Dental Public Health
State Activity Submission Form

ASTDD's goal in collecting information about successful state Dental Public Health activities (e.g., practice, program, service, event, or policy) is to share this information with other states, territories, and stakeholders who may be interested in implementing similar activities. We thank you for your time and willingness to share your experiences.

Please complete the form below and return to Lori Cofano, ASTDD Best Practices Project Coordinator, at lcofano@astdd.org

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STATE DENTAL PUBLIC HEALTH ACTIVITY (e.g., practice, program, service, event, or policy) Minimum=300 Maximum=500	
Activity title:	**Generating Equitable Health Rankings: Identifying Oral Health Burden Across Colorado**
State/Territory:	**CO**
Summary overview, which may include the following: • Objectives • Rationale • Personnel • Key partners • Costs & sustainability	
The Colorado Department of Public Health and Environment Oral Health Unit (CDPHE OHU) and chronic disease epidemiologist utilized modifiable determinants of health and county-specific race and ethnicity data to identify and prioritize counties in Colorado with the highest healthcare needs. The County Health Rankings (CHR) model was selected as the method of choice based on its applicability and proven ability to effectively rank counties. To include an equity lens, the race/ethnicity breakdown of each county was compared with the CHR composite scores. These results were compared to current partner coverage areas to identify and prioritize communities in need and opportunities for funding support for oral health interventions. Additional comparisons to communities with higher populations of adults identifying as non-white were also conducted in order to implement an older adult oral health collaboration initiative between the OHU and the Colorado Department of Human Services Unit on Aging.	

All 64 counties in Colorado were ranked from greatest to least oral health burden. Of the top 10 prioritized communities, current CDPHE OHU local public health grantees have conducted, or are currently conducting oral public health activities such as outreach, education, preventive services, etc. in roughly 50 percent. The OHU has also identified older adults (60+) as a priority population and results from these analyses showed a 100 percent overlap between prioritized communities and current OHU-funded grantees. Currently, CDPHE OHU and the chronic disease epidemiologist are working to create a map to visualize the county rankings in alignment with CDPHE OHU grantees.

The CHR model can be applied to program-specific planning to identify how need varies across the state. This work has helped guide the OHU in their upcoming strategic planning process, as well as strengthen partnerships and identify new ways to collaborate.

This project was supported by CDC, HRSA, and state funding.

Lessons learned (Successes and **Challenges**):

- The County Health Rankings Health Factors model is broken into four components: Health behaviors, clinical care, social and economic factors, and physical environment. Each of these components have assigned weights defined by County Health Rankings and Robert Wood Johnson's decade of research in this area. However, determining weights for indicators within each of the component areas had many challenges. In order to prevent these decisions being made subjectively, the process for determining weights was guided by several considerations, including what was seen in literature, input from program staff, program funding, and weights from other rankings.
- Similar to the above, special consideration was taken to identify the total number of indicators included in each component area. This is because too many indicators would dilute the model. The total number of indicators included in each component area was determined after gathering input from program staff and partners, while considering what programs we were currently funding, in order to determine what indicators were the most important to include.
- CDPHE elected to develop a general oral health model as opposed to developing specific models identified by topic areas. Due to limitations with data availability and small sample sizes, it was determined a general oral health index would provide the most reliable results until new data sets are created/available.
- Due to a lack of robust oral health databases as well as a lack of robust sample sizes at the county level, CDPHE elected to aggregate more than three years of data to have a large enough sample size.
- In addition to the lack of availability of data sets as highlighted above, CDPHE also encountered a lack of population specific data for communities at greatest risk for poor oral health outcomes (e.g. older adults ages 60+, Native American/Alaskan Native, Black/African American, etc.). The main data source for oral health data is the Behavioral Risk Factors Surveillance System (BRFSS), which is a population-based survey. Unfortunately, population-based surveys do not typically include a robust data collection for specific populations including Black, Indigenous and people of color (BIPOC). Colorado recognizes a need for additional surveillance data which utilizes other data collection methods such as community-specific surveys and recognition of social determinants of health leading populations to increased risk. In an attempt to address this challenge for the older adult Latinx project, CDPHE OHU elected to utilize the CDHS state demographic dataset, which included a population estimate classification of "Minority 60+".

TO BE COMPLETED BY ASTDD	
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