A. Title: Identification of Issues and Solutions for a Collaborative Oral Health Plan in Texas

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B. ABSTRACT

Objectives: To explore oral health barriers in Texas, find opportunities to improve oral health in the State, and based on the information gathered, activate a collaborative, evidence-based oral health plan in Texas. The plan was informed by Preventive Services Task Force evidential recommendations and the Association of State and Territorial Dental Directors (ASTDD) Best Practices and Guidelines for state oral health programs. **Methods:** The University of Texas Health Science Center at San Antonio (UTHSCSA), Department of Community Dentistry collaborated with the State Dental Director based at Texas Department of Health, which later was renamed as Texas Department of State Health Services (TDSHS), and Title V Maternal & Child Health Bureau Director, (MCHB). A Steering Committee was formed and met to define the role of committee members, discuss the project's aims and objectives, plan the five Regional Listening Sessions and review an initial draft of a Texas Oral Health Plan. A key component of this plan was the organization, conduct and summarization of listening sessions in five regions of the State which are described in this report. The Listening Sessions involved local stakeholders, consumers and community leaders. The regions for the Listening Sessions were Houston, Dallas, Lower Rio Grande Valley, El Paso and Austin. **Results:** Over 440 stakeholders from all regions attended. From each region a summary report was made and the key topics were extracted which were considered in terms of 'issues,' and the suggested oral health improvements in the particular region of Texas were considered 'solutions.' **Conclusion:** The project was successful in bringing advocates and stakeholders together and as a result several regions began coalition/advocacy work. An oral health plan for Texas was subsequently drafted and disseminated to TDSHS, MCHB, Texas Health and Human Services Commission (THHSC), and office of Health Resources & Services Administration (HRSA).

C. APPLICANT'S ROLES

As the coordinator for this phase, the author contacted potential committee members, and updated their contact information, which led to the final master contact list of the steering committee members. She wrote the timeline for the project while attending weekly project meetings with the directors. **Implementation:** The author by telephone, e-mail and in person worked with all the regional consultants providing guidance and technical, resource and informational support prior to, during and at the completion of each listening session. During each listening session, she recorded testimonies and later synthesized all the topics as issues and solutions per session with the Project Co-Directors. She forwarded the summaries to the Texas Dental and MCH Directors as well as members of the steering committee for additional feedback. She followed up each listening session with an electronic "thank you" to all the participants, addressed their further needs/questions, edited the summaries, exchanged a compiled listserv of all participants per region with the project secretary and assisted her as needed. **Contribution:** The author further summarized the listening session input for later application to the Collaborative Oral Health Plan in Texas (Appendix A). She attended the Texas Oral Health Summit in Austin and summarized the closing session for future use. **Participation:** The author participated extensively including traveling to the different regional sessions, reporting the results, researching ASTDD's and CDC's guidelines and providing technical support to the consultants. Additionally, she attended State Children's Health Insurance Program (SCHIP) coalition meetings; drafted letters to the State Senators (see Appendix B) to highlight the project, and wrote this report.

D. PURPOSE OF THE PROJECT

The purpose of this project was to explore oral health barriers in Texas, find opportunities to improve oral health in the State, and based on the information gathered; activate a collaborative, evidence-based oral health plan in Texas. The plan was informed by the Preventive Services Task Force evidential recommendations and the Association of State and Territorial Dental Directors (ASTDD) best practices and Guidelines for state oral health programs.

E. BACKGROUND, REVIEW OF THE CURRENT PERTINENT LITERATURE

Fluoridation of community water supplies along with school-based sealant programs have been found to be the most effective dental public health preventive measures, particularly for children[1]. Currently in the United States, despite efforts to reduce dental caries, tooth decay is the single most common chronic disease of childhood and is more prevalent than asthma[2]. Children in the lower socio-economic groups, which constitute 25% of the total population, experience up to 80% of dental caries in their permanent dentition and often lack access to dental care[3]. The low oral health utilization rates of vulnerable groups are exacerbated by a shortage of dentists who are willing to accept patients with Medicaid[4]. States report that inadequate reimbursement has been among the reasons why dentists don't accept patients with Medicaid[4]. Data from a few states that have raised fees show that the fees are only part of the reason why dentists are not willing to accept patients with Medicaid[5]. An Agency for Healthcare Research and Quality (AHRQ) supported study found that poor children also have significantly fewer preventive and more emergency dental visits than those from higher income families[6, 7].

Texas, with a growing population of 22 million, has 3.3 million people below the poverty level in its 254 counties of which 58 are metropolitan and the remainder either rural or frontier. Planning and implementing oral health advocacy efforts in Texas is challenging due to its geographic size, diversity and distance. The low income and vulnerable populations in Texas have higher levels of dental disease. According to a San Antonio area survey conducted by the Department of Community Dentistry, Dental School, UTHSCSA (WHO, 1997) among 12-13 year old students, 11% reported having had a toothache and missed school as a result of chronic dental pain[8]. This relates to 2,970 of the 6th-7th graders in San Antonio who had missed school as a result of pain and infection[8]. In 1999, the Department of Community Dentistry, UTHSCSA conducted a statewide Texas survey of children from lower income families and found that among the children of low income status there was a higher prevalence of caries experience (see Table 1)[9]. A collaborative study between the Dental Health Task Force of the Greater Houston Metropolitan Area and the Department of Community Dentistry, the Dental Branch, University of Texas Health Science Center at Houston on children was conducted for TDSHS in order to obtain baseline data for monitoring and evaluating future programs[10]. It highlighted the unequal proportions of untreated caries and preventive sealants present among the children in different counties of Region 6 (see Tables 2, 3)[10]. In A Behavioral Risk Factor Surveillance Survey of Bexar County[11] (2002), adult participants reported having an annual dental exam if they were more affluent, educated, white and had medical insurance (see Tables 4, 5, 6)[12]. It has also been indicated that "high risk" groups such as diabetics, smokers and chronic alcohol

users, who have an increased prevalence of oral disease, are not accessing routine dental care at the same rates as healthier adults[12].

This project responded to the call by the U.S. Surgeon General in his report "A National Call to Action to Promote Oral Health,"[13] on the need to contribute to a National Oral Health Plan that improves quality of life by promoting oral health, eliminating health disparities and collaborating among individuals, health care providers, communities and policymakers at all levels of society. The project also supported the call by the ASTDD for State Oral Health Improvement Plans[14], addressing Healthy People 2010 Health Objectives[15] as well as the Preventive Health Services Task Force evidence-based reports[16].

F. RATIONALE OF THE PROJECT

In a time of unprecedented state budget restrictions, the oral health budget of TDH was cut by 70% from $2.7M in FY 2003 to $0.805M in FY 2004 to an estimated $0.753M in FY 2005. The budget reduction resulted in the loss of 37 TDSHS oral health staff members and reduction of operating regions from 8 to 5. Major emphasis was placed at the state level since the greatest deficit in public oral health and dental services was being experienced at that level, such as the elimination of dental services from the State Children's Health Insurance Program (SCHIP), more stringent Medicaid enrollment/re-enrollment conditions and the closure of the Department of Community Dentistry, Dental Branch, University of Texas Health Science Center at Houston. Additionally, Texas does not have safety net dental Medicaid coverage for adults and the State continues to appeal the case for improved Medicaid access for children brought by Susan Zinn, J.D. for Texas

Rural Legal Aid; this despite the U.S. Supreme Court having ruled in the plaintiff's favor[17]. It was during the course of this project TDH underwent further reorganization and was renamed the Texas Department of State Health Services (TDSHS).

G. PROCEDURES AND METHODS

This project was exploratory in nature and involved qualitative research, encompassing observational techniques. A review of existing Texas oral health data and oral health strategy and policy was conducted for the project. The UTHSCSA, Department of Community Dentistry, TDSHS Dental and MCH Directors collaborated to create a Steering Committee of stakeholders who organized Oral Health Listening Sessions in five regions of Texas. The Steering Committee met to define the roles of its members, discuss the project's objectives, and approve planning of the five Regional Listening Sessions. Through an official invitation, the Steering Committee was comprised of fourteen members from diverse organizations (see Figure 1). A timeline for the Listening Sessions was drafted by the coordinator/directors of the project and sent to the members for revision and verification (see Table 7). The five listening sessions were organized, conducted and summarized to assess challenges and to express opportunities to improve oral health in Texas. The focus of the listening sessions was on oral health needs assessment, prevention of oral diseases, access to needed oral health services and the existing infrastructure for oral health services in Texas by region. The regions for the Listening Sessions were Houston, Dallas, Lower Rio Grande Valley, El Paso and Austin, which also included San Antonio.

Participants. In addition to the Steering Committee members, regional consultants participated in organizing the Listening Sessions. These consultants contacted opinion

leaders from community organizations and advocacy groups in the different regions of Texas and compiled a list of local attendees as well as sent invitation letters via fax, e-mail and post, encouraging local advocates to participate in the Listening Sessions. These consultants arranged flexible times for each listening session, opened each session and set the agenda. At each session the State Dental and MCH Directors along with the Project Directors served as the panelists 'to hear' the participants' testimonies as well as a Spanish translator who facilitated communication.

Data Collection. The data or 'testimonies' were collected in written form such as e-mail, post and oral personal presentations. A deadline of April 29, 2004 was set for forwarding additional written testimonies for all of those who were unable to attend the Listening Sessions. All of the Listening Sessions were tape recorded.

Qualitative Analysis. At the conclusion of each Listening Session, based on the information provided in terms of oral or written testimonies, a tentative summary was drafted for each session. This draft was shared for verification, editing and subsequently exchanged with the State Dental and MCH Directors and disseminated to the steering committee members for feedback. From these summaries key topics were extracted to include perceptions of oral health in the particular regions of Texas, which were considered 'issues,' along with suggestions for oral health improvements in the particular region of Texas, which were labeled 'solutions.' These five Listening Session summaries were analyzed by seeking different patterns of input, minority points of view and common themes.

H. FINDINGS

Attendees' Identified Oral Health Issues. A total of 440 participants from diverse backgrounds attended the five regional listening sessions (see Appendix C). They identified many challenges. They identified issues and recommended situations were categorized under the following findings: awareness; access to care; advocacy and policy; barriers and deprivation; communications and collaboration; oral health education; resources and funding; surveillance and needs assessment (See Appendix A). Although at the regional level core issues were expressed in different ways, striking similarities were noted between the regions. In general, testimony focused more on services and less on public health infrastructure and planning.

Awareness. Most regions had issues with the public's lack of awareness about existing public health facilities, availability of Medicare and Medicaid coverage and Medicaid eligibility criteria, which led to overutilization of hospital emergency rooms. Dentists expressed the common practice of 'writing off' dental services by not charging the Medicaid eligible patients. Such practices have led to a lack of awareness with regards to Medicaid billing criteria and contributed to lower participation rate data.

According to a TDSHS representative "*Oral health is not a luxury; it is the cornerstone for health.*" A group of dentists believed they had raised the public awareness through organized volunteer dental campaigns such as Texas Mission of Mercy (TMOM). Others felt that charity was a short-term solution to partially address the bigger issues in rural areas and while acknowledging TDA charitable efforts, they felt this could only enhance the current delivery system and not to replace it, i.e. "*Charity is not a health care system.*"

Other views ranged from raising oral health awareness of the mothers-to-be and focusing on their empowerment, development of culturally sensitive educational brochures for low income families, to updating and publishing the list of Medicaid dental providers on the web. A few dentists were not fully aware of the status of the public health system in Texas, as a private practitioner admitted *"I have been a private dentist for 32 years and never understood the extent of the problem until I retired and started to work in a community health center"* and as a public health dentist stated *".....every day I pass through a waiting room full of people to get to the dental chair."* A representative focused on raising awareness of dental students by providing them with internships in rural areas. A member of the Texas chapter of Diabetes Association wanted to increase awareness about diabetics' oral health to include availability of local dental providers. Overall, participants were not aware of the few regional collaborative oral health efforts such as the Arlington sealant program, Methodist Healthcare Ministries of San Antonio and the THEO project of Austin.

Access to Care. Attendees agreed that access to care was a direct result of the lack of oral health providers, lack of facilities for such care and lack of public resources for elderly patients, low income children, people living in rural areas and those physically and mentally challenged. The Head Start representatives felt that children below age 5 had limited access to oral health services and to dental coverage. Concerns were raised over the estimated dentist-to-population ratio that is as low as 1:4,400 for the El Paso region and 1:2,400 for Texas. Overall, many counties in each region lacked the presence of a licensed dentist and the great majority of dentists were not Medicaid providers. One School District Superintendent was concerned with Medicaid reimbursement, stating that

"The Texas reimbursement schedule is outdated and cheap." Solutions ranged from enhancing Medicaid provider participation through faster/electronic billing procedures, reducing prior authorization requirements, and that Medicaid needs to be more user friendly for patients to qualify. Most agreed that the TDSHS Regional Mobile Dental Unit Programs needed to be re-instituted since it had been very effective in delivering oral health care in frontier areas. Expansion of Federally Qualified Health Centers in rural communities was encouraged as well as the re-opening of previously closed clinics since these facilities were often the only place to access oral health care in rural areas. Great emphasis was placed on the fact that all community health centers could provide dental care. Currently only a percentage of community health centers provide dental services in Texas.

Advocacy and Policy. Many participants sought a change in current oral health policy through the mode of advocacy. A regional TDH dentist wanted the State to advocate for the oral health needs of the indigent children of Texas, by providing a uniform standard statewide dental program, *"Everyone knows what the dental needs are. It is time to stop having meetings and to start taking some action."* El Paso, Dallas-Fort Worth and Houston area regions had existing local coalitions to assess and advocate for the oral health needs of their populations and San Antonio had a fluoridation coalition which attained that goal in 2000. In most regions dental hygienists wanted a policy change in their professional duties by having less restrictions from the Texas Dental Practice Act, permitting them to provide a wider range of dental care to those in need. They wanted to provide topical fluoride and sealant applications under indirect dental supervision as well as reimbursements through a third party payer in order to be effective Medicaid providers

in Texas. Hospitals and faith-based organizations had initiated their own advocacy by addressing oral health discrepancies in Texas in terms of utilizing school-based clinics and mobile van units to increase access, thereby limiting the public's emergency room utilization.

The participants overwhelmingly advocated for reinstating the SCHIP Dental benefits for reimbursement, which in the past had effectively ensured that needy children had some level of oral health care. Prominent solutions were advocacy for community water fluoridation and influencing members of the legislature to become supportive of fluoridation policy changes. Other solutions ranged from: 1) the existing coalitions encouraging other regions to form similar groups; 2) a change of the existing dental licensure to include the provision of dental care for patients with Medicaid as a state dental licensure requirement; and 3) seeking federal/state legislation to give dentists and physicians a tax deduction/tax credit on their personal federal income tax in exchange for health care rendered to qualified indigent patients. A minority group sought to expand a new policy that would allow certified dental assistants to place dental sealants and a mandated policy regarding dental checkups and sealants which should exist in all schools prior to registration, similar to that of vaccination requirements.

Barriers and Deprivation. Attendees agreed that major barriers to the oral health care delivery in Texas included physical, educational, cultural, language, socio-economic and transportation factors. According to participants, deprivation played a significant role in oral health practices in Texas. With deprivation, oral health priorities declined not only for rural communities but also at the heart of metropolitan communities. Referrals to dental hygiene programs and dental schools due to provider barriers in turn manifested

other barriers such as transportation and finances for the patients. In the Presidio community, obtaining oral health care generally required travel to the El Paso or Midland areas and for a predominantly disadvantage population, this represents a hardship. Other issues ranged from the existence of severe tooth decay among children in Head Start with additional barriers related to beliefs and behaviors of the parents.

The District Dental Society of El Paso reported an unpublished 80-question dental health survey which was conducted at WIC clinics to assess the dental needs of the low-income children of El Paso[18]. The survey was administered to approximately 400 mothers and the results highlighted oral health barriers such as socio-demographic, oral health knowledge, dental history and dental health care practices (see Tables 8, 9). The U.S.-Mexico Border Health Commission agreed that in both countries Hispanic children and in particular the children of Hispanic migrant farm workers had the greatest oral health needs. They also lacked dental health insurance. Thus, an unknown proportion seeks culturally acceptable dental care in Mexico. Additional Listening Session participants reported that barriers existed for the elderly, that the elderly did not receive adequate oral health care and also were physically challenged due to transportation barriers. Solutions ranged from standardization of dental care for the border region to solving the special barrier for undocumented nationals, where the fear of being exposed reduces local dental clinic utilization and leads to increase utilization of the emergency room care.

Communication and Collaboration. In most regions, attendees expressed the need for multi-agency collaboration in order to facilitate effective oral health practice in Texas. A shared view was the lack of communication not only among oral health professionals but

also among health professionals. Some wanted dentists and physicians to exchange speakers at their monthly meetings and exchange articles for their journals. It was agreed that the ongoing lack of communication between professional dental organizations and coalitions may lead to the exhaustion of current resources and in turn duplicate efforts. Seeking participation and collaboration for dental services through school-based health centers was of importance in all regions, followed by collaboration between TDSHS and the Texas Education Agency (TEA).

As for solutions, the preference was to achieve a more effective collaboration between the dental and medical professionals as well as local oral health care coalitions, school districts to include nurses, dental hygiene and dental schools staff, social workers, legislators and all other community providers. Since physicians tend provide health care to patients of all ages, such level of professional communication is vital for the dental community. Many pointed to the current successful models of collaborations between the TAMU-Baylor and UT dental schools as well as dental hygiene programs involved with health related agencies and organizations in both prevention programs and dental care delivery. Some wanted school nurses to play a more collaborative role with regard to dental screenings while others emphasized the communication with dentists from Mexico could enhance quality of oral health along the border areas.

Oral Health Education, Promotion and Prevention. Most attendees emphasized the educational approach. They wanted to educate health care professionals including dentists, physicians, school nurses, dental hygienists, dental assistants, nursing home and long-term care managers and non-health professionals such as teachers, school administrators, legislators, public officials and members of the public that address

children, mothers and elderly caregivers. Some felt that a lack of patient education was among the reasons for current oral health disparities: *"Patients do not take responsibility for their own oral health"* and *"we must change the mindset of the public."* Solutions ranged from other members of the health professions such as physician assistants and nurses providing preventive services (e.g., fluoride varnish) to educational opportunities for school nurses to learn about standardized dental screening methods. Others wanted to educate legislators by way of personal visits or letter writing campaigns containing literature to be distributed in order to catch their attention about options: *"thinking outside the box."* The majority of attendees agreed that the shift should be away from treatment and towards preventive care especially for children. Advocates expressed the need for continued promotion of evidence-based dental practices such as increasing and monitoring community water fluoridation and expansion of school-based sealant programs. The school-based dental sealant program in Arlington was profiled as an example of a sustained effort in expanding community preventive service.

Resources and Funding. Attendees agreed that the current Texas Medicaid system of care, including the capping of available funds and limiting enrollment time of Medicaid cannot provide adequate coverage for all the actual dental expenses. Consequently, additional resources such as community-based dental clinics exist to provide oral health care services to the most vulnerable. Feedback from all the regions indicated that financial and dental health personnel shortages exist and expansion as well as re-direction of existing resources was necessary. Some attendees suggested employing additional trained personnel, retraining existing personnel as well as combining resources with other organizations/systems to expand access to dental care. Some attendees suggested

employing additional trained personnel, retraining existing personnel as well as combining resources with other organizations/systems to expand access to dental care. Some attendees wanted to attract dentists by providing loan repayment at the state level, as well as expand opportunities for dental programs in schools and nursing homes/ long-term care facilities and others expressed expanding the current dentist's hours of operation.

It was recognized that the current State oral health budget is limited. Due to TDSHS oral health budget reductions, oral health programs have been cut forcing some people in border regions not to seek regular dental care while others end up in city/county hospital dental clinics that only provide emergency adult oral health services. Constraints of resources have also influenced the mix of dental services available in some regions such as the El Paso Community College Dental Assisting/Hygiene program. Like dental care in most dental hygiene programs in community colleges the care in that facility is limited to dental hygiene services with the challenge of sustaining an effective referral system for patients needing follow-up treatments. A retired oral surgeon who teaches oral radiology at the El Paso Dental Hygiene Program is unable to provide oral surgery care for the patients at the school clinic. Some dental society members wanted more funds to target dental care from the federal government sources, *"Federal priorities on spending – Go to Mars? Or provide health care to our citizens."* Others wanted to access county funds to increase resources available for oral health services. The Presidio Independent School District suggested excluding orthodontic treatment from Medicaid, "*...We really don't need to be putting braces on kids,"* and focus on basic dental services.

Although the Texas Oral Health Program mobile dental vans delivered effective oral health care to children, they were terminated in some regions due to a scarcity of funding at the state level. As the director of one clinic stated *"... at state level there is no vision"*. According to some attendees, in effort to resolve oral health issues several resources may have been laterally delivering similar care without much direction or coordination from the State level. Some school districts members wanted dental services provided through a mobile dental unit; while other districts expressed that even with additional availability of such resources they still receive calls daily and have an extensive wait list. One district was supported by $400,000 from city funds to provide dental care and it was not enough to address the need. The El Paso City Dental Services applied and received funds from Title V of MCH to operate a mobile dental van through the county only to experience a shortage of dental providers.

Patients living on the U.S.-Mexico border utilize dentists in Mexico in order to deal with the shortage of resources. The quality of oral health care is questionable in many areas due to application of standards of dental care. In Juarez, Mexico, health officials estimate that about 1,000 individuals are practicing dentistry, of which less than half of those are believed to be licensed. A representative of the health commission expressed gratitude that at least there were available resources in Mexico for adults in the U.S. to access care stating that *"...dentists in Mexico may not provide the highest quality work but they provide services at least."*

Surveillance and Needs Assessment. Many attendees wanted the school nurses to screen children as part of an ongoing surveillance system and the TDSHS to coordinate surveillance efforts. Several participants at the regional oral health Listening Sessions

discussed local and health assessments but there appeared to be no state level coordination or standardization of methods in these efforts.

I. DISCUSSION

The participants in all the regions were dedicated to enhance oral health care for Texans. They came from many different educational backgrounds; many of them had spent their entire career in public health. Their major concerns were access as an issue and resources in terms of time and money as solutions (See Figure 5). Dentists had the perception that if fees for dental services in Medicaid were increased the proportion of patients needing dental services will decrease. This view was expressed despite the fact that studies have indicated that raising Medicaid fees alone has not led to a substantial increase in participation of Medicaid dental providers and that other factors influence access to dental care for individuals enrolled in Medicaid. The dental hygienists were willing to expand their services to improve access to dental care if the current Dental Practice Act in Texas was changed. Given that dental professionals are directly or indirectly involved in the promotion of oral health, it is important that oral health promotion is focused around achieving equity in health, reducing oral health diseases and ensuring resources in a supportive environment. According to Ottawa Charter for Health Promotion, access to information and oral health education along with life skills and opportunities for making healthy choices is only part of an effective strategy for influencing determinant of health and improving health outcomes for populations[19]. Health promotion actions also include building healthy policy, creating supportive environments, advocacy, enabling individuals to achieve their fullest health potentials, strengthening of community action, development of personal skills and reorienting health services[19](See Figure 2,3,5). While

attendees were concerned about a more educational approach to oral health, it is important to remember that oral health education is one component of oral health promotion that allows individuals to make better oral health decisions(See Figure 4). Few advocates were interested in a more prevention oriented approach of oral health strategies. Other advocates requested additional community health centers to deliver effective clinical oral health care. Some thought that their region had adequate human resources while lacking financial incentives for dental professionals. Only two regions reported utilizing the available Title V MCH resources for oral health programs in their communities. Listening Sessions brought together people who came to express their views and frustrations as well as those who came to listen only and ended up voicing their opinions. They were eager to learn about other available programs/solutions in the oral health arena for the state of Texas.

CONCLUSIONS

This project accomplished the mission of expanding oral health awareness among advocates and policymakers of Texas. Outcomes included raising awareness of existing successful collaborative practices and state/community oral health programs that have been implemented through partnerships and collaborations. Lessons were learned from successful oral health approaches within communities in the state of Texas, while ideas were gathered and shared. The "gold standard" and "best practices" guidelines were highlighted from the Preventive Services Task and ASTDD respectively. The most significant outcomes of this project was to bring forward collaborative oral health efforts and link communities, coalitions and advocates together in order to bring about changes

in Texas. Since the implementation of this project, an oral health coalition has been formed in the Lower Rio Grande Valley (LRGV), addressing the needs of that region as remarked by an attending LRGV dentist *"local problems need local solutions."* A network of community organizations and health advocates has been formed following the state oral health summit to promote oral health efforts and advance oral health agendas and issues in Texas. Moreover, the TDSHS has since been able to utilize support from the different sources including the MCHB, HRSA, Division of Oral Health at CDC and ASTDD for follow-up initiatives while a Texas oral health coalition is developing.

K. LIMITATIONS & DIRECTIONS FOR FUTURE RESEARCH

A major limitation of this project pertained to sampling. Since the advocates and participants accepted an invitation to attend, which were sent to regional stakeholders, bias could be inadvertently injected. Intuitively, participants selected in this manner tend to be more motivated and expressive. It must be acknowledged that due to barriers such as time and resources the possibility of having a greater number of oral health consumers, i.e. parents diminished at the Listening Sessions. Therefore, advocates who attend health related forums regularly comprised the majority of the participants. Future efforts should seek broader input from additional non-dental providers and the general public. Additional studies should examine and use quantitative methods and needs assessments in bridging the gap between public and professional perceptions in Texas. Research needs to establish what the public wants and needs, and empower them to take charge of their oral health. Hence, these participants were only part of a multi-level approach to enhance oral health and initiate a strategy for Texas. At times, Listening Sessions were

led by individuals and organizations with an agenda voicing the need to change the Dental Practice Act and while such changes may lead to improved oral health delivery system of care, other solutions were left out.

Lessons Learned. Participants were vocal about their views; however the views expressed by these advocates and attendees for this project may not be completely representative of the Texas population as a whole. Future efforts could support community forums and social marketing campaigns by engaging the general public in identifying key issues and priorities while empowering them towards better oral health choices by individuals and communities leading to improve oral health outcomes.

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Table 1: 1999 Statewide Texas Survey of Children[11]

Grades	% lacking any insurance	% with Medicaid coverage	% experiencing dental caries
2nd	49.0%	35.0%	66.0%
8th	52.0%	28.0%	53.0%
2010 US Goals			42.0%

Table 2: Prevalence of Sealants among All Children by County in TDH Region 6[10]

County	Prevalence of Sealants %
Galveston	51.0%
Ft. Bend	45.8%
Harris	44.3%
Brazoria	42.5%
Colorado	39.6%
Liberty	33.8%
Matagorda	27.8%

Table 3: Prevalence of Untreated Decay among Children in Counties of TDH Region 6[10]

County	10th Grade Children %	7th Grade Children %	2nd Grade Children %	Pre-K Children %
Galveston	29.2%	14.6%	28.1%	47.2%
Ft. Bend	25.8%	19.8%	35.8%	45.0%
Harris	27.0%	31.2%	45.9%	52.4%
Brazoria	37.2 %	13.5%	48.9%	43.2%
Colorado	23.4%	29.4%	25.7%	31.7%
Liberty	33.0%	25.9%	51.2%	28.3%
Matagorda	31.3%	38.2%	49.3%	54.3%

Table 4: People Who Visited the Dentist or Dental Clinic within the Past Year for any Reason in San Antonio[12]

	Yes	No
%	**60.0**	**40.0**
CI	(58.4-61.5)	(38.4-41.5)
n	3739	2329

Table 5: People Who Visited the Dentist or Dental Clinic within the Past Year for any Reason by Income in San Antonio[12]

Income		Yes	No
Less than $15,000	% CI n	**40.3** (35.7-44.8) 292	**59.7** (55.1-64.2) 448
$15,000- 24,999	% CI n	**48.2** (44.4-51.9) 529	**51.8** (48.0-55.5) 512
$25,000- 34,999	% CI n	**57.2** (53.0-61.3) 466	**42.8** (38.6-46.9) 315
$35,000- 49,999	% CI n	**64.7** (61.1-68.2) 625	**35.3** (31.7-38.8) 317
$50,000+	% CI n	**76.4** (74.2-78.5) 1389	**23.6** (21.4-25.7) 426

Table 6: People Who Visited the Dentist or Dental Clinic within the Past Year for any Reason by Educational Attainment in San Antonio[12]

Education		Yes	No
Less than H.S.	% CI n	**40.1** (36.1-44.0) 398	**59.9** (55.9-63.8) 589
H.S. or G.E.D.	% CI n	**55.7** (52.7-58.6) 941	**44.3** (41.3-47.2) 714
Some post-H.S.	% CI n	**65.4** (62.4-68.3) 1039	**34.6** (31.6-37.5) 534
College graduate	% CI n	**73.5** (71.1-75.8) 1357	**26.5** (24.1-28.8) 485

*% = Percentage, CI = Confidence Interval, n = Cell Size
Percentages are weighted to population characteristics, Use caution in interpreting cell sizes less than 50[12]

Table 7: Final Timeline for the Listening Sessions

Date	Activity	Regional Location
02-18-04 (Wed.) [1:30 – 4:30 pm]	Listening Session for Houston	Houston
03-17-04 (Wed.) [1:30 – 4:30 pm]	Listening Session for Dallas	Dallas
04-07-04 (Wed.) [3:00 – 6:00 pm]	Listening Session for Lower Rio Grande Valley	Lower Rio Grande Valley
04-15-04 (Thurs.) [3:30 –6:30 pm]	Listening Session for El Paso	El Paso
04-29-04 (Thurs.) [1:30 – 4:30 pm]	Listening Session for Austin and San Antonio	Austin

Table 8: Overall Results of the Survey of Mothers in El Paso[19]

Tooth brushing habits of children	Only 52% reported tooth brushing/cleaning of a child's teeth should begin when a child is lees than 1 years of age or when teeth first appear
Ethnicity	81% were Hispanic
Last Dental visit	53% of mothers had visited a dentist/dental clinic in the past year
Bedtime habit of children	Only 36% reported their children were going to bed with a bottle containing milk, formula, fruit juice or other sweet liquid
Importance of teeth	95% reported it to be very/extremely important to keep all their natural teeth

Table 9: Mother's Dental Health Knowledge of El Paso Survey was Lower if[19]:

Place of Birth was	Level of Knowledge was	Level of Education was	Ethnic background was	Spoken Language was
Mexico	Minimal	Less than High School	Hispanic	Spanish

Figure 1: Steering Committee Composition

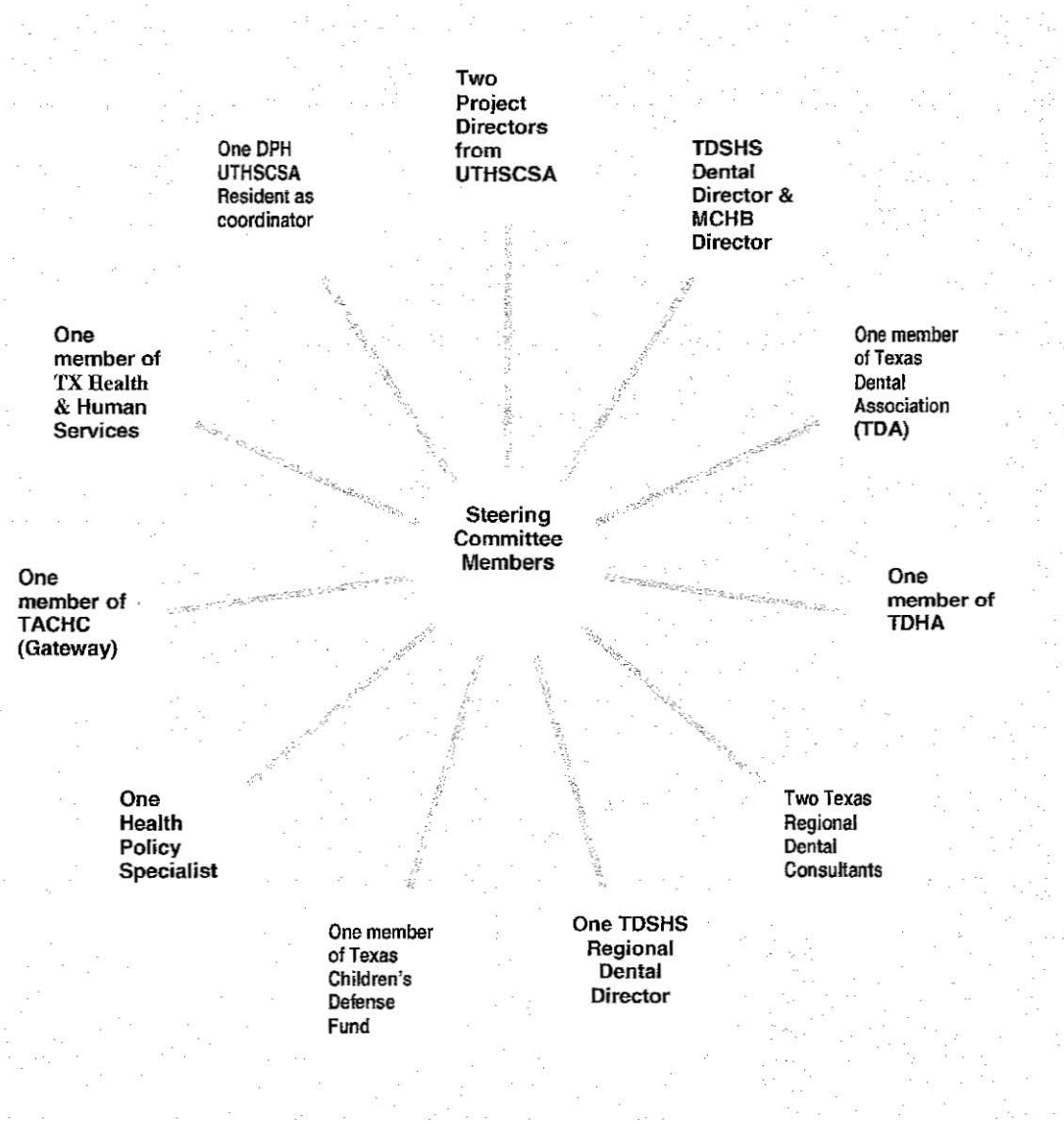
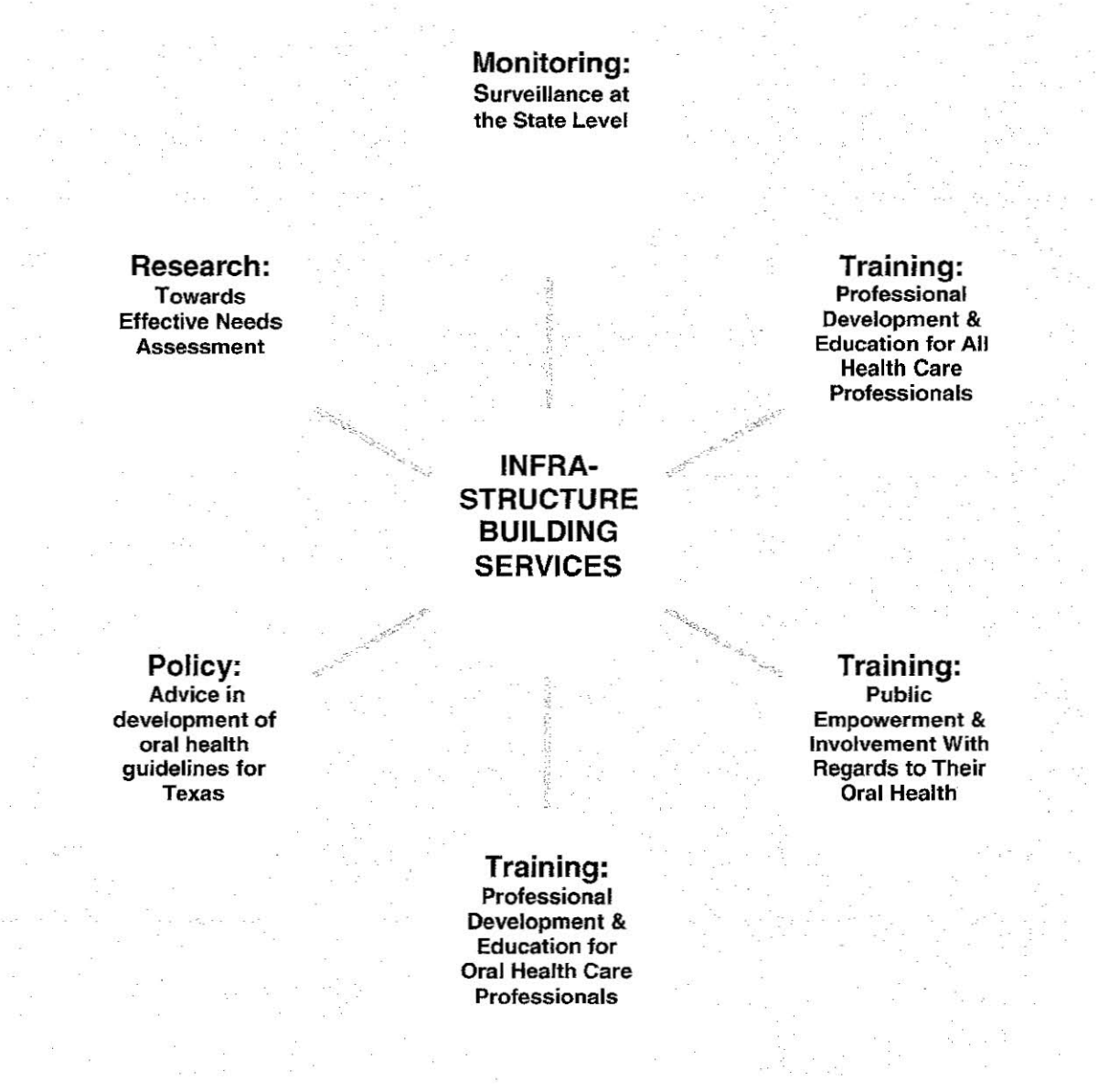


Figure 2: Summarized Conclusive Recommendations on Oral Health Infrastructure:



*Needs Assessment, Policy Development, Monitoring/surveillance, Training and Research

Figure 3: Summarized Conclusive Recommendations on Communication and Collaboration:

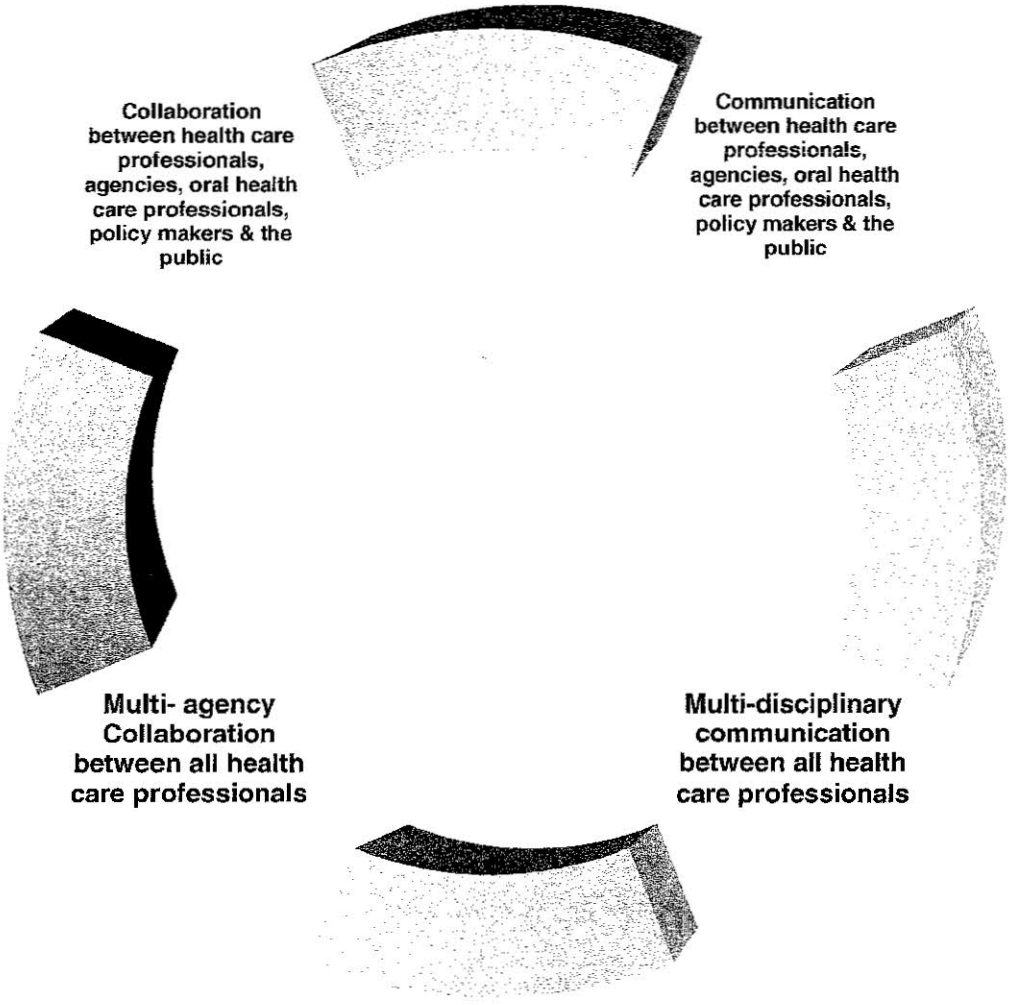


Figure 4: *Summarized Conclusive Recommendations on Population-Based and Enabling Oral Health Services:*

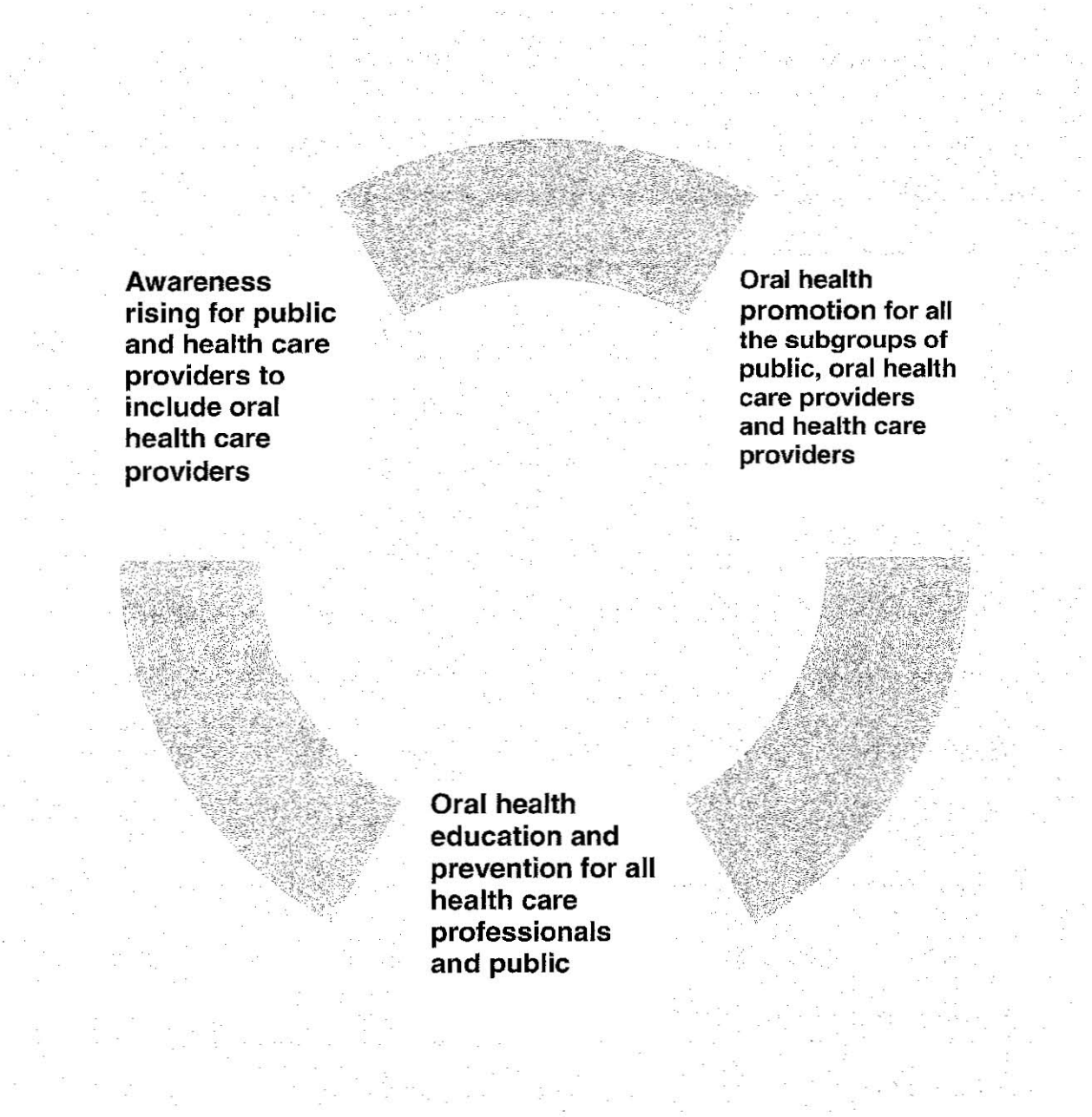
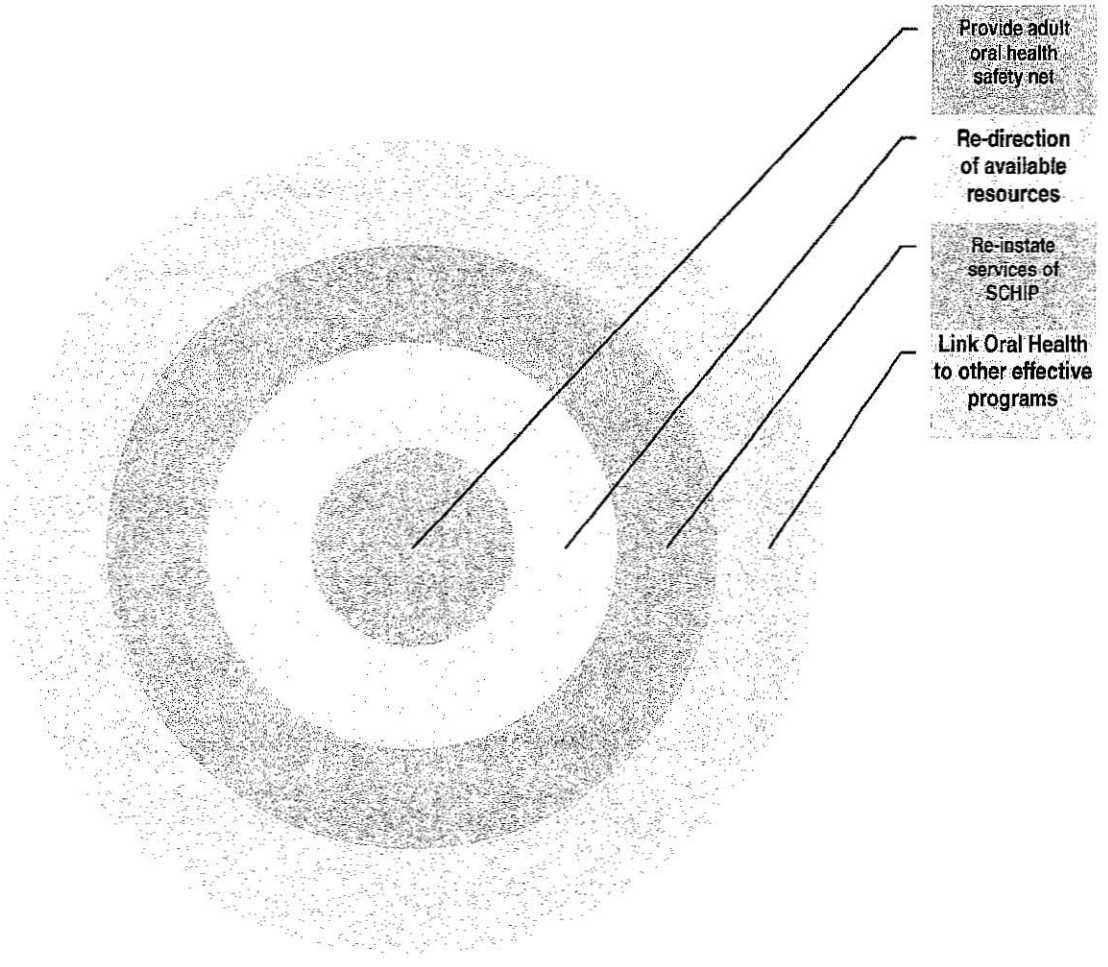


Figure 5: Summarized Conclusive Recommendations on Health Care Services:



APPENDIX A

Summary: Regional Oral Health Listening Sessions for Activation of a Collaborative Oral Health Plan in Texas

Mosh Farokhi DDS, MPH, FAGD, Resident in Dental Public Health, Department of Community Dentistry, University of Texas Health Science Center at San Antonio Dental School assisted in summarizing the testimony provided during the Regional Oral Health Listening Sessions.

Overview and Aims

The Project, Activation of a Collaborative Oral Health Plan in Texas, included five Regional Oral Health Listening Sessions held across Texas in Spring 2004. The Project was coordinated by the Department of Community Dentistry, University of Texas Health Science Center at San Antonio Dental School in collaboration with the Oral Health and Maternal and Child Health (Title V) Programs, Texas Department of Health, TDH (now called the Texas Department of State Health Services - DSHS). The project was funded by the Division of Child, Adolescent and Family Health, Maternal and Child Health Bureau, (MCHB), Health Resources and Services Administration (HRSA), USDHHS through a State Oral Health Collaborative Systems (SOHCS) grant.

Local Listening Sessions are a well tested approach used at the national level for the development of the National Call to Action to Promote Oral Health and respond to Oral Health in America: A Report of the Surgeon General. Also, Regional Community Forums have been organized by United Ways across Texas in collaboration with the Texas Health and Human Services Commission for input on state planning of health and human services.

The Regional Listening Sessions were designed to obtain input and suggestions for improving oral health and expanding access to clinical oral health services and community-based prevention by involving local stakeholders, consumers and community leaders in the process. Participants at the local listening sessions had the opportunity to share their stories by identifying unmet oral health needs in communities and outlining improvements needed to increase accessibility and delivery of services. The agendas for the Listening Sessions included invited participants and an open forum for public input to focus on oral health issues and ways to better address oral health needs. Participants were asked to discuss oral health challenges as well as local solutions that successfully address oral health issues.

Those listening included the State Dental Director and the Director for the Maternal and Child Health (Title V) Program from the Texas Department of Health, TDH (now called the Texas Department of State Health Services - DSHS) as well as the Project Co-Directors. The aims of the Listening Sessions were to:

- Increase local involvement and participation in the state oral health planning process.
- Solicit input from the communities and the region on the effectiveness of current oral health efforts. How are communities doing in addressing oral health problems?
- Identifying oral health needs in communities and regions. What are the oral health needs in communities and regions in Texas?
- Assess local capacity to address oral health needs the strategic priorities. What is being done at the local level to improve oral health and address oral health issues? Are there other ways for local communities to partner together to address oral health problems?
- Foster grass roots support for and build a community-based coalition in Texas to improve oral health and expand access to clinical oral health, community-based prevention and oral health promotion.

- Members of district dental societies and dental hygienists' associations
- Directors of community college dental assisting and dental hygiene programs
- Dental health care professionals from various universities in Texas
- Members of the Texas Academy of Pediatric Dentistry

Summary Regional Oral Health Listening Sessions

The next section summarizes the testimony presented at the five Regional Oral Health Listening Sessions as well as written materials submitted to the project staff. The Oral Health Issues identified can be categorized under the following headings:

- Access
- Advocacy and Policy
- Awareness
- Barriers
- Collaboration and Communication
- Education
- Evaluation and Surveillance
- Funding
- Oral Disease Prevention and Oral Health Promotion
- Resources

The next section synthesizes the solutions identified across all five regions of Texas.

Access

- Reinstate dental and other Children's Health Insurance Program (CHIP) services/eligibility/enrollment and re-enrollment
- Provide school-based oral health services to increase access
- Increase the percentage of persons receiving optimally fluoridated water
- Establish community health center dental clinics for indigent and medically compromised patients
- Require dental care for the underserved as part of the process of obtaining or renewing dental licenses for dentists and dental hygienists
- Restart DSHS dental van services with ability to provide preventive sealants
- Increase access to care for all segments of the population including adult indigent, physically and mentally challenged, nursing home residents and elderly and other home bound persons
- Provide greater access to preventive oral health services as well as targeting high risk groups
- Incorporate a primary dental care treatment component in existing dental hygiene schools as an expansion of roles
- All Community Health centers should include dental clinics as a component, as now required of new start-up grants for Community Health Centers
- Allow the working poor segment of the population access to reduced cost oral health care

Advocacy and Policy

- Encourage and expand legislative advocacy
- Form a coalition to network on oral health policies

- Need to have a strong Oral Health presence at Bi-National Border Health Symposia
- Organize an institute to train advocates and local officials on how to effectively promote oral health and advocate legislatively
- Teach parents to be advocates for their children's oral health
- Advocate the role of federal and state legislation with regards to oral health policy
- Create a task force to fluoridate water systems, to advocate and educate for ongoing and new systems of community water fluoridation, increase the percentage of persons receiving optimally fluoridated water. Enhance water plant operator training, improve quality assurance and enhance system design.
- Promote legislation to expand dental services and community based preventive services to rural areas

Awareness

- Increase public health dental information and awareness
- Increase community awareness
- Empower parents and others to act on behalf of the children
- Provide information about the location of community health center clinics and the availability of care
- Dental students need to be further encouraged to participate and practice within the community health centers
- Provide internships for dental residents in rural and frontier areas to increase their knowledge and ability in such care
- Update and publish on the web the list of Medicaid (and potentially CHIP) dental providers and show those accepting new patients

Barriers

- Bring back CHIP dental coverage and reimbursement to reduce financial barriers
- Barriers with regards to oral health care according to the attendees may be related to distance, transportation, awareness of preventive orientation, financial, physical, language, and cultural factors
- Provide dental care to children at schools to reduce many of these barriers
- Establish a system of referral to willing private dental providers to decrease oral health care barriers
- Remove supervision for hygienists to perform educational and preventive programs and other services
- Employ Spanish speaking staff as well as translation of materials to limit language barriers. Translate from English to Spanish and to other appropriate languages
- Increase Medicaid reimbursement rates to encourage provider participation
- Increase dentist participation by speedy electronic reimbursement for Medicaid
- Change Medicaid Fraud rules
- Medicaid administration, fee schedule and age restrictions are limiting oral health care provision
- Lack of dentists in certain counties and in particular in the rural and frontier areas is a barrier for many children and adults

Collaboration and Communication

- Encourage public and private partnerships through state and local oral health coalitions
- Establish communication between the different local, state and national health agencies and with health care providers

- Link oral health into existing programs, such as exercise and nutrition education for obesity. Periodontal and other disease prevention is linked through diabetes prevention.
- Increase participation or establish collaboration of health care agencies and providers in the public, nonprofit, and private sectors, including dentists, dental hygienists, dental assistants, physicians, nurses, office staff members, social workers as well as dental, dental hygiene, and dental assistant students.
- Support collaboration and communication with the Dentists from Mexico in the border region
- Encourage multi-agency collaborations, for example, partnerships between dental and dental hygienists associations, health departments, community health centers, dental and dental hygiene programs and community-based organizations including School Districts, Head Start Grantees, local American Cancer Society offices, etc.

Education

- Provide In-service training for Head Start health coordinators and school nurses
- Train members of the health care professions, including social workers about oral health
- Educate the parents about their children's oral health
- Educate the community about oral health and dental care
- Educate local public officials and state legislators on importance of oral health
- Focus oral health education programs with pregnant women
- Provide professional and patient education with regards to oral health and chronic diseases such as diabetes
- Provide better training for dental and dental hygiene students in providing oral health services to children and vulnerable population groups
- Integrate oral health education into existing school curriculum

Evaluation and Surveillance

- Strengthen and expand the existing system of oral health surveillance. Collect data which can be compared with that of other states and local jurisdictions
- Evaluate programs and assess capacity to expand to adult dental care within Medicaid to provide an adult dental primary care safety net, lacking in Texas
- Increase surveillance programs with regards to assess and compare oral health needs of all the segments of the population, as well as the population at risk

Funding

- Seek funds to support school-based oral health programs
- Require a match of federal funding to be utilized for a variety of under budget oral health care services
- Restore the funding and scope of the Children's Health Insurance Program, including dental services
- Consider a grant mechanism to encourage existing organizations such as non-profit organizations, dental schools, health departments, and private providers to collaborate in creating innovative approaches to address the oral health needs in their communities
- Increase access to health care by using county funds
- Funds need to be available for Mobile Dental Van units regardless of which resources are utilized to provide such care
- Apply for private foundations grants, utilize Title V funds, community development Block Grant Funds, County funds for oral disease prevention, oral health promotion, and dental care access

Oral Disease Prevention and Oral Health Promotion

- Restore dental CHIP program
- Emphasize the community oral disease prevention and oral health promotion

- Pilot a basic program of dental preventive services for all eligible children
- Promote among physicians, parents and front line primary care providers for children the idea that oral heath is a critically important component of the child's complete health and well-being, and engage these providers in the process of prevention and early interception of oral disease in children
- Implement school based preventive dental sealant programs in Texas communities to reduce oral health disparities
- Shift from a dental model to a medical model and thereby treat and prevent dental disease not just its consequences
- Geriatric population needs root caries prevention
- Prioritize population segments, start with the children to include regular basic dental care and preventive care at a young age
- Identify the high-risk children through case finding and early intervention at the early stages of dental caries

Resources

- Reinstate dental CHIP program
- Allow Dental Hygienists to work effectively in schools, Head Start programs, WIC, nursing homes and other locations without direct supervision of dentists
- Utilize existing models such as the Florida Model by requiring work in a public dental services agency for continuing education credits as well as other means to encourage volunteerism and donated dental care
- Incorporate oral screening of school age children by the school nurses in the state of Texas
- Provide incentive for dentists to serve populations without access, such as lower malpractice insurance rates, higher reimbursements rates, or loan repayment programs for their services
- Recruit more pediatric dentists to areas of need
- Deliver oral health care through existing facilities saving on time and money
- Encourage dental practices to see a minimum number of Medicaid patients

Conclusions

In summary, the attendees of the Regional Oral Health Listening Sessions were highly concerned about issues that are similar to the Association of State and Territorial Dental Directors (ASTDD) Guidelines for State and Territorial Oral Health Programs, 2001avaialble at <http://www.astdd.org/docs/ASTDD_Guidelines.PDF>. These Guidelines and Best Practices serve as a reference assessing the role of oral health for state dental public health programs and of public health program administrators. The guidelines, as well as the attendees, emphasized a priority need for states to include an oral health surveillance system, leadership of a full time state dental director, resources to build community capacity and to establish health systems interventions.

The ASTDD Guidelines are summarized below for comparison with the Listening Session issues and solutions.

- Emphasizing that state and local stakeholders need to assist state dental directors and state Medicaid dental consultants to develop strategies and incorporate plans to resolve dental access barriers
- The State dental hygiene associations need to establish and/or increase their involvement with state oral health programs, and to be assisted in doing so
- Collaboration between local, state, and national efforts for effective, accessible, and high quality oral health care services

- Maximize resourced and link people to needed oral health services
- Assess oral health status and needs, identify problems and address them
- Evaluate the quality and report effectiveness of oral health services
- Evaluate accessibility and availability of oral health services.
- Assess oral health knowledge, opinions, and practices of the community such as the perspectives provides by attendees of these listening sessions
- Educate and empower the public regarding oral health problems and solutions
- Promote and enforce laws including resources as well as regulations that protect and improve oral health
- Assess the fluoridation status of water health, ensure safety, and assure systems, and other sources of fluoride
- Implement oral health surveillance
- Link people to needed population-based system to identify, investigate oral health services, oral health problems and provide support
- Assure the availability, access, and acceptability of these services by enhancing system capacity
- Develop plans and policies through a collaborative process that support individual and community oral health efforts
- Support services and implementation of programs that focus on primary prevention
- Mobilize community partnerships between and among policy makers, professionals, organizations, groups and the public
- Evaluate effectiveness, accessibility, and quality of population-based oral health services.
- Conduct research, support projects to gain new insights and applications of innovative solutions to oral health problems
- Identify barriers to access such as Medicaid provider participation
- Prepare and submit funding proposals and applications for Maternal and Child Health (MCH) Block Grant that integrate evidence-based oral health interventions
- Pursue private sector resources, private service organizations and corporate business contributions
- Develop plans and policies with a collaborative oral health approach and address oral health needs in communities
- Support and promote dental professionals to provide personal oral health services to low income clients
- Create incentives for dental professionals to provide oral health services for Medicaid eligible clients and working poor
- Support promotion efforts to educate public officials, policy makers, program administrators, and professional(s) to increase awareness of oral health
- Mobilize community partnership based on findings from needs assessment and oral health problems and issues
- Support collaborations between public, private and nonprofit agencies and organizations interested in oral health issues
- Educate and empower the public about oral health status and oral health service needs
- Provide resources to assure accessibility to and availability of effective oral health services for all residents to include vulnerable, undocumented, disabled children, adults, and elders
- Support oral health promotion, nutrition, social services, welfare programs, developmental services and education
- Support early intervention such as school based preventive dental sealant programs and utilize evidenced based findings and studies to design and implement intervention
- Implement culturally competent services by assuring services that are available, accessible, acceptable, coordinated, and effective

- Support transportation, child care, interpretation, and financial support in order to increase access to oral health services

APPENDIX B

Sample Letter Sent highlighting the Project and Gathering of Support for SCHIP:

Dear Senator:

We, the Department of Community Dentistry at the University of Texas Health Science Center in San Antonio, The Texas Department of Health (Oral Health Program) and Maternal and Child Health Bureau (MCH Title V) are currently collaborating on Project Activation of a Collaborative Oral Health Plan in Texas. The project involves a total of five Listening Sessions being held in Austin, Dallas, El Paso, Houston, and The Lower Rio Grande Valley as well as a state workshop in September 2004.

The aim of the Listening Session is to learn about ways to improve dental health and oral health in Texas. We have conducted the Dallas and Houston Listening Session and restoring dental benefits in the Children's Health Insurance Program (CHIP) is a major issue that keeps surfacing.

We know that there is a News Conference scheduled tomorrow in San Antonio (10:00 a.m.) at San Fernando Cathedral Plaza for the Campaign to restore CHIP. Please include the important issue of restoration of dental benefits in CHIP in your speech.

I am forwarding an attachment with our upcoming Listening Sessions as well as information about our project. Thank you very much for your time and consideration.

Regards,

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APPENDIX C

Attendees at the Listening Sessions represented:

- Dentists, Dental assistants, Dental hygienists from private, public & private sectors
- Dental health care professionals from various branches of the University of Texas
- Members of other educational centers in Texas
- Directors of community college dental assisting & dental hygiene programs
- Members of District dental societies
- Members of Texas Pediatric Dental Association
- Community Health Center managers and providers
- Safety Net Dental Clinic managers and providers
- TDSHS representatives
- County hospital oral health and health care providers
- Nurses/Social workers
- Parents
- Superintendent of independent school districts,
- Representatives of insurance companies
- Head Start executives/coordinators
- Staff from non-profit organizations/agencies
- Members of charitable/community based and faith organizations
- Representatives from Regional/Local Oral Health Coalitions
- Representatives of Area Councils of Government

- Representatives of regional Diabetic Associations
- Members of local advocacy organizations/community coalitions
- US-Mexico Boarder Health Commission administrators
- Members of the local chapters of Area Agency on Aging
- Members of Regional American Diabetes Associations
- State/local elected public officials representatives

Public health administrators

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