activities to Bev Isman, who will then share them with other consultants and the BOD. We can also add other workgroups as needed. Chris Vesuschio also resigned as the Associate Member Coordinator, so Kimberlie Yineman will assume that role. Note the new testimonial quotes from associate members on the Membership Information tab on the website. We now have more than 300 associate members, demonstrating the value that professionals perceive in our organization! One new project for this year is an update of the State Oral Health Plan Comparison Tool developed by the Children’s Dental Health Project. Dr. Danny Kalash, a dental public health resident, will be leading this project assisted by an ASTDD workgroup.

Evaluation Consultants
Carissa Beatty (through a contract with Emory University for training and evaluation assistance) and Mary Davis will continue to serve as our Evaluation consultants this year. They provided valuable assistance in writing our CDC applications and collecting information from state dental directors to help conceptualize our final five-year report. They also are assisting CDC DOH staff in reviewing previous CDC funded states’ final evaluation reports and newly funded states’ evaluation plans and providing TA.
John Welby:
A Voice for Oral Health

Seven years ago, John Welby couldn’t have imagined sitting on the ASTDD Board of Directors. At the time, oral health wasn’t on his radar. Today, John is an active ASTDD Board Member who is making an impact marketing the value of oral health.

In 2011, John interviewed to be the Social Marketing Director at the Maryland Office of Oral Health. He was well qualified for the position as he possessed more than 30 years of experience in health care marketing and communications. Sitting across the interview table was Dr. Harry Goodman, former ASTDD Board President and Director of the Maryland Office of Oral Health. John remembers Dr. Goodman asking, “What do you know about oral health?” John paused for a minute, then replied, “Nothing. No one ever talks about oral health in health care.”

Dr. Goodman, a bit frustrated in hearing John’s response that, yet again, oral health was off the radar, passionately exclaimed, “Exactly, that’s the problem! No one talks about oral health in health care.” John understood Dr. Goodman’s concern.

Once he was hired for the position, John worked diligently to convey the importance of oral health throughout Maryland by launching a series of successful social marketing campaigns. He created television advertising that reached out to mothers of young children, providing them with the skills needed to take care of their kid’s teeth. He placed more than 250 oral health news stories in the media as well as radio advertisements to reach Latinas promoting the safety and benefits of drinking tap water. Most recently, he conducted a statewide campaign reaching dentists and their patients with messaging promoting the importance of hypertension screenings in the dental setting.

John attributes the success of Maryland’s social marketing campaigns to many factors. Among them are three principles he feels are essential for successful communication campaigns.

1. **Define the audience you intend to reach and take time to understand them.** Accept the fact that you cannot reach everyone. Conduct focus groups to determine your audience’s knowledge and perceptions of the subject and discover how they react to your content and messaging.

2. **Keep the message simple and easy to understand.** Don’t try to say too much. This is the number one mistake people make when communicating. Restrain yourself. Effective communication is not always about what you want to say; more often it is about what the audience is ready or willing to consider.

3. **Set goals and objectives that are clear and reasonable to achieve.** Understand what the campaign is capable of and articulate what you want your audience to do after hearing or seeing it. Let the goals and objectives drive the campaign. All campaign elements such as content, strategy, and creative approach should work to achieve the campaign goals.

John follows these basic rules every time he creates a social marketing campaign. According to John, “The principles may seem simple, but their importance cannot be underestimated!” He should know, they have certainly helped him put oral health on Maryland’s radar.
California (CA) is home to more than 39 million people (U.S. Census Bureau, 2017) and has the most diverse population in the United States (Hispanic 38.9%, Non-Hispanic White, 37.7%, Asian 14.8%). A report, *Status of Oral Health in California: Oral Disease Burden and Prevention 2017*, found that the state is not on track towards achieving many of the Healthy People 2020 Oral Health national objectives, including community water fluoridation, dental sealants and tooth decay prevalence. National reports consistently rank California in the lower quartile among states with respect to children's oral health status and receipt of preventive dental services.

There are marked oral health disparities with respect to race/ethnicity, income, and education. A large diverse population, low oral health literacy, lack of resources to scale up programs, uneven distribution of the workforce, and inadequate infrastructure and capacity in the public health system have presented difficulties in delivering preventive and early treatment services. The racial and ethnic diversity of the workforce is not congruent with that of the population, possibly affecting access to services and culturally appropriate delivery of dental care.

In 2014, the California State Legislature set forth a vision to assess and improve oral health in the state. The legislature requested that the California Department of Public Health (CDPH) prepare an assessment of the burden of oral diseases in California and lead the development of an oral health plan based on the findings of the assessment. It also established the position of a State Dental Director and an Oral Health Epidemiologist with the charge of building the infrastructure for a robust oral health program. The authority to maintain a dental program is in the Health & Safety Code that includes:

- development of comprehensive dental health plans;
- consultation necessary to coordinate national, state and local agency programs related to dental health;
- program evaluation related to preventive services;
- consultation and program information to health professions, health professional educational institutions, and volunteer agencies;
- establishment of a Dental Director; and,
- ability to receive funds to establish a State dental program.

In 2015, in collaboration with the Department of Health Care Services, CDPH convened an advisory committee including state and local governmental agencies, professional and advocacy organizations, foundations, academic institutions, and other partners to develop the California Oral Health Plan 2018-2028 (Oral Health Plan). The advisory committee identified several major oral health issues to be addressed in the Oral Health Plan. These issues include insufficient infrastructure to promote culturally sensitive community-based oral
health programs; insufficient data to inform interventions; a range of barriers preventing access to care; a lack of implementation of evidence-based and demonstrable models of oral disease prevention and dental treatment; and a lack of consistent and effective messaging to encourage improvements in oral health, among other issues.

**California’s Commitment to Improve Oral Health**

California state and local governmental agencies, professional and advocacy organizations, foundations, academic institutions, and other groups have worked collaboratively and demonstrated a commitment to improving oral health in California. There have been several recent positive developments, including the re-establishment of CDPH’s Office of Oral Health (OOH); the strengthening of the dental services under Medi-Cal program, including the implementation of the Dental Transformation Initiative; and expanding dental insurance coverage under Covered California for children and families.

**Office of Oral Health**

The OOH is structured around the core public health functions of assessment, policy development and assurance identified in the 1988 Institute of Medicine Report, The Future of Public Health. The role of OOH for each of the functions is based on ASTDD’s framework -- Ten Essential Services to Promote Oral Health in the U.S. that correspond directly to the Essential Public Health Services.

*The OOH serves as a backbone organization for collective action to address oral diseases, one of the most common conditions across the life span. In collaboration with its partners, it promotes oral health and reduces oral diseases through prevention, education, and organized community efforts.*

**Current oral health initiatives include:**

- The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 includes an Oral Health Initiative, through which funding in the amount of $30 million is available annually to implement the California Oral Health Plan 2018-2028;
- Oral Health Workforce Expansion Program, which is funded by the federal Health Resources and Services Administration (HRSA); and
- Perinatal Infant Oral Health Quality Improvement Project also funded by HRSA.

**California Oral Health Plan 2018-2028 and Its Implementation**

The Oral Health Plan identifies five key goals for improving oral health and achieving oral health equity for all Californians. The Oral Health Plan details corresponding strategies and activities for each of these five priority goals. It offers the structure for collective action to assess and monitor oral health status and oral health disparities, prevent oral diseases, increase access to dental
services, promote best practices, and advance evidence-based policies. While the Oral Health Plan covers a 10-year timeframe, OOH, and its partners have used the Oral Health Plan as a basis to develop two-year action plans providing guidance to local and state entities on short-term priorities.

The OOH is partnering with 59 Local Health Jurisdictions (LHJs) to develop a statewide program for:

- building local infrastructure and capacity to promote culturally sensitive community-based oral health programs;
- supporting effective policies, funding, and communication strategies to implement both evidence-based and demonstrable models of oral disease prevention and dental treatment;
- creating visible, consistent, effective messaging;
- assessing the magnitude of the oral health challenges through surveillance that informs interventions; and,
- evaluating those interventions for effectiveness.

The OOH is collaborating with partners to improve the oral health of Californians by doing the following:

- Worked closely with the oral health advisory committee including state and local governmental agencies, professional and advocacy organizations, foundations, academic institutions, and other partners to hold an Oral Health Summit on June 19-20, 2018. OOH will continue this partnership to implement the Oral Health Plan.
- Continues to maintain and enhance collaborations within the California Department of Public Health. Staff work with the Tobacco Control Program (tobacco cessation counseling), Nutrition Education Obesity Prevention Branch (Rethink Your Drink campaign) Chronic Disease Control Branch (diabetes management), and Maternal, Child and Adolescent Health (oral health of children and pregnant women).
- Collaborates with the Department of Health Care Services’ Medi-Cal Dental Program to improve dental services including the implementation of the Dental Transformation Initiative (DTI) and Smile California, a statewide awareness and education campaign.
- Collaborates with the Department of Education (CDE) to implement the Kindergarten Oral Health Assessment requirement and conduct a statewide survey of third-grade children.
- Partners with the State Water Resources Control Board to promote the benefits of community water fluoridation and monitor fluoridation levels in public water systems.
- Contracts with the UCSF-School of Dentistry to develop a Technical Assistance (TA) Center to help local health departments (LHDs) implement the local oral health program goals and objectives.
1. What sparked your interest in evaluation?

**Carissa Beatty (CB):** I became interested in evaluation many years ago when I participated in applied projects in program evaluation and community needs assessment with local community-based organizations while I was an MPH student. I have stayed passionate about evaluation because I have seen how important it is to bridge the gap between data collection and public health action by getting the right information, in a format that is useful, into the hands of stakeholders who are in a position to use it.

**Mary Davis (MD):** When I started graduate school in public health --many years ago--evaluation was becoming increasingly important to demonstrate program effectiveness. Now I see it as an opportunity to help others make the most of their efforts to serve others and learn how to work with data and use resources wisely.

2. How did you become involved in dental public health?

**CB:** When ASTDD approached Emory Centers several years ago for evaluation support, it was an easy “yes” to join such a dynamic and interesting group of consultants! At Emory Centers, I am part of a virtual team just like the ASTDD consultants – about half of our staff are located at the Rollins School of Public Health at Emory University, while the rest, like me, are stationed at remote offices around the country.

**MD:** I became involved in dental public health through ASTDD. When I started working as a consultant, Bev and Chris reached out to me to work with ASTDD.

3. How does your educational and professional background support your work with ASTDD?

**CB:** I got my start in tobacco control and worked with a variety of public health and chronic disease prevention programs; so, I have become adept at applying “evaluation thinking” to many different circumstances and program areas.

**MD:** having two degrees in public health (DrPH and MSPH), my education focused on health promotion, health behavior, and evaluation research. From a professional perspective, I spent more than 13 years at the North Carolina Institute for Public Health where I worked with state and local health department staff on evaluation projects, accreditation preparation, and performance improvement efforts. So, I’m very familiar with how state and local health departments are organized and the types of technical assistance and support they need.

4. Why is evaluation essential in oral health programming and how can our members assure they include evaluation in their work?

**CB:** Evaluation is critical throughout the lifecycle of any public health program. From needs assessment to determine where to invest to limited resources, process evaluation to optimize the methodology and quality of our efforts to best serve our states and communities, and outcome evaluation to identify and communicate
the impact of our work – and make the case for continued funding and support. ASTDD members should keep in mind that data collection and data use should be integrated into your operations, from start to finish, so your oral health program can make the best use of its resources, and achieve the greatest impact possible.

**MD:** Evaluation and performance management can be an everyday way of doing business through a culture of quality and customer service. Evaluation and performance management don’t need to be big efforts, these can be incorporated into your work in small ways, such as asking customers if they are satisfied with the services you provide or partnering with other offices or programs on larger evaluation efforts. Evaluation and performance management let you know where you are succeeding and where you could improve.

**5. Explain your responsibilities as a consultant for ASTDD.**

**CB:** I provide training and technical assistance to states, to the ASTDD team, and to the other ASTDD consultants at all stages of evaluation – from the development of evaluation plans, to data collection and analysis, sharing lessons learned, and ensuring data are used effectively and consistently to drive decision-making. I work closely with ASTDD, CDC, and the other evaluation consultant, Mary Davis, to identify states’ training needs related to evaluation, share relevant resources, and develop training and tools to meet those needs.

**MD:** I work with state oral health programs to meet CDC oral health cooperative agreement evaluation requirements through reviewing evaluation plans and reports and connecting these programs to resources to improve their evaluation work. Also, I keep an eye out for trends in performance management that might benefit ASTDD members and assist with ASTDD’s cooperative agreement evaluation efforts.

**6. What do you like most about being a consultant for ASTDD?**

**CB:** The flexible and dynamic ways in which ASTDD facilitates collaboration among states and the consultants. The many emails, calls and virtual meetings throughout the year allow us to stay connected; speaking with states and the other consultants at NOHC each year in person is an invigorating reminder of the impact we are able to achieve through collaboration.

**MD:** Having an opportunity to work with oral health program staff and improve their evaluation efforts, work with data, and make the best use of minimal resources.

**7. What would you like to accomplish over the next twelve months as a consultant for ASTDD?**

**CB:** As many states enter into a new funding cycle, I see opportunities to collaborate with ASTDD and CDC to continue to build an even more robust evaluation culture both within ASTDD and the SOHPs.

**MD:** I would like to continue to expand my work with CDC-funded state oral health programs through advising on development of evaluation plans. Also, I’d like to support state oral health program capacity to use evaluation and performance management.
New ASTDD CDC Cooperative Agreement Activities

by Beverly Isman, RDH, MPH ELS

Activities will focus on three strategies required by CDC:

**Strategy 1: State Technical Assistance and Capacity Building** around BSS and dissemination of oral health surveillance information, performance of core functions and essential public health services to promote oral health, evaluation and quality improvement, and evidence-based prevention, especially school-based sealant program and community water fluoridation. ASTDD will work collaboratively with CDC to coordinate peer communities of practice, professional development opportunities, and templates and resources for states and highlight state successes. As noted in my regular column, we have initiated contracts with AAP and Jacob Strategies.

**Strategy 2: State Oral Health Program and Capacity Assessment** primarily through use of the State Synopses and other queries that allows comparison by state and funded vs non-CDC-funded states.

**Strategy 3: Territorial Oral Health Program Assessment** and Technical Assistance (year 01 only) provides a new opportunity. ASTDD will assess and report on oral health program infrastructure and capacity, identifying strengths, gaps and needs for the U.S. Affiliated Pacific Islands (U.S. Flag Territories of Guam, the Commonwealth of the Northern Mariana Island and American Samoa); the three Freely Associated States of the Republic of the Marshall Island, the Republic of Palau, and the Federated States of Micronesia) and the Caribbean islands of Puerto Rico and the U.S. Virgin Islands. Specifically, we will:

- Convene an advisory workgroup of representatives from key organizations (e.g., Pacific Islands Health Officers Assoc, Pacific Basin Dental Assoc, Pacific Island Primary Care Assoc, HRSA, CDC, NACDD’s Pacific Chronic Disease Coalition, ASTHO), to be staffed by an ASTDD territorial liaison (Dr. Reg Louie)
- Review existing information, and identify potential challenges and resources for territorial oral health programs
- Develop and administer a needs assessment that documents past and current infrastructure and capacity and future needs for TA, training and other resources. We plan to use an ethnographic approach that shows cultural influences and highlights issues using stories and examples. We will conduct most of the needs assessment for the Pacific Islands at a meeting in Honolulu of the dental chiefs who can highlight the history of oral health status and programs on their islands, their current efforts and existing resources, and ongoing needs for the islands and their programs. This would include how to reinvigorate the PBDA to promote communication. We have contracted with PIHOA and Dr. Ohnmar Tut, a long-time friend of ASTDD who has provided years of assistance to the islands, to help accomplish this. We also have contracted with Magda de la Torre from San Antonio to be our Caribbean consultant.
New ASTDD CDC Cooperative Agreement Activities

continued

• Analyze and summarize findings and compile into a draft report that will be reviewed by the dental chiefs with recommendations to CDC for how they and other groups can help address the diverse needs of the islands. We will submit an abstract for a panel at the 2019 NOHC to highlight the project and territorial needs.
• Provide selected TA/training to territories. Some training/TA will be offered during the Honolulu meeting, based on topics selected by the dental chiefs. Dr. Tut and other consultants may be able to provide TA to individual islands depending on needs and funding.

In implementing the activities for this strategy, the great distances and varying available logistical, cultural and administrative infrastructures, and other significant challenges will need to be addressed and surmounted. We have made wonderful progress already, with multiple emails and phone calls among the key players, and contracts negotiated with NACDD, PIHOA and the consultants. Dr. Tut and Bev Isman were able to connect at the recent IADR meeting in London, where Bev also talked briefly with the Chief Dental Officer for Puerto Rico. On September 5 and 6 Dr. Louie presented an overview of our proposed approach at the PIHOA meeting in Honolulu where he was able to discuss the project with many of the health ministers and directors. In addition to establishing formal contacts with PIHOA, contacts were made with two more key project partners, PBDA and PIPCA, and other partners/stakeholders, e.g., HRSA, CDC and the NACDD-Pacific Chronic Disease Coalition.
National Maternal and Child Oral Health Resource Center News

ASTDD Early Childhood Committee (EC) and National Center on Early Childhood Health and Wellness (NCECHW)

Michelle Landrum is the consultant to the EC and also ASTDD’s primary consultant to the NCECHW. Because most of the EC activities relate to the NCECHW project, having a separate committee in addition to the NCECHW oral health workgroup is somewhat redundant, so ASTDD will be retiring the committee as a whole and only working through specific workgroups, such as the home visiting one. We would like to thank Chris Farrell who has served as the chair, and all the members for their valuable contributions over the years!

The NCECHW oral health team will continue to call upon their expertise when needed. ASTDD hosted a webinar in July for the Dental Hygienist Liaisons (DHLs) on Promoting Key Oral Health Messages in Early Childhood Programs. We submitted our 3rd quarter DHL report to the OHRC and will be submitting the 4th quarter one in the next two months. See the separate article on NCECHW recent meetings.

COHSII and PIOHQI Project

As highlighted in previous issues and elsewhere in this newsletter, the National Maternal and Child Oral Health Resource Center (OHRC) is the recipient of a four-year COHSII cooperative agreement from MCHB. OHRC and its consortium partners, ASTDD and the Dental Quality Alliance, work with key stakeholders to improve existing systems of care in support of a quality improvement, patient-centered approach that addresses the comprehensive oral health needs of the MCH population. Examples of progress for year 1 include:

- Responded to 278 requests for TA and training, working in or with state Title V agencies,
- All states addressing Title V National Performance Measure (NPM) 13 on oral health received TA and training,
- Supported PIOHQI states by hosting a discussion list, 10 learning events and meetings, and monthly interest group web meetings,
- Responded to 194 requests for TA and training from PIOHQI projects,
- Produced and disseminated 12 educational resources

ASTDD consultants continue to participate in weekly team calls and monthly learning events with OHRC and FrameShift Group for the PIOHQI state grantees. At the end of 2019, PIOHQI projects will have defined and implemented evidence-informed models used to successfully integrate high-quality oral health care into perinatal and infant primary-care-delivery systems with statewide reach. FrameShift Group brings a unique perspective and

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expertise in quality improvement—a key part of this project. The state teams are expected to establish “learning laboratories” at local sites such as FQHC’s, and test ideas at these single sites; the datasets collected are small and generally limited to the site. If successful, the states will try to sustain the site and, if possible, replicate it elsewhere and perhaps statewide. If not successful, they analyze the situation and apply quality improvement strategies. An onsite Learning Session in Alexandria, VA took place on Oct 15-17, with much of the focus on using a sustainability framework. For more information about the COHSII-PIOHQI activities go to: https://www.mchoralhealth.org/projects/piohqi.php.

The OHRC also received supplemental funding from HRSA, MCHB to work with six state Title V MCH agencies that are addressing NPM13 and implementing strategies to improve access to oral health in primary care settings. The intervention will provide TA and training to one selected primary care setting for each MCH agency to focus on implementing the interprofessional oral health core clinical competencies for primary care to increase integration of oral health care into primary care. Planned activities build on a pilot program funded by HRSA in 2013 and implemented by the National Network for Oral Health Access (NNOHA). The project runs through June 30, 2019. Together, OHRC and its consultants will facilitate state teams’ ability to advance systems change in workforce training and clinical care.

The COHSII Quality Indicator Advisory Team (QIAT) has developed a set of maternal and child health (MCH) quality indicators to monitor oral health services delivered in public health programs and systems of care at the national, state, and local levels and to inform the development of a national MCH oral health action plan. *Report: Oral Health Quality Improvement for the Maternal and Child Health Population: Identifying a Set of Quality Indicators.*

Evaluation data show high positive response to the OHRC’s *Bright Futures: Oral Health Pocket Guide* (3rd edition), and *Special Care: An Oral Health Professional’s Guide to Serving Young Children with Special Health Care Needs* (2nd edition) is the second most popular resource on their website, with 321 professionals taking the course for CE credits.
Recent Meetings

NCECHW Oral Health Workgroup Meeting
August 1, 2018, Georgetown University, Washington DC
Reporting: Michelle Landrum and Gina Sharps

The National Center on Early Childhood Health and Wellness (NCECHW) Oral Health Workgroup Meeting was held on August 1, 2018 at Georgetown University in Washington, DC. The meeting was hosted by the National Maternal and Child Oral Health Resource Center. Participants included NCECHW Oral Health Workgroup members, federal representatives from the Office of Head Start and the Office of the Surgeon General, and a representative from the American Academy of Pediatrics.

The purpose of the meeting was to gain insight from the participants on recent and upcoming activities or policies to inform the NCECHW year 4 oral health workplan. Highlights of the meeting included: proposed changes for the 2019-2020 Head Start Program Information Report; the Surgeon General’s report on oral health; collaboration between the NCECHW and other national centers; expanded training and technical assistance provided by NCECHW; review of NCECHW key oral health messages, activities, and implementation strategies; results and implications of the dental hygienist liaison (DHL) annual survey; and discussion of hot oral health topics to be addressed in the NCECHW year 4 oral health workplan.

Regional Dental Hygienist Liaison Coordinators Meeting
August 13, 2018, Chicago, IL
Reporting: Michelle Landrum and Gina Sharps

The regional DHL coordinators met at the American Dental Hygienists’ Association (ADHA) headquarters in Chicago, IL on August 13th, 2018. ADHA’s Ann Battrell, Ann Lynch, and Bob Moore were on site to extend a warm welcome and to personally thank the DHLs for their work in improving oral health equity. The purpose of the meeting was to evaluate year 3 activities and develop priorities for the year 4 DHL project workplan. Goals of the workplan specifically target activities to promote the DHL as a communication link between the National Center on Early Childhood Health and Wellness (NCECHW), state-level stakeholders, and early childhood education programs.

Key Priorities for Year 4 of the DHL Project
• Enhance DHLs’ capacity through training and technical assistance
  – Targeted activity includes the development of an implementation guide that defines “oral exam” versus “oral health screening” and how to access the dental periodicity schedule. The guide will provide instructions on how to locate the dental periodicity schedule and who can legally perform an oral exam in each state.
• Build or enhance DHL relationships at the state level through collaboration with key stakeholders
  – Example of planned activities include presentations at the Head Start virtual health managers’ orientation and hosting a webinar on utilizing Early Childhood Learning and Knowledge Center (ECLKC) oral health resources to increase DHL collaboration with stakeholders.
• Improve DHL recruitment and engagement by promoting the DHL project within ADHA
  – Example activities to build upon from 2018 include a presentation at the ADHA 2018 annual conference, a reception at the NOHC and a feature article in ADHA’s Access publication highlighting the work of DHLs.

Contact information for all state DHLs can be found at www.astdd.org/head-start-state-dental-hygienist-liaisons-information. Click on “DHL Roster” at the top of the page.
States with new state dental directors from 6/2018 through 10/2018. For their contact information and to welcome them to ASTDD please go to www.astdd.org/membership-roster

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