OPEN Oral Health Progress and Equity Network

REPORT ON PROGRESS TOWARDS THE 2018 MILESTONES

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INTRODUCTION

In October 2013, oral health stakeholders from across the country came together to build a shared set of goals aimed at transforming the U.S. oral health care system to support overall health and wellbeing. The stakeholders realized that some fundamental approaches to social change would be required to achieve their vision for a health care system that gives everyone equitable opportunities to be fully healthy.

Following the recommendations of the Surgeon General's **National Call To Action To Promote Oral Health** in 2003 and national work initiated at the American Dental Association **Access to Dental Care Summit** in 2009, the stakeholders determined that a network approach to change — one that engaged partners at national, state, and local levels — was essential to accomplishing their goals. The value set that guided this approach was the belief in a just health care system that provides everyone with equitable access to all types of health care, including oral health care.

From these conversations, a Network was born. Originally launching under the name Oral Health 2020, the Network went through a branding process, arriving at its name today: Oral Health Progress and Equity Network (OPEN). With more than 1,400 members from national, state, and community-based organizations nationwide and in all 50 states, OPEN is the largest social impact network of its kind and in the oral health space. Its diverse membership includes all key health care system stakeholder groups, including: federal and state agencies and administrators; national, state, and local advocacy organizations; policymakers; community-based organizations; providers and provider associations; payers; academics; health professionals; youth leaders; and others. In keeping with the Network's commitment to diversity and inclusion, its membership and leadership include the racial and ethnic diversity required to represent the full set of experiences of people impacted by a broken system.

In 2014, the Network refined its future vision and goals, and built seven specific targets to achieve by 2020. The goals and targets reflected two themes that the Network identified as essential to success: (1) framing oral health as health, and (2) focusing on oral health across the lifespan. Supported by training from the **Association of Black Foundation Executives**, the Network conducted a racial equity impact analysis that analyzed the goals and targets through an equity lens, in order to design Network strategies that addressed equity from the start. In doing so, it aimed to counteract historical and structural barriers to equitable outcomes, while avoiding unintended negative consequences of its work.

The following year, the Network developed a series of roadmaps that identified local, state, and national strategies to achieve each goal and target. Together, the seven roadmaps represent the most comprehensive national oral health improvement strategy developed to date. In 2016, the Network added a set of 2018 milestones to serve as indicators of progress toward fulfillment of the targets as a result of implementing the roadmap strategies.

The Network launched an audit of the milestones In May 2018. This highly ambitious project entailed partnering with **state and grassroots representatives** to collect relevant state-level data for every milestone in order to evaluate nationwide progress. Target teams, each comprising Network members with relevant interests and expertise, provided guidance on data collection and subsequently aggregated and analyzed the findings. (See "Methodology" for details.)

This report represents the progress of the Network toward the 2018 milestones based on the results of the audit. It discusses the importance of each target to achieving oral and overall health across the lifespan, and then describes progress on each milestone, driven by Network member efforts across the country. The report and its findings reflect the Network's commitment to utilizing a network approach to social change and promoting equitable outcomes throughout its work. It presents a clear picture of the Network's progress and challenges, as well as successes of which members are proudest.

Moving forward, the findings shared herein will help the Network to identify what is going well, what needs more attention and effort, and what approaches might need to be reconsidered. This process will inform changes to the Network's strategic plan for the next two years, in optimal support of achieving all targets by the end of 2020 and improving the health and wellbeing of fellow community members nationwide.

METHODOLOGY

DATA COLLECTION PROCESS

In July 2018, target teams for each of the Network's seven targets were formed, comprising Network members with relevant content expertise or interest, and facilitated by members of the Network Support Team (NeST). Each target team convened virtually throughout the summer to develop uniform data collection templates for use by state and grassroots representatives, relying on a template created by the NeST. The templates included: questions to identify progress toward each milestone; data collection guidance and specifications; and fields for inputting answers to the questions, the data sources used for each, and facilitating and hindering factors that affected achievement of each milestone.

Once the data templates were developed, the NeST shared them with state and grassroots representatives, who were asked to gather the state-level information in partnership with stakeholders in their states. The target teams collected data for any national-level milestones. Data collection took place in August and September 2018.

State and grassroots representatives submitted their findings to the target teams, which then aggregated, discussed, and analyzed the data. The teams interpreted the results against the original intent of the milestones, arriving at an overall progress determination, defined as follows: milestone could not be assessed (information collected was insufficient to assess progress); little or no progress (insufficient evidence to demonstrate progress on the milestone); on our way (measurable progress identified in the data collected); and milestone achieved (sufficient evidence exists to assert empirically that the milestone was fulfilled as written).

STUDY LIMITATIONS

All of the data requested were empirically verifiable, yet given the lack of a comprehensive oral health measurement system, limitations to data collection still existed. A wide variance of infrastructure in states led to space for individual judgments to impact data collection. In states with robust oral health departments that include epidemiologists, for instance, much of the milestone data are readily available. In states without access to such quality information, and even in those that do collect it, the use of the data may be restricted significantly. As a result, data sources across states were not uniform.

In evaluating progress toward the milestones, target teams preserved the original language of the milestones as written in 2016. This prevented redundancy bias, gaming the measures in any way, and inconsistency with intent. However, this approach did not acknowledge shifting environmental conditions, learning and adaptation, and sensitivity to progress achieved outside of the bounds of the original milestones. For example, the milestones were developed prior to the 2016 election cycle; strategies developed to promote the inclusion of an extensive dental benefit in Medicare were altered significantly in response to the policy environment that followed. While significant progress was achieved toward the Medicare target, the milestones do not capture that strategic pivot.

Due to the broad nature of the milestone language in many cases, defining the milestones operationally required restrictive choices as well. Operational definitions also reflected the short project timeline, information available, and the data collection agents. In many cases, this led to milestone measurements that are not comprehensive, yet still offer important information about progress.

While many of the data used in this evaluation were self-reported, and the operational definitions of the milestones were constrained by data collection feasibility, ultimately falling short of the rigor of an academic research design, this evaluation is the most comprehensive assessment of national oral health improvement conducted to date. In all cases, conclusions offered are cautious and reflective of the limitations of the data. As a progress assessment and a guide for future Network strategy, the data contained in this report are robust; however, conclusions do not extend beyond the bounds of what can be asserted reasonably based on observations contained in the findings.

CHILDREN

GOAL Eradicate dental disease in children.

TARGET With a closing of disparity gaps, 85% of children reach age five without a cavity.

Why This Target Matters: The first five years of a child's life are critical to his development — cognitively, emotionally, and physically. Oral health is no exception. The Surgeon General's 2000 report, **Oral Health in America**, further told us that poor oral health in childhood can affect children's abilities to learn, eat, and socialize. Children who experience excellent oral health in their early years are also more likely to have continued oral health across their lifespan. Conversely, childhood dental decay is associated with poor oral health into adulthood.

Why It Takes a Network: Improving oral health care access and outcomes for children — particularly those from racial/ethnic minority groups and low-income families — requires large-scale changes in multiple interdependent systems. The need for involvement among these systems, including health care, education, public health, and government, reflects the numerous environments and levers that can both obstruct and open doors to better access to care. Improving oral health for the youngest children further requires engagement of health care teams led by obstetricians, pediatricians, and family medicine providers, who interact with young children and their families.

The tragic and preventable 2007 **death of 12-year-old Deamonte Driver** in Maryland from an untreated tooth abscess that led to an infection that spread to his brain underscores how the absence of a comprehensive and integrated approach falls short. Before Deamonte's death, individual stakeholders and organizations in Maryland had various ideas about how to improve the oral health of low-income populations, but were all working separately on their own agendas — with little to no success. The tragedy forced them to come together and shed their mistrust of one another and their siloed points of view about what needed to be changed. Only then were they able to gain a comprehensive view of the problem in all parts of the system — providers, schools, families, advocacy, and government — and create a set of systemic solutions. This multi-stakeholder approach is especially needed because **Medicaid is a federal-state partnership**, calling for commitment, engagement, and change at both levels of government. After those solutions were implemented, Maryland climbed from one of the 10 worst-performing states to one of the 10 best in delivering oral health services to Medicaid-enrolled children.

LOOKING THROUGH AN EQUITY LENS

Over the last generation, childhood tooth decay has been largely addressed in certain populations, but oral health care utilization and outcomes remain a challenge **among low-income populations and families of color**. Consider:

- Among young children, **disparities are greatest** in children who are black, non-Hispanic, or Mexican-American.
- **Even when controlling for insurance status**, children from low-income families and those in racial/ethnic minority groups are **less likely than their more well-off peers to receive preventive oral health care**.
- The rate of tooth decay among Hispanic and African-American children ages 2 to 8 is **twice that of non-Hispanic, white children**.
- Preschool-age, Native American children experience **four times as many cases of untreated tooth decay** as their white counterparts.

The "knee-jerk" reaction to these disparities is a set of pervasive misconceptions regarding their root causes. These include the belief that some parents don't care about their children's oral health or feed them unhealthy foods that fuel dental disease. A shift in this narrative is needed for underlying and systems-based contributors to disparities to be recognized and addressed. For example, children who cannot safely drink tap water in their schools or homes are forced to drink bottled water and lose the benefit of fluoridated water systems. Some live in "**food deserts**" and are unable to consume a healthy diet. Others do not go to the dentist because there are no dentists in their neighborhood (or none who accept Medicaid), and/or they face barriers such as transportation to appointments, language, and dental office hours limited to traditional business hours, when parents may not be able to miss work. All of these scenarios are structural inequalities that must be exposed and addressed.

OVERVIEW OF CHILDREN'S MILESTONE ACHIEVEMENT

ON OUR WAY: There is a 15 percentage point increase in the number of kids receiving oral health preventive services from any health care provider on an annual basis by age two.

Progress toward this milestone was made, with a 6.8 percentage point increase nationally. According to **CMS-416 data**, 12.1 % of children ages 2 and under who were eligible for **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** services enrolled for at least 90 continuous days in Medicaid received a preventive dental service in 2014. That percentage rose to 18.9% in 2017. Further, only 12 states reported a decline in utilization over that time period; the majority of states/territories saw an increase[1]

What helped us? Several factors drove progress: an increased focus on prevention; school-based screening, fluoride varnish application, and sealant programs; and federal, state, provider, and other efforts to improve children's dental care quality and access. A notable example was the **CMS Oral Health Initiative**, launched in 2010 to increase preventive dental service and sealant delivery to Medicaid- and CHIP-enrolled children.

What held us back? The current oral health care delivery system structure does not prioritize prevention (e.g., reimbursement and payment structures do not always incentivize prevention). Changing this requires cultural and structural shifts that will take time. Further, many general dentists remain uncomfortable seeing very young children, and there simply are not enough pediatric dentists to serve all children of this age.

ON OUR WAY: A detailed understanding of which populations have the lowest percentage of children reaching age five without a cavity in each state will have been developed.

Data from **Healthy People 2020** and the **Centers for Disease Control and Prevention's** (CDC) **National Center for Health Statistics** break down caries risk experience by race/ethnicity and family income nationally.[2] These data demonstrate that children from low-income families and/or those of color are more likely to experience a higher prevalence of dental caries and untreated dental caries. However, states do not consistently measure caries prevalence for the 0-to-5 population, so this understanding at the state level has not yet been achieved.

[1] It is not clear which states' increases were statistically significant.
[2] Because the data reported from individual states came from different sources and were most likely measured in different ways, the target team reported the most reliable national data.

What helped us? Moving the Network towards this milestone has been states' recognition that oral health surveillance data disaggregated by age, race/ethnicity, and income level are necessary for determining how to target limited resources, including public health funding. As states focus more on prevention, it is important to know how young children are faring, and knowing who and where the populations with the greatest need are.[3]

What held us back? Available data are very sporadic, inconsistent, and in many cases, outdated: most states do not collect it into a centralized database at regular intervals. There is also a need for better referral processes and integration of electronic health records (EHRs) to provide a true picture of what services children are receiving and where.

ON OUR WAY: There is a 15 percentage point increase in the number of non-dental providers that have delivered preventive services, anticipatory guidance, education, and/or referral for continuous care for kids under age five. Movement on this milestone is slow and ongoing, as evidenced by an increase in service delivery within Medicaid. Between 2014 and 2017, the percentage of children who were eligible for **EPSDT** services, enrolled for at least 90 continuous days in Medicaid, and received an oral health service from a non-dental provider **increased from 5.3 % to 8.0 %**.

Notably, these data do not include children served by the **Children's Health Insurance Program (CHIP)**, private insurers, or through public programs (e.g., the **Women, Infant, and Children's Program (WIC)**, **Head Start**, school-based programs) or charitable sources that may not bill Medicaid for services. Data for services delivered through these channels are not available. Further, the data speak to the percentage of children receiving services, rather than the percentage of non-dental providers delivering these services, for which data are not available.

What helped us? A number of policies and changes fueled progress toward this milestone, such as: the **U.S. Preventive Services Task Force (USPSTF) determination** that children ages 5 and under receive fluoride varnish application from their primary care provider as a B-grade recommendation (i.e., to be provided with no cost-sharing under the **Affordable Care Act (ACA)**; **Medicaid reimbursement for fluoride varnish application by primary care providers** in all states and the District of Columbia; **CPT code (99188)**, which allows medical providers to bill for the service. Other facilitating factors have been training of medical providers by state-based programs to provide preventive oral health care services; online training for medical providers available through **Smiles for Life** and Colorado's **Cavity Free at 3**; and investment by national and state medical and dental associations in medical-dental collaboration and interdisciplinary oral health teams.

What held us back? Factors preventing achievement of this milestone were: no private-payer reimbursement for these services; the absence of a national registry for the data; minimal medical-dental collaboration; lack of dental referrals available to medical providers, especially in Medicaid; and service delivery that is not billed, impeding data reporting. And lastly, practice change is hard.

ON OUR WAY: 65 percent of kids under age five have access to consistent, evidence-based oral health care. States continue to face barriers to this milestone, as evidenced by **mean national rates** of service utilization in Medicaid that are well-below 50%. In 2017, utilization rates were 42% for any dental or oral health service; 38% for any dental service; 36% for dental diagnostic services; and 35% for a preventive dental service.[4] A bright star on the map was Texas, which had utilization rates in the 60's for all of these measures.

What helped us? As noted above, the CMS Oral Health Initiative boosted progress on this measure. Additionally, the U.S. Health Resources and Services Administration (HRSA's) **Oral Health Strategic Framework (2014-2017)** includes a number of measures (e.g., the **Perinatal and Infant Oral Health Quality Improvement Initiative**) aimed at decreasing early childhood caries and outlines partnerships with agencies such as the **Administration for Children and Families**. Other efforts have been underway by the American Academy of Pediatrics' (AAP's) **National Center on Early Childhood Health and Wellness**, as well as the **National Maternal and Child Oral Health Resource Center** and the **Association of State and Territorial Dental Directors** (ASTDD) in support of **oral health programs** through Head Start.

[3] An example is the California state oral health plan, which calls for school districts to comply with the **Kindergarten Oral Health Assessment (AB 1433)**. The importance of the KOHA was underscored by passage of **SB 379** in 2016, which strengthened the data collection and reporting procedures of the KOHA program.

[4] The target team explored service utilization among children enrolled in Medicaid, where access challenges are the greatest, as a proxy for access nationwide.

What held us back? Additional progress was **hindered by** frequent misalignment (or lack of incentives connecting) payment and evidence-based practices; lack of medical and dental collaboration or integration; and the absence of education and awareness-building aimed at current and prospective parents about the importance of oral health for young children. Further, there is no agreed-upon, evidenced-based approach to oral health care for children.

ON OUR WAY: 90 percent of early childhood programs will deliver oral health education and prevention to the children they serve.

National Head Start data suggest a promising level of engagement of young children.[5] For example, 69% of children and infants enrolled in Head Start are up-to-date on a schedule of age-appropriate preventive and primary oral health care;[6] and 83% received a preventive care service in the past year.[7]

What helped us? Factors supporting this milestone have been **American Dental Hygienists Association** (ADHA) dental hygiene liaisons in each state; and Head Start's **Brush Up on Oral Health** newsletter and its **oral health initiative**. Many states also have resources for early childhood learning and recognize that nutrition and good oral health are essential to that.

What held us back? A key hindering factor is lack of data from early childhood programs outside of Head Start. Data are needed from private schools to determine the full extent of needs.

LITTLE OR NO PROGRESS: Number of fluoridated communities increased by 10 percent and no communities currently fluoridated eliminate fluoridation.

Assessing the first half of this milestone was not possible. Data on community water fluoridation (CWF) are reported voluntarily by states to the CDC's **Water Fluoridation Reporting System (WFRS)** based on the number of persons receiving CWF, not the number of communities. The most recent data are for 2014, when that number was 74.4 %.[8]

Another way to measure progress is the number of communities experiencing challenges to CWF, including attempts to remove it from the water, also known as rollbacks. The **ASTDD** has **tracked this activity** for each year beginning in 2014 ***see Figure 1***. Its data show that the number of communities initiating CWF is very small. Over the four years reported, CWF has been maintained about 78% of the time in the face of challenges. Notably, the number of challenges dropped significantly in 2017. However, these data also show that the Network did not meet the second half of this milestone, as a number of communities eliminated fluoridation in the past four years.

YEAR	CWF CHALLENGES	MAINTAIN		ROLLBACK	INITIATE
2017	48	39	80%	9	5
2016	89	63	70%	26	7
2015	84	69	82%	14	7
2014	88	72	81%	16	10

Figure 1

What helped us? Numerous factors have facilitated progress toward this milestone, as measured by maintaining CWF in a high percentage of challenged communities and a reduction in the number of rollback attempts. For example:

- There has been increased investment and advocacy at the national, state, and local levels. Funders such as the **DentaQuest Foundation**, **The Pew Charitable Trusts**, **Arcora Foundation**, and others have invested in fluoridation advocacy.
- The **American Dental Association** and its **National Fluoridation Advisory Committee** have continued to stay on top of the science of fluoridation, educate the public, and advocate for the practice.

[5] National data are only available for Head Start programs, and not for all early childhood programs.
[6] According to each state's EPSDT schedule.
[7] Head Start does not report on the delivery of oral health education and prevention.
[8] From 2008 to 2014, the percentage of the population receiving CWF increased by two percentage points.

- The CDC continues to collect data and educate the public about water fluoridation.
- In 2012, the **AAP** adopted the **Campaign for Dental Health**, established by the **Pew Charitable Trusts** as the hub of a network of advocates for CWF; and has invested in search-engine optimization of its **website** to "outrank" anti-fluoridation information online. In addition, the **American Fluoridation Society** travels to local communities to train and assist advocates contending with rollback attempts. Both organizations, working collaboratively and in different sectors, educate the public, and promote the preventive benefits of CWF before rollback attempts occur. Local advocates are drawing upon increasingly available resources such as these to promote and defend CWF.
- Awareness of children's oral health disparities as a function of the social determinants of health has increased among health care providers and the public.

What held us back? Factors slowing progress have been: competing priorities and a lack of funding for fluoridation infrastructure; strong and influential national and local opposition organizations with effective online presences; reluctance of local decision-makers to advocate for a contentious issue; and supporters' failure to "drown out the noise" of a small group of highly vocal opponents.

LITTLE OR NO PROGRESS: The U.S. Preventive Services Task Force includes an oral health strategy for prospective parents and primary care givers.

No oral health strategy for these critical stakeholders has been put forth by the USPSTF.

What may help us? The **USPSTF recommends** that primary care clinicians prescribe oral fluoride supplementation (starting at age six months for children whose water supply is deficient in fluoride) and apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. This recommendation and the role of primary care physicians in providing health education laid the groundwork for additional recommendations targeting prospective parents and primary caregivers.

What held us back? Direct advocacy of the USPSTF for a strategy that targets prospective parents and primary caregivers has not occurred, at least not with a consistent and cohesive voice. No one has taken the lead to harness the power of the Network to do so.

CELEBRATING OUR SUCCESS

With the majority of this target's milestones in view, there has been meaningful progress toward eradicating dental disease in children. There have been consistent improvements in oral health care access rates; a continued reduction in caries experience in young children; and ongoing interest, discussion, and programs in federal and state agencies to improve access to dental care for Medicaid-enrolled children. The USPSTF recommendation that children ages 5 and under receive fluoride varnish applications from their primary care provider was also significant, requiring all insurers that participate in ACA marketplaces to reimburse physicians for this service.

In addition, there is momentum for improving children's oral health through: medical-dental integration and collaboration; lifting up consistent, evidence-based oral health care as necessary to a child's overall health; and improving oral health education and messaging to be targeted and delivered through multiple channels.

Looking ahead, a full and complete picture of collective impact and areas for future focus calls for consistent, reliable, and stratified data.

SCHOOLS

GOAL Incorporate oral health into the primary education system.

TARGET The 10 largest school districts have incorporated oral health into their systems.

Why This Target Matters: School systems build the foundation for happy, healthy, and successful lives by providing education, supporting social development, and improving children's health and wellbeing. They enhance a child's ability to grow, learn, thrive, and establish lifelong healthy habits, by offering health education and connections to health care services. While all primary education systems provide health education, oral health is largely absent from the topics and services included.

The implications of oral disease for children extend to their overall health, self-image, and quality of life, and affect their ability to be successful in school. Oral discomfort and pain can impact a child's ability to pay attention, learn, and perform well academically. At the same time, schools are optimal settings for *improving* oral health, relying on community-based and person-centered care models. Through existing educational and communication channels with students and families, as well as care delivery facilities, school-based oral health strategies can be one of the most effective ways to reach children most at-risk for oral disease. Critical to their success, however, is obtaining parental consent for student participation,[10] which is challenging.

Consent allows for students to access the spectrum of service options where they spend most of their day, at school, while parents stay at work or at home. School-based oral health services also teach students the importance of oral health as part of overall health.

A school-centered, cross-sector collaborative strategy has the potential to:

1. Increase oral health literacy among a population of high-risk children.
2. Build lifelong knowledge, skills, and habits that are essential to oral health.
3. Address powerful determinants of oral disease such as family and peer influences.
4. Ensure systematic delivery of age-targeted, preventive services such as topical fluoride and dental sealant applications.
5. Integrate oral health with behavioral health and primary care within the school environment.
6. Create care-management systems to help families navigate community services and connect children to a dental home.

The school districts included in this target are:[9]

- Broward County Public Schools (FL)
- Chicago Public Schools (IL)
- Clark County School District (NV)
- Hawaii Department of Education (HI)
- Hillsborough County Public Schools (FL)
- Houston Independent School District (TX)
- Los Angeles Unified School District (CA)
- Miami-Dade County Public Schools (FL)
- New York City Department of Education (NY)
- Puerto Rico Department of Education School District (PR)

[9] Of the 10 targeted school districts, Broward County, Hawaii, and Puerto Rico did not participate in the learning collaborative led by the School-Based Health Alliance, which was the focus of the target, in year one. Miami-Dade participated during the first year only.

[10] Stakeholders working on this target viewed consent as a proxy measure for access to care. At the start of this work, it was discovered that many of the districts provided oral health services, but had consent rates below the national average. In order for programs to get care to the students and remain sustainable, higher consent, and thus access to services, was needed.

Why It Takes a Network: An underlying aim of the schools goal and target is to create agreement on how oral health should be integrated into primary education systems. Doing so calls for engagement across multiple stakeholders and stakeholder environments. These encompass school nurses, administrators, and care providers, as well as parents/caregivers, teachers, after-school providers, students, insurers, and others. Their individual and collective perspectives, as well as experiences with failed and successful approaches, are needed at the table.

The target focuses on the country's 10 largest school districts because they have the resources and scope needed to test strategies and bring them to scale. They are also diverse in their approaches and expertise, which they share with others in a learning collaborative that was launched in 2016 as the primary vehicle for achieving the target.

LOOKING THROUGH AN EQUITY LENS

In lower-income areas, oral health disparities are exacerbated due to social injustices and inequalities, both historical and contemporary. People of color, particularly black and Hispanic children, carry an unusual burden of dental caries and periodontal diseases, which are preventable. Cultural and/or language barriers also influence signing and understanding consent forms, nutritional counseling, and home care practices. The focus on obtaining parental consent for services addresses a key equity challenge. Parents who are more engaged and involved in their children's schools — who are disproportionately in higher socioeconomic brackets — are **more likely to give consent**.

The 10 school districts included in this target present meaningful opportunities to better understand and address disparities. Many districts, such as Los Angeles Unified, encompass both urban and rural areas, and many serve student bodies with wide-ranging incomes. All of the districts have diverse populations and high rates of participation in the **Free and Reduced Price School Meals**, which is a good example of **targeted universalism**. These are also school districts with highly mobile family units.

OVERVIEW OF SCHOOLS MILESTONE ACHIEVEMENT[11]

ON OUR WAY: X%[12] of schools in districts are delivering oral health services in the 10 districts.
Across the responding districts, an average of half (51%) of schools offer access to oral health education services; about one third (32%) offer preventive oral health services, such as fluoride varnish and/or sealants; 13% offer access to restorative oral health services; and 14% offer access to oral health case management or case navigators.

> **What helped us?** The work of one central organization, the **School-Based Health Alliance** (SBHA), to advance school-based oral health in these districts has been the primary supportive factor. By leading the learning collaborative described below, SBHA worked diligently to advance great work already underway in the districts, focused primarily on increasing rates of parental consent for oral health care service delivery.
>
> **What held us back?** For all milestones of this target, additional progress was hindered by a number of factors. First, oral health is often buried deep in educational curricula, where changes take time, and resources are often beyond the scope of the school or district. Second, SBHA's learning community model utilizes "on the ground" approaches and **small tests of change**, often without explicitly addressing policy barriers. Another challenge was actually measuring impact, as there are tremendous barriers to linking student and health data.

ON OUR WAY: National learning collaborative has created measurable district-wide improvement in cross-cutting policy barriers in the 10 districts.
In a recent survey of learning collaborative participants, all reported that the initiative's change ideas around school district policy, administration, staff engagement, community/school partner engagement, and oral health education for students and families to be either somewhat or very successful. These drivers were used by many of the districts, mostly to change approaches to obtaining consents — practicing small change rather than pursuing big policy change. Examples included a five-year consent policy and inclusion of consent forms in back-to-school packets.

[11] Data for this target reflect responses from seven of the 10 targeted school districts. Data were not submitted by Miami-Dade, Broward County, or the Puerto Rico Public School Systems.
[12] A target percentage for this milestone was never identified.

What helped us? A number of factors advanced progress toward reducing policy barriers, including: (1) a focus on relationship-building with school administrators, teachers, and pupil-support professionals; (2) family engagement; (3) pursuit of community-based partnerships; and (4) use of data to test the effectiveness of small changes.

What held us back? A major component of the learning community was "meeting school teams where they were" and supporting their choices to work on specific drivers of change. Most teams implemented small increments of change at the site, rather than district-wide. As they achieved success, they tried "spreading" ideas to other schools in the district. The teams often did not include a district representative who could facilitate broader conversations about policy.

ON OUR WAY: The Network has adopted the defined parameters of oral health integration into primary education. Seventy-one percent of Network organizations that are engaged in school-based oral health issues are aware of the **framework for oral health integration in schools**.[13] This framework, created by SBHA, proposes five complementary components along the continuum from preventive oral health services to treatment of oral disease, namely: (1) oral health education; (2) oral health screening; (3) oral health preventive care; (4) care coordination and linkage to community-based oral health care; and (5) oral health treatment in schools. Most organizations reported full implementation of the frame, primarily through education and a broad range of clinical applications such as fluoride varnish, sealants, restorative care, and care coordination.

What helped us? SBHA and the Network led a comprehensive effort of oral health experts to define the parameters of the framework. This engendered the buy-in needed among key organizations to advance subsequent dissemination and adoption.

What held us back? While many organizations are aware of the parameters, additional work is needed to more fully disseminate them. Prompting adoption is an even heavier lift, requiring further strategizing among national organizations.

ON OUR WAY: All 10 districts include oral health in their wellness policy.
Half of the 10 districts — Chicago Public Schools, Houston Independent School District, Los Angeles Unified School District, New York City Department of Education, and Hillsborough County Public Schools — address oral health in their wellness policy.[14] Five districts include oral health education; care coordination and linkages to community-based health care; and/or preventive oral health care; and four districts address oral health screening and/or oral health treatment in schools.

What helped us? Factors that advanced the milestone include: support from the administration; an oral health assessment policy; promotion of services and parental consent; collaboration among the school district, city department of health, and other oral health stakeholders; grant funding; and partnerships with academic institutions and the community.

What held us back? Hindering factors to additional progress included: teachers' abilities to opt out of oral health education classes; school principals' abilities to choose not to offer oral health care services in their schools; having only one mobile unit that provides treatment across multiple schools; and insufficient funding.

LITTLE OR NO PROGRESS MADE: Consent rates for student participation in oral health programs in the 10 largest school districts has increased by 20 percentage points.
Chicago Public Schools saw increased consent rates for the six schools in its pilot program, but consent rates across the reporting districts decreased overall.

What helped us? Promising approaches noted by responding districts included community partnerships; offering incentives to schools for rates of consents; dentists' willingness to see any student with a positive consent, regardless of insurance status; and clear language on consent forms to define sealants and reinforce that there is no cost for services to families.

What held us back? This milestone was particularly challenging due to: the absence of program champions in schools; fear among families with undocumented members; low knowledge levels about the importance of preventive care and restoration; concerns about potential costs; inadequate assistance with Medicaid enrollment; lack of school interest in oral health; no funding for oral health investment; and competing mandates and priorities.

[13] Finding reflects a survey conducted in September 2018 of 92 Network members who subscribe to the Schools Community on the Network's Socious platform.
[14] The answer is unknown for the remaining five school districts..

CELEBRATING OUR SUCCESS

With leadership from SBHA, the Network is on its way to meeting four of this target's five milestones. School districts participating in SBHA's learning community are representative of the broader nation, therefore successes and failures within their tests of change are likely to be applicable in most districts, making the "spread" of successful initiatives possible. The "cross-pollination" of learning among districts was also tremendous — allowing them to develop and share creative, simple, and cost-effective ways to engage with schools, students, parents, and providers. One example was posting a simple dry-erase board that says "the dentist is coming on XXX date" in the front office, which was very effective at engaging school staff and students in Chicago.

In addition to fostering cross-district learning, work toward this target produced the framework for oral health integration in schools, guided by the varied programs, services, and unique collaborations among school districts, public and private providers, and families. This framework was needed for schools to design and "scale up" their programs.

Some districts, as well, did take on policy challenges, both prior to and through the work of the learning collaborative. The **Future Smiles** program in Clark County determined how to tie student ID numbers to their dental records, in order to track their overall long-term health. Future Smiles also implemented a five-year consent, approved through the school district's legal department. This was approved recently to serve all students enrolled in one of the district's schools, along with their siblings (regardless of school enrollment). New York City focused on passive consent; and Los Angeles took on implementing **mandated oral health assessments for kindergärtners** and mapping providers to facilitate care coordination.

MEDICAID

GOAL Include an adult dental benefit in publicly funded health coverage.

TARGET At least 30 states have an extensive Medicaid adult dental benefit.

Why This Target Matters: While access to extensive dental benefits through publicly funded health coverage is the most effective way to support equitable access to care, **less than half of states** cover critical oral health services for adults in Medicaid. **Prevalence of untreated dental caries** is accordingly much higher among lower-income adults — 42% for those at or below 100% of the Federal Poverty Level (FPL), compared to 17% of those with incomes of 200% of FPL or more.

Given the **connection between oral and overall health**, the impact of this inequitable access to care is great, even more so for Medicaid beneficiaries. Adults served by Medicaid have **higher prevalence of chronic diseases** that may lead to and be exacerbated by oral disease. Serious gum disease may **affect blood glucose control and contribute to the progression of diabetes**, and having deep cleanings (i.e., root planing and scaling) performed by an oral health care provider **can help to lower HbA1c levels**. Extensive dental coverage can thus drive improved clinical and quality-of-life outcomes, while potentially reducing Medicaid costs.

Other issues that underscore the importance of an extensive Medicaid dental benefit are:

- **Healthy pregnancies and birth outcomes** — Women with better oral health before and during pregnancy have more positive birth outcomes than those without it: pregnant women with periodontal disease may be up to eight-times more likely to deliver prematurely, and over 18% of preterm low birth weight babies may be attributable to the disease As **Medicaid pays for nearly half of all births** in the U.S., the oral health of this population is of particular importance to the program.

- **Impact on children** — **A child is four-times more likely to visit a dentist** if a parent does so. If the child's preventive **dental care begins by age one, dental care costs during preschool years are 40% lower**.

- **Avoidable and costly use of emergency departments (EDs)** — Each year, **two billion dollars are spent** in the U.S. on ED visits for dental care; in most cases, these needs **could have been addressed in community settings** if dental coverage were provided.

- **Employability** — **Almost one third (29%) of low-income adults** (below 138% of FPL) say the appearance of their mouth and teeth affects their ability to interview for a job, compared to 15% of those with incomes above 400% of FPL.

- **Nutrition among nursing home residents** — An unhealthy mouth with decayed or missing teeth **makes proper nutrition difficult**. For nursing home residents in states without an extensive dental benefit, this can exacerbate health issues and drive expenses for Medicaid, which **covers 62% of nursing home residents nationwide**.

Why It Takes a Network: Given that Medicaid dental coverage for adults is **optional for states**, coverage decisions are subject to the support of governors and state legislatures. State experiences have shown that a broad spectrum of advocacy is needed to convince these decision-makers to increase coverage. For example, one of the strongest "voices" in Virginia's successful efforts to enact an extensive Medicaid dental benefit for pregnant women came from obstetricians. They joined traditional oral health stakeholders such as the **state's oral health coalition** on legislative visits and attested that good oral health was necessary for their patients to have healthy pregnancies.

The state-level nature of decisions about Medicaid adult dental coverage further calls for a network approach that facilitates the sharing of best practices and cross-state problem-solving. Messages, outreach tools, approaches to data analysis, and other strategies that have proven successful in one state can be adapted and adopted by others.

LOOKING THROUGH AN EQUITY LENS

Individuals enrolled in Medicaid — whether they qualify based on income or health needs — have an increased likelihood of health disparities. Low-income populations have less access to a number of things that others take for granted, such as health care, transportation, employment, and healthy foods. Medicaid beneficiaries are also disproportionately members of racial and ethnic minority groups, who represent **58% of non-elderly Medicaid beneficiaries in the U.S., but only 39% of the overall non-elderly population**. The prevalence of dental disease and tooth loss is disproportionately high among low-income populations; and racial and ethnic disparities are further pronounced. Utilizing a health equity lens is essential to eliminating these disparities. Arguments are often made for reduced coverage for Medicaid beneficiaries as a tool to minimize public health care spending. Yet, insufficient coverage or access to care often further disadvantages Medicaid recipients, potentially driving worse outcomes and higher costs.

Disparities in the Medicaid population are also more pronounced among individuals with physical or cognitive disabilities, who are disproportionately represented: **more than one in three non-elderly adults under age 65 enrolled in Medicaid has a disability**. Not having a healthy mouth and living with oral pain can exacerbate their existing inequities.

OVERVIEW OF MEDICAID MILESTONE ACHIEVEMENT

MILESTONE ACHIEVED: Four states increase the level of covered services for all Medicaid-eligible adults.
Since 2014, 20 states increased the number of dental services covered for Medicaid-enrolled adults, and 26 did not. Frequently mentioned services that were added to coverage included silver diamine fluoride, periodontal services, and sedation. Twenty-seven states responded that an expanded set of services is covered by one or more contracted managed care organizations (MCOs).[15]

What helped us get here? The overriding factor facilitating the Network's far-surpassing this milestone was strong and engaged advocates, including state oral health coalitions. Also playing a role were: strong relationships with legislators, policymakers, and government officials; community engagement and participation; proactive Medicaid directors and state dental directors; use of managed care models; funding; and an understanding of the return on investment.

What held us back? In states where benefits were not expanded, a lack of funding was, by far, the most frequently cited barrier.[16] States also noted lack of support from the governor, cabinet members, legislators, and other policymakers; absence of consensus among stakeholders; and the length of time needed to educate policymakers, especially given their high turnover rates.

[15] Some respondents may have answered "yes" simply if the state contracts with an MCO, and not necessarily if the MCO covers a more extensive set of services than does the state itself.
[16] In some cases, however, it may be that the states are not prioritizing the use of limited funding on oral health.

MILESTONE ACHIEVED: Four states have enhanced the oral health benefit offered to specific eligibility categories in their Medicaid program.

Twenty-one states increased coverage of adult dental benefits for the Medicaid eligibility groups of pregnant women[17] (10 states), adults with an intellectual/developmental disability (six states), the elderly (three states), or the Medicaid-expansion population (two states). In several states, increases pertained to varied services and/or the annual expenditure cap. Eleven states noted that an expanded set of services is covered by one or more contracted MCOs.[18]

What helped us get here? Factors facilitating achievement of this milestone included legislation, advocacy efforts, and collaboration.

What held us back? In states where coverage for these groups did not expand, impediments included funding and state budgets; politics/partisanship; and impediments (e.g., low reimbursement rates and administrative requirements) to providers' participation in Medicaid.

MILESTONE ACHIEVED: A comprehensive set of resources and supports exists for any state to implement an advocacy campaign to increase coverage.

Most states have access to state-specific talking points, fact sheets, and prepared testimony, with the common themes of the economic and overall importance of oral health. Other available resources are a state-specific website produced by the state dental association, patient stories, and advocacy toolkits. Respondents cited a variety of state partners (most commonly, state coalitions, dental societies, and the Primary Care Association) as coordinators of these resources, and suggested that the materials are generally current.

At the same time, unmet needs include assistance accessing, compiling, and analyzing ED data; utilization data; and a cost-benefit analysis. Further, while helpful resources exist from state and national organizations, not all states are accessing them. It is unclear if this is because they are unaware they exist or are unsure how to customize, augment, and use them.

What helped us get here? The availability of comprehensive resources and supports for state advocacy around Medicaid adult dental coverage has been advanced by coordinated messaging; Medicaid dental as a shared priority among many partners; national partners' creation of tools that can be customized easily; and states' willingness to share tools and resources.

ON OUR WAY: The Network adopts a definition of an extensive Medicaid adult dental benefit.

In 2014, Network members formed a workgroup[19] to develop a rubric for assessing whether a state's Medicaid dental benefit is "extensive." Its intent is to replace the **currently used definition of "extensive,"** which relies on the number of services covered and caps on expenditures, with one that calls for coverage of specific services with recommended frequencies across various categories of care. The new rubric more accurately defines an extensive dental benefit as "one that provides coverage for a range of dental procedures considered adequate for the prevention of disease and promotion of oral health, the restoration of oral structures to health and function, and the treatment of emergency/urgent conditions for adult Medicaid beneficiaries…." It will: (1) capture point-in-time information at the state level about specific adult dental procedures covered by Medicaid; (2) better enable states to evaluate the extensiveness of their Medicaid adult dental benefits and serve as a self-assessment tool to identify specific opportunities for improvement; and (3) promote understanding of the term "extensive."

Development of the rubric has involved several iterations of the scoring tool itself, as well as a user's guide. It is currently being tested by state Medicaid agencies across the country.

What helped us? Leadership from organizations participating in the core workgroup, as well as willingness from other national and state-level experts in the field, contributed to the strong progress made.

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[17] Some states have dental coverage for pregnant women ages 19-20 and consider those to be adult benefits, though some states would consider this to be under the umbrella of EPSDT coverage.
[18] Some respondents may have answered "yes" simply if the state contracts with an MCO, and not necessarily if the MCO covers a more extensive set of services than the state.
[19] Core group members have included representatives from the ADA Health Policy Institute, American Network of Oral Health Coalitions, Center for Health Care Strategies, DentaQuest Foundation, and National Academy for State Health Policy.

What held us back? Given the potentially far-reaching impact of this tool and its use, and the lack of a clear consensus around what specific services (and the frequency of their delivery) are most critical to oral health, this has been a long and challenging process. Input from a wide range of stakeholders beyond the core workgroup was solicited, considered closely, and incorporated into iterative drafts of the rubric. This process, followed by the current testing phase, will help to ensure its validity and usefulness, but it also takes time.

LITTLE OR NO PROGRESS MADE: No states have rolled back Medicaid adult dental coverage.

Three states — Montana, Nebraska, and Wyoming[20] — reduced dental coverage for Medicaid-enrolled adults since 2014.[21] Rollbacks included loss of coverage for services such as dentures, fillings, and crowns, as well as a decrease in annual spending caps.

What helped us? Additional rollbacks were likely prevented by the factors that facilitated expansion in the above-referenced 21 states.

What held us back? Challenges to preventing rollbacks are rooted in the benefit being optional — it is often and relatively easily one of the first benefits to be cut when savings are needed.

CELEBRATING OUR SUCCESS

Progress toward the Medicaid milestones has been very strong. The Network achieved three of the five milestones and is on its way to meeting another. The most impressive and promising findings were 20 states' increases in covered services for all Medicaid-eligible adults, and 21 states' coverage increases for specific Medicaid eligibility groups. This happened during a time of great uncertainty about the future of the Medicaid program and other funding related to the **ACA**, suggesting strong will among states and other stakeholders to maximize coverage and access as long as laws and resources allow.

[20] Montana eliminated coverage for crowns and dentures; Nebraska reduced its expenditure cap by $250; and Wyoming eliminated coverage for dentures and fillings.
[21] The Medicaid target team contacted any state that indicated it did not increase coverage between 2014 and 2018 to see if it had a decrease during that time period.

MEDICARE

GOAL Include an adult dental benefit in publicly funded health coverage.

TARGET Medicare includes an extensive dental benefit.

Why This Target Matters: We count on Medicare to support our transition into the later stages in life and help keep us healthy, yet millions of aging Americans are **shocked to learn** that Medicare does not include any oral health benefit. This is particularly problematic for older, low-income adults who live in states without an extensive dental benefit in Medicaid and lack the resources to purchase commercial coverage or pay out-of-pocket for care. Almost 60% of low-income, older Americans **lack dental insurance**, and 80% of those uninsured **cannot afford to pay for major dental procedures** themselves. Even with coverage or other resources, older adults struggle to access care: **33 million live in dental provider shortage areas**. Not surprisingly then, **about half of older adults have untreated cavities; 30% are missing some or all of their teeth; and 23% have severe gum disease.**

Oral disease can contribute to the severity of comorbidities, such as diabetes and cardiovascular disease, which have **higher prevalence rates among older adults**. One way this happens is by **preventing the proper nutritional intake** needed to stay healthy. Lack of regular dental care can also directly lead to poor disease control: there is an **association between gum disease and several serious health conditions**. Older Americans are also more likely to have dementia, a condition **associated with elevated rates of oral disease,** and face **greater barriers to self-care**, including a decline in motor skills. Together, these risks and comorbidities make a Medicare dental benefit critical to older Americans' overall health and quality of life. To wit: **86% of likely voters among the general public support the idea**.

Why It Takes a Network: A network approach to including an extensive dental benefit in Medicare is critical for several reasons. To begin, Medicare program changes on this scale require a number of federal legislative actions. As reported in **Oral Health America's** 2018 white paper, **An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care**, these include first and foremost, removing the statutory exclusion of oral health benefits from the Medicare program that appears in **Section 1862(a)(12) of the Social Security Act**. Legislation would also be needed to establish dental coverage in **Medicare Part B** and allow for payment of services covered by the benefit; dental services would need to be defined in the Medicare statute; and sections addressing provider payment would need to be amended. Lastly, CMS would require authority to promulgate any regulations needed to implement and administer the new benefit. These changes would represent a tremendous shift in both the mindset of legislators and the scope of a long-established program, calling for voices from a large and diverse set of stakeholders.

Movement toward this target has been, and will continue to be, a slow and measured process, with many incremental steps taking place at state and community levels. Leadership from **state oral health coalitions**, providers, community-based organizations, and state legislative champions — aligning their messaging and efforts — is needed to effect such change.

Lastly, determining the optimal benefit design around which stakeholders will rally and request of Congress demands that they reach consensus. A network-based approach that draws from the unique expertise and perspectives of key stakeholders is the necessary path for doing so.

LOOKING THROUGH AN EQUITY LENS

Access to extensive dental benefits through publicly funded health coverage is the most effective way to support equitable access to oral health care. Unlike Medicaid, Medicare is not based on income and is available to anyone age 65 or over based on his own or his spouse's work records. As there is robust provider participation in Medicare, the program equitably enables access to health benefits to a growing older population regardless of demographic characteristics and health status. While this allows for a healthy end of life in many respects, without oral health coverage, only seniors who can afford additional expenses will be able to reliably access needed care. In long-term care settings, where many residents require assisted living, lack of dental coverage leads to exacerbated comorbidities in addition to specific oral health complications. Medicare is designed to provide equal access for all participants who have left the workforce; without dental coverage as a part of this, the intended effect of Medicare cannot be fully realized. If not addressed, this will only widen disparities in outcomes.

OVERVIEW OF MEDICARE MILESTONE ACHIEVEMENT

ON OUR WAY: The Network has adopted a consensus Medicare dental benefit design.

Though there has not been Network adoption of a consensus benefit design, **Oral Health America's** white paper, **An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care**, written in partnership with the **ADA**, **Center for Medicare Advocacy**, **Families USA**, **Justice in Aging**, and the **Santa Fe Group**, presented a consensus approach endorsed by these leaders in the field. Through the paper, whose authors are all Network members, this diverse group of stakeholders illustrated their support for a particular benefit design, which will be vetted with the broader Network.

What helped us? Factors that facilitated significant progress toward this milestone included: alignment among a core group of national organizations; awareness among stakeholders that Medicare dental benefits are an important issue among their constituents; and strong support for the benefit among older adults.

What held us back? Achievement of the milestone was hindered by competing priorities and scarce resources among state groups to devote time to Medicare. Following the 2016 election, the Network also revised its timeline for adoption of the benefit to the 2020 election cycle, as success requires a supportive president in office. It then focused on legislative activity to coincide with dental Medicare as a part of the 2020 campaign, and on advocating directly to CMS to expand its working policy to cover medically necessary dental care.

ON OUR WAY: A consensus advocacy agenda and approach have been adopted by a critical mass of key influencers with position and clout to support passage of a bill.

To assess progress toward this milestone, the target team looked at two markers at the state level. The first was how many state oral health coalitions have a Medicare dental benefit as a priority and/or are doing work around Medicare awareness; finding only 13. The second was how many state oral health plans have a program or approach for older adults; here, identifying 23.[22] This suggests meaningful attention being given at the state level.

There has also been movement nationally, illustrated by the above-referenced white paper. The national organizations that jointly authored the paper have "signed on" to move forward with advocating for the principles contained therein. Further, while there is nothing "official" to cite, visits with congressional staff and several Senators and Members of Congress indicate an understanding of the need for a Medicare dental benefit and a desire to be updated on and involved in additional discussions.

What helped us? Movement toward the milestone was facilitated by several factors, including: the prioritization of older adults by state oral health coalitions and community organizations; collaboration and interest among multiple stakeholders; funds available to focus on advocacy for older adults; large older-adult populations; coalition-building around older adults and the issues facing them; and messaging from national partners around Medicare. Network involvement

[22] Among those states indicating that their state oral health plan does not have a program or approach for older adults, four said they have no state oral health plan, and four did not know if their state has one.

from many critical and influential organizations on the issues (e.g., **AARP**, **ADA**, **National Association of States United for Aging and Disabilities**, and others) has also driven progress.

What held us back? Barriers to this milestone are at both state and national levels, and mirror some facilitating factors. Within states, there is little work toward the benefit. At the state level and nationally, there is continued low awareness about Medicare; a lack of consensus prioritization of older adults; little non-elderly issue advocacy group involvement in Medicare issues; the absence of state dental directors or state oral health coalitions; inadequate resources for an adult oral health advocacy agenda; and competing child-focused agendas. Further, while some state oral health coalition strategic plans and state oral health plans address older adults, this does not always translate into "clout" to support passage of a bill.

LITTLE OR NO PROGRESS MADE: Dental benefit in Medicare is part of the midterm election discussion.

Only 11 states indicated that state-level stakeholder organizations are including Medicare dental benefits in their midterm advocacy efforts; and only four said that safety net providers are including Medicare dental benefits in theirs. Further, only seven were aware of any candidates (either one or two) in their state for the U.S. Senate or House in the midterm election with public positions on dental coverage in Medicare.[23]

What helped us? The majority of candidates with public positions on the issue are Democrats and reportedly well-informed about it. Other facilitating factors are national messaging about the need for the benefit; strong support among seniors; and collaboration among stakeholders.

What held us back? Factors hindering additional progress included: competing health care issues; the absence of Medicaid adult dental benefits in a state, which takes precedence as an issue; perception of the issue as federal, rather than state; a lack of understanding among candidates; the absence of a sign-on letter or other requested specific actions; and the potential high cost of the benefit.

LITTLE OR NO PROGRESS MADE: Senate committee of jurisdiction holds hearing on benefit.

As no Senate hearing on a Medicare dental benefit was held, the Network explored progress toward this milestone by looking at how many state legislatures have introduced resolutions on a Medicare dental benefit. Only two states — Hawaii and New Jersey — have done so,[24] and neither bill passed.

What held us back? In line with impediments to other Medicare milestones, factors include competing state priorities; low awareness among public officials; and a lack of political will. The Network also changed its strategy to wait to seek legislative champions after the 2018 midterm elections when it becomes clear which party controls leadership roles and who could best file legislation.

MILESTONE PROGRESS UNCLEAR: There is a 15 percent increase in the number of Medicare-eligible people that are aware of and actively advocating for this coverage.

Data to assess this milestone are not currently available. However, Oral Health America and partners in aging, Medicare and oral health, have worked since 2015 with **Marketing for Change**, a behavior change firm that utilizes social psychology and behavioral economics, to build a consumer campaign — **Demand Medicare Dental** — to engage and motivate adults ages 50 and older to advocate for a dental benefit in Medicare. While there is no baseline against which to measure an increase in awareness and advocacy, data from this work have assessed engagement of the older population where Oral Health America implemented pilot awareness campaigns. The pilot campaigns include an **online presence** where consumers can learn their candidates' positions on adding a dental benefit to Medicare and call or send a toothbrush to let legislators know "I have teeth and I vote." To drive audience action, the campaigns also include event activism, where on-the-ground partners educate seniors on the issue and collect signatures on toothbrushes at local events to send to legislators. In each of these states, the term "Medicare dental" tended to have higher peaks and more sustained Google searching during the campaign compared to the time period immediately prior to the campaign and the same time period in 2017.

[23] Hawaii introduced a bill in its 2018-19 legislative session, urging Congress to require adult dental coverage under Medicare and Medicaid; New Jersey introduced a bill during each session since 2014-15, memorializing Congress to provide Medicare coverage for eyeglasses, hearing aids, and dentures.

[24] Response validity may have been hampered by the following: some candidates identified by respondents may not be up for re-election; in at least one state, it is likely that the respondent considered candidates for state office; states have primaries at different times, muddling which candidates to consider; and 13 respondents indicated "unknown" — it is not clear if they searched for candidates' positions and found nothing, or did not search.

What helped us? The campaign framework designed by Marketing for Change is supporting awareness and advocacy around the issue among older adults.

What held us back? The primary impediment to this milestone appears to be a lack of data around both baseline and subsequent rates of awareness and advocacy. Network leaders' perceptions of these rates in 2014 are not clear, nor is how they envision assessing change.

CELEBRATING OUR SUCCESS

Key accomplishments toward this target include the engagement of a wide group of subject-matter experts, Medicare advocates, and other stakeholders to design a benefit and advocacy strategy. This consensus includes agreement on a strategy to advocate that CMS use its current regulatory ability to cover medically necessary dental procedures.

Stakeholder work toward extensive dental coverage in Medicare produced agreements that are reflected in the **Oral Health America white paper** — profound in its representation of consensus on difficult issues including concrete ideas on benefit design and financing structure. Congressional visits, while modest, have formed a ground floor for greater advocacy.

Another key accomplishment was the impact of the **Demand Medicare Dental** campaign piloted in 2017 in Orlando, Florida, which produced broad support from constituents of different political leanings and age groups. The pilot created **an advocacy platform** to help consumers take action; generated conversation and debate in the community; and provided more than 2,000 points of contact with lawmakers. Based on its success, the pilot was expanded to Iowa, West Michigan, and East Tennessee in 2018.

MEASUREMENT

GOAL Build a comprehensive national oral health measurement system.

TARGET A national and state-based oral health measurement system is in place.

Why This Target Matters: The U.S. has made significant advances in expanding dental coverage and access to oral health care, especially among children and low-income families. Despite this progress, the oral health community still lacks timely, consistent, and readily available data to describe adequately the state of oral health and/or the impact of health interventions across populations. To better inform policy and improve accountability, policymakers and advocates continue to seek a comprehensive and well-aligned system of oral health measurement.

Why It Takes a Network: Oral health data are currently collected, analyzed, and distributed in highly fragmented and ineffective ways. Data that are collected reside with multiple stakeholders that are not necessarily aligned in approach or their timelines for data analysis and release to the public. Given how critical access to data is to the success of all Network goals, it is essential to develop a multi-stakeholder approach that engages policymakers, data consumers, data analyzers, and data collectors such as federal agencies to develop a measurement system that meets their diverse needs.

Further, despite consensus around the importance of access to information, policy change that supports a comprehensive measurement system is not a current policy priority. A group of aligned advocates who represent the consensus of key stakeholders has a much greater chance of advocating successfully for such change.

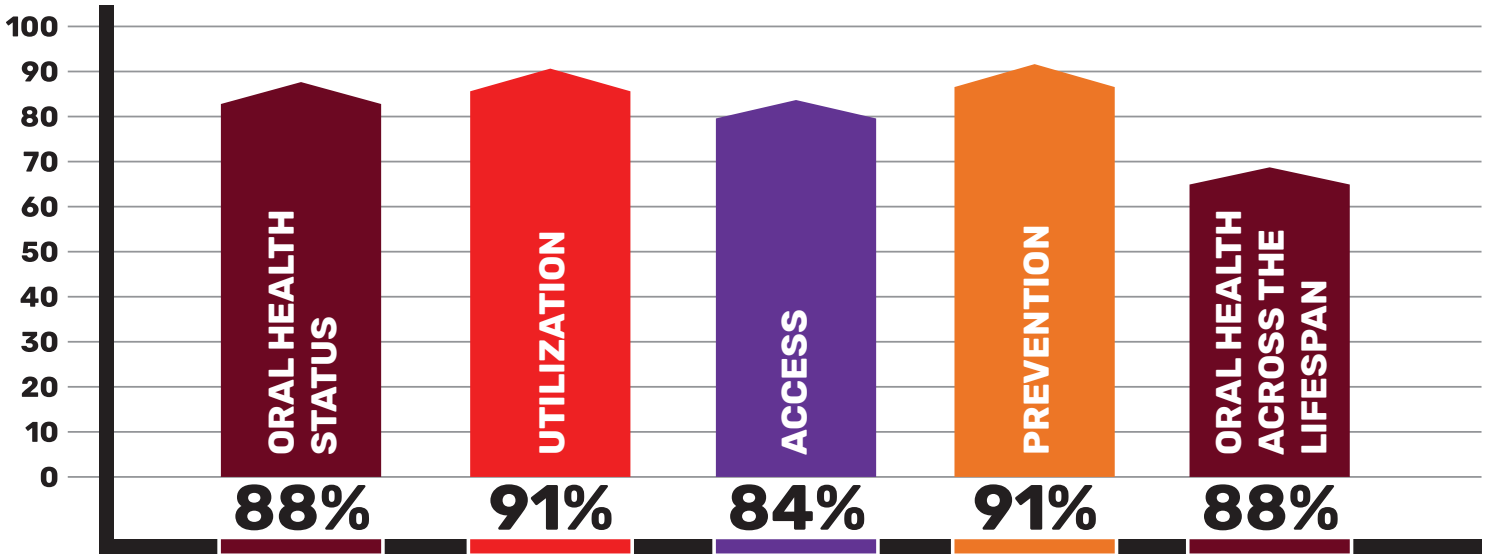
LOOKING THROUGH AN EQUITY LENS

There is an adage that 'you measure what you care about'. Much of the existing, fragmented data does not recognize disparities or magnify health inequities because the data cannot be disaggregated to reveal them. In an age of increasing complexity, **big data** analysis has become a critical strategy in making policy decisions, designing and refining programs, and allocating resources. However, data can reinforce structural and racial inequities if it does not present an accurate representation of the population. Data that can be disaggregated to meaningfully reflect people's lived experiences is vital to lifting up health inequities and avoiding unintended, inequitable outcomes.

OVERVIEW OF MEASUREMENT MILESTONE ACHIEVEMENT

MILESTONE ACHIEVED: Forty percent of states are collecting data aligned with the recommendations of the Network. Fifty-three percent of states collect measures in the areas of oral health status, utilization, access, prevention, and oral health across the lifespan, surpassing this milestone (see Table 1). These data most commonly come from Medicaid, the CMS 416 Report, **3rd Grade Basic Screening Survey for Children**, **Head Start Basic Screening Survey**, **Older Adult Basic Screening Survey**, the CDC's **Pregnancy Risk Assessment Monitoring System**, and the **Behavioral Risk Factor Surveillance System.**

Table 1: Percentage of States Collecting Data in Each Category



What helped us get here? The most frequently noted factors driving achievement of the milestone were: use of epidemiologists; an active state oral health program; inclusion of data collection in the state oral health plan; data collection requirements of grant applications and CMS; and collaboration between state Medicaid agencies and departments of health. Also helpful were: external data-sharing partnerships; oral health surveillance systems and data collection funded by foundations or federal grants; and growing awareness that oral health is related to overall health.

What held us back? The primary challenge to data collection in other states is a lack of financial and staffing resources. Other factors were: lack of access to the data; an inadequate data collection/reporting infrastructure; and the absence of a state dental director.

ON OUR WAY: Consensus recommendations for a core set of measures with sufficient granularity and a measurement and reporting strategy have been adopted by the Network.

While consensus recommendations have not been written or adopted, meaningful progress has been made. In 2017, the Network convened federal agency officials and a working group of expert advisers who, with the **Children's Dental Health Project** and ASTDD, developed a matrix of oral health measurement priorities and a driver diagram listing priorities for improving oral health measurement systems.

What helped us? Progress was driven by the cultivation of relationships among key leaders in oral health measurement. The white paper **Making Oral Health Count: Toward a Comprehensive Oral Health Measurement System** represents a consensus among stakeholders including federal agency officials working on oral health measurement. This would not have been possible without a strong set of aligned relationships built through ongoing interactions in the Network. There has also been uniform agreement that an improved measurement system is necessary to achieve all of the Network's goals.

What held us back? A challenging political environment resulted in disruption of many improvement efforts. With significant change in federal agencies, available funding, and increased partisanship, opportunity for action on this milestone was inhibited. Network members faced competing priorities such as protection of the Medicaid program.

LITTLE OR NO PROGRESS: Key federal agencies, policymakers, and the Network are aligned around a core set of measures with sufficient granularity and a measurement and reporting strategy.

What held us back? Before this alignment can occur, consensus recommendations for the core set of measures (the milestone above) are needed.

MILESTONE PROGRESS UNCLEAR: Thirty percent of care delivery settings using electronic health records have integrated medical and dental records.

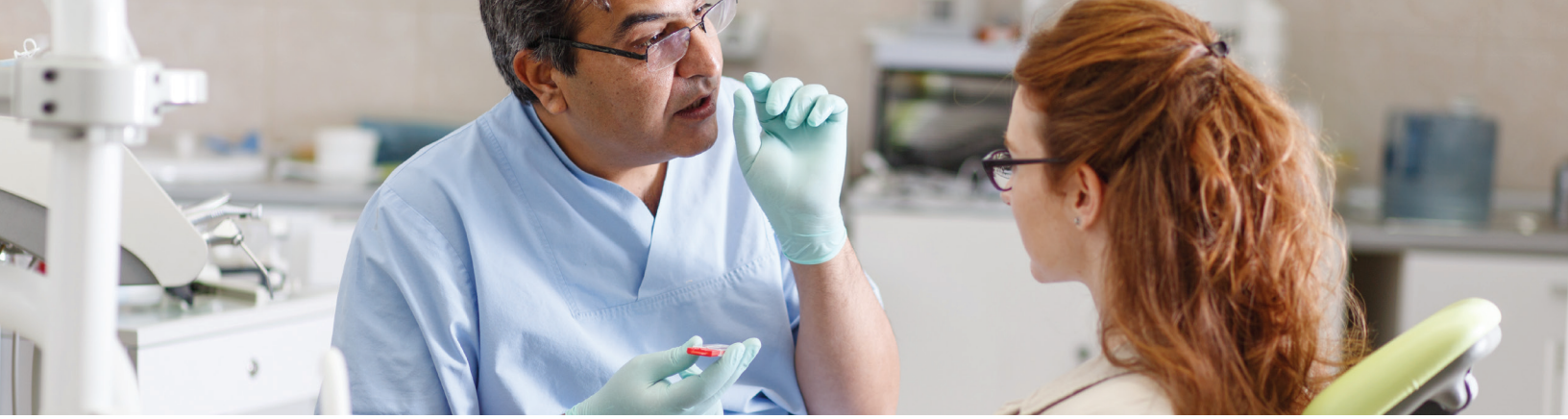
States reported on: (1) the percentage of care delivery settings with fully integrated EHRs; and (2) the percentage of care delivery settings with some interoperability between medical and dental records. Respondents were challenged to answer these questions. Of the 41 states that responded to question one, 19 said data are not available; nine reported some degree of integration without a known percentage; and 13 states gave an estimate (with an average of 46% having interoperability between medical and dental records).

What helped us? Several federally funded initiatives support the milestone, notably **Meaningful Use**, a CMS initiative initiative to improve the infrastructure and use of EGRs in health care settings. Other supportive factors were technology improvements and growing recognition that access to data can improve health care efficiency and effectiveness.

What held us back? While the value of integrated records is widely acknowledged, most EHR vendors do not offer interoperable records. Additionally, converting from paper to electronic records is a significant undertaking for health care systems, causing some resistance. In some cases, resources are not available to support record integration work.

CELEBRATING OUR SUCCESS

Progress toward the measurement target has been mixed, with bright spots around aligned Network-wide data collection and the development of recommendations for a core set of measures. The white paper **Making Oral Health Count: Toward a Comprehensive Oral Health Measurement System** was a tremendous accomplishment in this area, including a matrix of oral health measurement priorities and a driver diagram outlining factors that may advance progress toward a more ideal oral health measurement system. The brief resulted from a multi-year effort to gather oral health stakeholder input on the state of oral health measurement and data collection, and opportunities to move toward the Network's measurement target. With input from key stakeholders in the measurement space, it represents both strong consensus and technical precision.



PERSON-CENTERED CARE

GOAL Integrate oral health into person-centered health care.

TARGET Oral health is integrated into at least 50% of emerging person-centered care models.

Why This Target Matters: The ACA paved the way for innovation in care centered around the patient or individual, including **creation of a fund** to support innovation in accountable care and regulation of accountable care organizations. The **patient-centered medical home** and **accountable care organizations** are two prominent models that arose, but neither explicitly includes oral health. However, person-centered health care without oral health care is not sufficient. Oral health *is* health. Ensuring that oral health is included in these and other emerging person-centered care models requires innovations in education, clinical care models, reimbursement, and patient expectations.

Why It Takes a Network: Meeting this target requires multiple changes within the health care system, including alterations to payment methodologies, clinical care models, communications processes, and technology. To that end, a broad, interprofessional stakeholder group — including policymakers, administrators, coalitions, health care providers, payers, and educators with knowledge and influence in each of these areas — is vital to realizing change. These parties must work together to promote a health care system that is held accountable for the health, including the oral health, of the people it serves.

LOOKING THROUGH AN EQUITY LENS

Chronic diseases can affect lifelong health and quality of life. While diabetes and heart disease are widely recognized examples, **oral health is the most common chronic disease** in America today. Yet many individuals are only able to access care from a primary care provider, and not an oral health care provider. However, primary care providers have limited time with patients, and many do not feel adequately trained to address oral health needs nor see their patients' oral health as their responsibility. Furthermore, oral health care providers often do not focus on broader health indicators or view themselves as part of the overall health care team. Access challenges are even more pronounced for people supported by public health care dollars through Medicaid and/or Medicare, for those living in rural areas, and those with limited access to transportation. These factors underscore the importance of using a health equity lens when striving to provide person-centered care.

OVERVIEW OF PERSON-CENTERED CARE MILESTONE ACHIEVEMENT

MILESTONE ACHIEVED: Twenty percent of provider education and training programs include a focus on oral health and interprofessional care.

Of 45 states reporting, 30 (67%) have provider education programs that address interprofessional care including oral health, far exceeding the milestone. Twenty one of these programs educate providers in a multidisciplinary setting, while 22 do so for professions separately.

What helped us get here? Factors driving the Network to surpass this milestone included: federal grant funding; willing and geographically close partners; access needs in rural areas, where the scarcity of providers mandates they address the full range of health needs; the Institute of Medicine's report **Integrative Medicine and Patient-Centered Care**; the World Health Organization's **Framework for Action on Interprofessional Education and Collaborative Practice**; the **Smiles for Life** online oral health curriculum for primary care providers; innovative or visionary academicians; and **state oral health coalitions'** ongoing work with physicians and dentists.

What held us back? While progress toward this milestone was impressive, a number of challenges were faced. For example, low or inconsistent reimbursement rates for oral health services in a medical setting limit the number of private health systems willing to include oral health in their practices. Other hindering factors were: lack of reimbursement by third-party payors; low perceived value of team-based care among the separate professions; the absence of team-based care role models and persistence of a siloed approach to health care; the lack of a state dental director; inadequate buy-in on the importance of oral health education; inadequate time for clinic staff to participate in oral health education; and lack of knowledge about no- or low-cost oral health education resources.

ON OUR WAY: The Network is aligned around a definition of integrated person-centered care.
State data make clear that an emerging consensus among key stakeholders is beginning to take shape, and that this consensus contains elements of the definition of person-centered care used in this analysis. In the majority of states, organizations representing the fields of advocacy (36), public health (40), providers (36), and community programs (38) work or have policies aligned with this definition.

For the purpose of this assessment, the target team defined person-centered care as: a health care delivery system in which all aspects of patient care among health care providers — for example dental, medical and behavioral care and community resources — are integrated and coordinated, and are valuable and meaningful to the patient; and the system has goals of improving health care quality and outcomes and lowering health care costs.

What helped us get here? Primary supporting factors have been a shift in perception within key stakeholder groups (e.g., OBGYNs, nurses, other health care providers, policymakers, administrators, public health advocacy organizations, etc.) toward recognition of the importance of including oral health in person-centered care.

What held us back? Greater progress has been hindered by lack of time and other resources, and low prioritization of oral health.

ON OUR WAY: Oral health is included in key national accreditation standards for person-centered care.
The **National Committee for Quality Assurance (NCQA)**, **The Joint Commission**, the **Public Health Accreditation Board (PHAB)**,[25] and the **Accreditation Association for Ambulatory Health Care (AAAHC)** all include oral health in accreditation standards for **patient-centered medical homes**, a widely accepted model for patient-centered care.[26] However, these standards are only mandatory for PHAB accreditation, and optional for the others.

What helped us? Increased awareness of the importance of oral health to overall health has made organizations more willing to focus on oral health, driving accrediting organizations to recognize it. Other supportive factors include: research showing correlations with comorbidities; **USPSTF** guidance around including preventive oral health care in primary care; and the **Institute for Health Improvement Triple Aim**, which drove public discourse that created a receptive environment for inclusion of oral health.

What held us back? The accreditation process is "high stakes," so changing the standards is not easy.

[25] Local and state health departments must obtain accreditation from PHAB.
[26] Patient-centered care focuses on the development a multi-disciplinary health care team that addresses the clinical needs of patients. Person-centered care broadens the health team to include community resources that can address issues beyond the care setting and impact social determinants of health.

ON OUR WAY: Twenty-five states have oral health incorporated into their person-centered care policies.
While some states have oral health provisions in regulatory guidance around person-centered care, it is lacking in the majority of state policy: 11 states include oral health in their regulatory guidance around person-centered care that is delivered by publicly funded programs (such as Medicaid); 11 states have guidance about oral health in their person-centered care policies for publicly funded coverage; and eight have a policy related to private payers that regulates oral health inclusion in person-centered care.

What helped us? Inclusion of oral health in state person-centered care policies has been supported by institutional, legislative, and strong state partnerships that advocate for and/or implement mandatory programs to change health care delivery systems.

What held us back? Additional progress has been hindered by a lack of funding for states to test innovative care models, particularly for reimbursing the delivery of integrated care; uncertainty about the return on investment of oral health care; the slow pace of change; and low levels of integration between electronic health and dental records.

ON OUR WAY: Quality metrics for oral health care integration have been developed by key national stakeholders.
While most national stakeholders — including HRSA's **Maternal and Child Health Bureau**, the **Dental Quality Alliance (DQA)**, and **PHAB** — lack quality metrics for oral health care integration, the **National Network for Oral Health Access (NNOHA)** produced a set of seven metrics that Federally Qualified Health Centers may implement. These metrics are:

- Number and percentage of fluoride varnish applications for high-risk patients.
- Number and percentage of patients receiving oral health preventive interventions.
- Number and percentage of patients referred from medical to dental care.
- Number and percentage of patients who are linked to definitive oral health care and treatment.
- Changes in quality of care/outcome indicators.
- Knowledge and skills of primary care providers.
- Patient experience and knowledge of oral health.

NNOHA promotes opportunities for the deployment of the above standards, and provides training and capacity-building for community health centers interested in implementing them. This helps to lay the groundwork for the future implementation of value-based care models.[27]

What helped us? Several HRSA-funded initiatives are providing resources and developing knowledge that will be critical in the eventual development of these metrics. The CDC's funding of state oral health programs will also support the development of metrics by funding collaboration between oral health and chronic disease departments in five states. In addition to this public agency involvement, several private stakeholder organizations such as NNOHA and the **DQA** are working to advance metrics.

What held us back? A lack of consensus around which metrics to include (e.g., process vs. outcome metrics) has inhibited advocacy for inclusion of oral health in integration metrics. This is another milestone that has been impeded by a lack of funding, disenfranchisement of the importance of the issue, and inadequate staffing resources (including providers to deliver care).

LITTLE OR NO PROGRESS MADE: A diverse set of pilot programs that serve as a model for fully integrated person-centered care and are reimbursed based on health outcomes has been launched.
Across the country, respondents identified an impressive 30 state pilots that are testing an innovation in where, how, or by whom care is delivered. However, only four pilots are coupled with a reimbursement mechanism, and only one reimburses based on health outcomes.

[27] Value-based care is the combination of person-centered care models with a funding model that provides reimbursement incentives for achievement of patient-relevant health outcomes (value equals improved outcomes at lower cost).

What helped us? The establishment of these pilot programs has been advanced by grant funds that target integration, as well as greater awareness and research demonstrating the importance of oral health to overall health.

What held us back? Progress toward incorporating reimbursement that rewards health outcomes has been hindered by a lack of additional Medicaid funds to reimburse for health outcomes, long-term funding, and interoperable electronic software for patient care and data gathering. The practicality of achieving this milestone anytime soon was also questioned.

CELEBRATING OUR SUCCESS

Considering the importance of engaging non-dental providers as part of the full person-centered care team, the need for provider education and training is paramount. It is heartening to see, then, that the Network made meaningful progress toward oral health integration in person-centered care models, with foundational achievements including two thirds of states' reporting provider education programs that address interprofessional care including oral health (far exceeding that milestone).

Pivotal to provider education programs has been the **Smiles for Life** online oral health curriculum, required for many providers to qualify for reimbursement for the application of fluoride varnish, and widely recognized as the most comprehensive online training program available. From 2014 to present, the site has had over one million discrete site visits, 50,000 registered users, and a 90% user satisfaction rate. As a way of delivering training and education to providers, it continues to be one of the most impactful tools available.

Movement in national accreditation standards, person-centered care policies, and quality metrics for oral health care integration further point to recognition of the target's importance in advancing both oral and overall health outcomes.

PUBLIC PERCEPTION

GOAL Improve the public perception of the value of oral health to overall health.

TARGET Oral health is increasingly included in health dialogue and public policy.

Why This Target Matters: Dialogue continues in the U.S. about what it means to be healthy and what Americans expect and deserve out of their health care system. The outcomes of these conversations will create social norms that drive what it means to be healthy. Policy change without a corresponding shift in social norms has little impact; policy change without public support is difficult to achieve.

Changing the public discourse about oral health — that it is not just about the teeth and mouth, but about overall health, quality of life, and equity — is critical to creating an environment where oral health equals overall health. Shifts in perceptions are also needed away from personal responsibility (or blame) for poor oral health to consideration of the systemic barriers and forces that lead some populations to fare much worse than others. These changes are critical to improving oral health.

Why It Takes a Network: Oral health is a "wicked problem" that requires a coordinated, collaborative approach to make progress. Changing the public discourse about oral health calls for the widest range of voices, engagement, and sharing of available information. Efforts are needed to educate and embolden people to think about oral health as more than teeth and dentists — moving beyond personal responsibility and direct care delivery to a community-based mindset. Strategies to achieve this include: awareness campaigns; securing input from community-based organizations and other stakeholders about current perceptions; and creating an aligned knowledge base about framing messages. That is the focus of social movement: to create systems change, changes are needed in the way people think and talk about the issue.

Through continuous sharing of promising practices and emerging information, a network enables us to stay at the forefront of new and evolving platforms for engaging with the public and other decision-makers. It also helps to ensure that everyone is up-to-date on the evidence and science bases for oral health improvement.

LOOKING THROUGH AN EQUITY LENS

Current public mindsets that put responsibility and blame on individuals for their oral health create an immediate equity issue: individuals who have greater incomes and stability, and are already welcome in the health care delivery system, are more likely to access services. Instead, an understanding is needed of the systemic factors that create a "locked door" to oral health for others.

Disparities also arise when thought-leaders and providers create a policy agenda without adequate representation of public interests. This tends to maintain the status quo, rather than driving exploration of new solutions that are rooted in communities and other systems.

OVERVIEW OF PUBLIC PERCEPTION MILESTONE ACHIEVEMENT

ON OUR WAY: Twenty-five states have legislative committees of jurisdiction with oral health as a priority in their health policy agenda.

The target team looked at how many states have a committee, caucus, or commission in its legislature that explicitly mentions oral health in its documentation or website:[28] Only 15 of 48 states responded yes, most commonly noting Health, Insurance, Health and Human Services; and Ways and Means committees. Others were: Senate Finance — Health Subcommittee; Legislative Statutes; House Appropriations; Health and Welfare; and Oral Health Caucus.

What helped us? Among states with such committees, facilitating factors were: advocacy by a dental board, dental hygiene committee, dental director, tribes, or advocacy groups; dental provider association; Department of Medicaid; legislators; Cabinet for Family Services; proactive planning by multiple organizations; oral health recognition by legislative leaders; relationships with General Assembly members; presentations to committee members; coordinating grassroots efforts; Healthcare Workforce Committee; Access to Care Committee; webinars for targeted audiences; a data repository to support legislative decisions; a coalition or network; an oral health coalition position statement; and broad stakeholder engagement.

What held us back? Further progress was hampered by: inadequate funding for advocacy; absence of health care leadership; support of health, but not explicitly oral health; competing policy priorities; lack of a state dental director; and need for more direct lobbying/advocacy to develop an oral-health focused committee.

ON OUR WAY: Engagement of congressional champions has resulted in all committees of jurisdiction having oral health as a priority in their health policy agendas.

Since the above milestone was not met, neither could this milestone be. However, most respondents identified individuals, legislative, and congressional champions of health in their states; and most have targeted champions at a single level of government (state or federal; legislative or executive). Most have used champions of health as entry points to oral health; some identified champions already focusing on oral health; and a few specifically reported champions working to expand Medicaid dental coverage.

Respondents also noted a wide variety of awareness and education activities/materials[29] in use by organizations in the state to elevate awareness of oral health among legislative stakeholders. The most commonly cited materials were fact sheets, one-pagers, and handouts; others were social media, state health department resources, newsletters/magazines, and reports. Awareness/education activities included: an annual legislative meeting or oral health day; oral health testimonies; legislative meetings; lobbying; and activities for legislators.

What helped us? Collaboration with local and national organizations, as well as strong and active oral health coalitions, drove progress toward this milestone.

What held us back? Factors hindering progress included a lack of support/funding, competing health priorities, and absence of an oral health coalition or political/legislative champions.

ON OUR WAY: The Network has consensus policy priorities that promote the achievement of the 2020 targets.

To assess progress toward this milestone, the target team considered whether written policy priorities that promote achievement of the 2020 targets exist. While these do not formally exist yet, the Network's **Policy Network Response Team** (NRT) articulated some policy priorities, tied to specific goals, in its **Why statements**. This document, along with the NRT's bi-weekly calls to educate Network members about policies that feed into the goals, reflect progress toward the milestone.

What helped us? The Policy NRT plays a critical role in moving work on this milestone forward. Its **Why statements** document is a good stepping off point for focus on this target and milestone. The NRT plans to use the Why statements as a foundation for developing guiding principles for Network priorities. Once developed, the NRT will share it with the Network for feedback and to help Network members identify how policy initiatives relate to programmatic goals.

[28] This approach was taken because committees of jurisdiction do not identify policy priorities; however, an oral health caucus or other appointed or convened group would do so. Changes to the milestone language are thus needed.

[29] "Awareness" and "education" were treated as a unit for purposes of data analysis, as respondents did not distinguish them.

What held us back? The Policy NRT determined that creating an exhaustive list of policy priorities was not feasible given the varying jurisdictions, perspectives, and nuances of each goal. Further, Network members are working on a wide variety of policy initiatives: some are defensive measures, others proactive, and all specific to the jurisdiction the policy oversees. This makes agreement on policy goals that are appropriate for the entire Network challenging.

ON OUR WAY: All Network members are delivering framed messages in their oral health communications.
Network members' familiarity with and use of framed messages to communicate about oral health are substantial. The majority are aware of the **FrameWorks Institute's** work in this space (77%), and have attended a Network meeting at which FrameWorks provided training on the topic (69%). Accordingly, 59% have used FrameWorks' messaging guidance to create new or update existing communications materials, and 77% are somewhat or very comfortable using framed messages in oral health communications.[30]

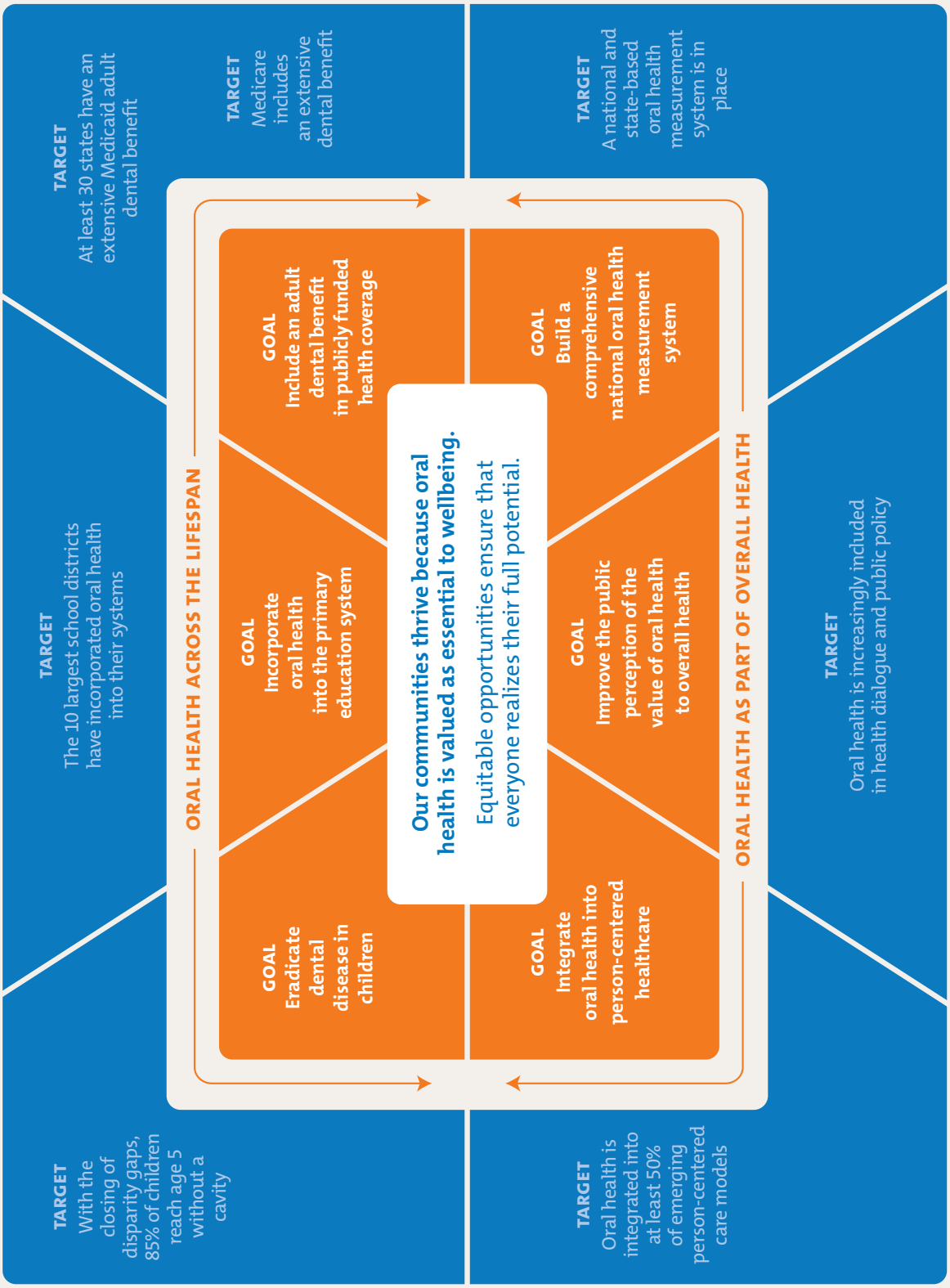
What helped us? FrameWorks delivered and reinforced guidance on framing at Network in-person and virtual convenings, and also provided direct technical assistance upon request from Network members. This undoubtedly helped to raise awareness of and comfort with using framing techniques.

What held us back? Achieving the milestone of all Network members delivering framed messages is likely not a realistic expectation. Further, movement toward the milestone will be slow, as it calls for a significant shift in mindset about approaches to communication. In the face of these challenges, the findings of this milestone assessment are particularly promising.

CELEBRATING OUR SUCCESS

The Network made meaningful progress toward all four of the target's milestones, due largely to collaborative efforts of the Policy NRT and concerted efforts by Network members to understand and apply framed messages to their work. The February 2018 *New York Times* article "**How Dental Inequality Hurts Americans**" was a clear example of a well-framed media piece on oral health that resulted directly from Network efforts. The article highlighted connections between inadequate access to oral health care through Medicaid and dental disease, systemic disease, social interactions, pain, personal appearance, and employability.

[30] Findings are based on an electronic survey of conducted of Network members in September 2018. Responses from 131 members were received.


Our communities thrive because oral health is valued as essential to wellbeing.
Equitable opportunities ensure that everyone realizes their full potential.
ORAL HEALTH ACROSS THE LIFESPAN
ORAL HEALTH AS PART OF OVERALL HEALTH
GOAL
Eradicate dental disease in children
GOAL
Incorporate oral health into the primary education system
GOAL
Include an adult dental benefit in publicly funded health coverage
GOAL
Integrate oral health into person-centered healthcare
GOAL
Improve the public perception of the value of oral health to overall health
GOAL
Build a comprehensive national oral health measurement system
TARGET
With the closing of disparity gaps, 85% of children reach age 5 without a cavity
TARGET
The 10 largest school districts have incorporated oral health into their systems
TARGET
At least 30 states have an extensive Medicaid adult dental benefit
TARGET
Medicare includes an extensive dental benefit
TARGET
Oral health is integrated into at least 50% of emerging person-centered care models
TARGET
Oral health is increasingly included in health dialogue and public policy
TARGET
A national and state-based oral health measurement system is in place

ON THE ROAD TO THE GOAL:
ERADICATE DENTAL DISEASE IN CHILDREN

ON THE ROAD TO THE GOAL:
INCORPORATE ORAL HEALTH INTO THE PRIMARY EDUCATION SYSTEM

ORAL HEALTH FOR ALL 2020℠

At the end of the journey the vision becomes **reality.**

TARGET
THE TEN LARGEST SCHOOL DISTRICTS HAVE INCORPORATED ORAL HEALTH INTO THEIR SYSTEMS.

GOAL
INCORPORATE ORAL HEALTH INTO THE PRIMARY EDUCATION SYSTEM.

Milestones are markers along the road to reaching a target, and can happen in the network in any order, and even at the same time.

2018 MILESTONES

- X % of schools in districts are delivering oral health services in the ten districts
- National learning collaborative has created measureable district-wide improvement in cross-cutting policy barriers in the ten districts
- The Oral Health 2020 Network has adopted the defined parameters of oral health integration into primary education
- All ten districts include oral health in their wellness policy
- Consent rates for student participation in oral health programs in the ten largest school districts has increased by 20 percentage points

NATIONAL TACTICS
- Convene the ten districts to share best practices
- Engage national partner organizations with reach and influence in school-based healthcare to integrate oral health
- Host national convening (or integrate into larger health conference) of best practice in school-based oral health programs
- Define parameters of oral health "integration" in schools and compile all supporting tools and resources
- Define a standardized set of school-based measures and data collection tools and resources
- Create a case statement for the value of oral health integration into primary education

STATE TACTICS
- Identify and spread best-practice financing models for school-based oral health programs
- Engage state partners in exploring alternative workforce and care delivery models in school-based settings
- Engage state partners in collecting and reporting state-wide school oral health data
- Develop and implement a comprehensive model in the ten districts

COMMUNITY TACTICS
- Assess landscape and expand relationships in ten districts to identify best partners and obtain buy-in
- Develop and implement comprehensive models for each of the 10 districts
- Engage broader range of community partners to promote equity and disparity reduction through school-based oral health programs in school districts
- Engage district partners in collecting and reporting district and individual school oral health data
- Assess current community needs and existing programs delivered in school settings
- Include oral health representation in school health advisory councils, school boards, etc.

Tactics, as they are implemented, will help to achieve milestones, Tactics happen at multiple levels, and often simultaneously, across the network.

ON THE ROAD TO THE GOAL:

INCLUDE AN ADULT DENTAL BENEFIT IN PUBLICLY FUNDED HEALTH COVERAGE

ORAL HEALTH FOR ALL 2020℠

At the end of the journey the vision becomes **reality.**

TARGET 1

AT LEAST 30 STATES HAVE AN EXTENSIVE MEDICAID ADULT DENTAL BENEFIT.

GOAL

INCLUDE AN ADULT DENTAL BENEFIT IN PUBLICLY FUNDED HEALTH COVERAGE.

TARGET 2

MEDICARE INCLUDES AN EXTENSIVE DENTAL BENEFIT.

Milestones are markers along the road to reaching a target, and can happen in the network in any order, and even at the same time.

2018 MILESTONES

- Four states enhance the oral health benefit offered to specific eligibility categories in their Medicaid program
- The Oral Health 2020 Network adopts a definition of an extensive Medicaid adult dental benefit
- A comprehensive set of resources and supports exists for any state to implement an advocacy campaign to increase coverage
- Four states have increased level of covered services for all Medicaid eligible adults
- No states have rolled back Medicaid adult dental coverage

2018 MILESTONES

- Oral Health 2020 Network has adopted a consensus Medicare dental benefit design
- Dental benefit in Medicare is part of the mid-term election discussion
- Senate committee of jurisdiction holds hearing on benefit
- A consensus advocacy agenda and approach has been adopted by a critical mass of key influencers with position and clout to support passage of a bill
- There is a 15% increase in the number of Medicare-eligible people that are aware of and actively advocating for coverage

NATIONAL TACTICS

- Build national and state awareness about lack of coverage and access to care
- Define extensive benefit and survey where states stand
- Conduct and disseminate ROI analysis of Medicaid adult dental coverage
- Educate states about differences and overlaps between Medicaid and Medicare coverage
- Develop specific strategies and supports that are reflective of states' current and desired levels of Medicaid coverage
- Evaluate viability of national strategy to mandate dental benefit for adults in Medicaid
- Conduct ongoing monitoring and reporting of state action on Medicaid adult dental coverage

STATE TACTICS

- Develop and spread story (why and how) of states expanding/maintaining Medicaid adult dental coverage
- Translate state lessons and ROI analysis into comprehensive resources to support movement in states
- Convene state Medicaid Directors and other key stakeholders to build increased will and action on value and impact of benefit
- Mobilize and educate advocates in states where expansion action is likely
- Support states working to implement or improve coverage

COMMUNITY TACTICS

- Mobilize community members to demonstrate impacts of lack and benefits of coverage
- Develop a comprehensive set of advocacy resources for community champions
- Create community partnerships to build awareness and utilization of current and/or new benefits through robust education and navigation programs

Tactics, as they are implemented, will help to achieve milestones, Tactics happen at multiple levels, and often simultaneously, across the network.

NATIONAL TACTICS

- Build partnerships with key national organizations that have position, clout, and influence to support consideration and passage of a bill
- Engage national partner(s) to draft needed legislation and supporting materials
- Develop and implement continuing education programs for care providers serving older adults
- Develop a consistent national message about the importance of the Medicare benefit and a strategic plan for delivering the message
- Engage national partner to conduct Congressional Budget Office (CBO) scoring of benefit and bill
- Define and build consensus on definition of comprehensive dental benefit in Medicare
- Develop and disseminate sign-on letter supporting benefit to be signed by all states and delivered to policymakers

STATE TACTICS

- Support state and local organizations to engage administration and legislative champions for appropriations
- Engage and mobilize state and local advocates to drive movement from the state and grassroots, including partnerships with legislative champions

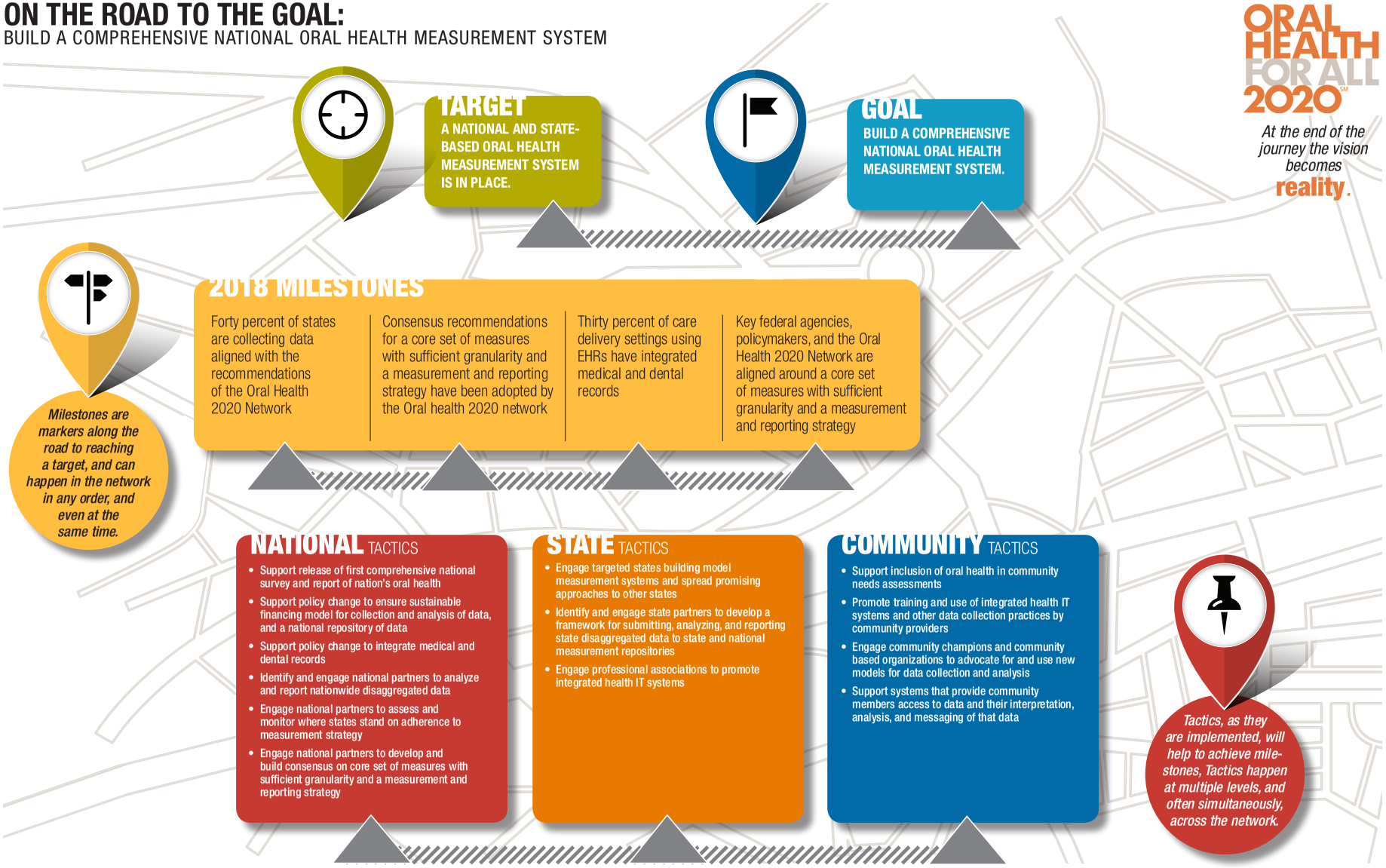
COMMUNITY TACTICS

- Mobilize community members to demonstrate impact of lack of coverage
- Develop comprehensive set of advocacy resources for community champions

ON THE ROAD TO THE GOAL:
BUILD A COMPREHENSIVE NATIONAL ORAL HEALTH MEASUREMENT SYSTEM

ORAL HEALTH FOR ALL 2020℠

At the end of the journey the vision becomes **reality.**



ON THE ROAD TO THE GOAL:
INTEGRATE ORAL HEALTH INTO PERSON-CENTERED HEALTHCARE

ORAL HEALTH FOR ALL 2020℠

At the end of the journey the vision becomes **reality.**

TARGET
ORAL HEALTH IS INTEGRATED INTO AT LEAST 50% OF EMERGING PERSON-CENTERED CARE MODELS.

GOAL
INTEGRATE ORAL HEALTH INTO PERSON-CENTERED HEALTHCARE.

Milestones are markers along the road to reaching a target, and can happen in the network in any order, and even at the same time.

2018 MILESTONES

- Oral health included in key national accreditation standards for person centered care
- Twenty-five states have oral health incorporated into their person-centered care policies
- Quality metrics for oral health care integration have been developed by key national stakeholders
- Oral health 2020 network is aligned around a definition of integrated person-centered care
- A diverse set of pilot programs that serve as a model for fully integrated person-centered care and are reimbursed based on health outcomes have been launched
- Twenty percent of provider education and training programs include a focus on oral health and interprofessional care

NATIONAL TACTICS
- Develop alignment around effective care model
- Engage national organizations to develop oral health accreditation standards and certification
- Engage national dental providers and payer associations in design and regulation of PCMH, ACO, other payment reform efforts
- Identify and engage oral health champions in primary care health professions to prioritize the integration of oral health
- Build and expand interprofessional education resources that include oral health for broad range of clinical professions
- Support published and adopted integrated care model implementation tools
- Engage DQA to develop and test dental quality metrics as NCQA is engaged to include robust oral health measures
- Support implementation efforts to integrate medical and dental records
- Support national orgs to influence state-based program design and implementation
- Engage professional organizations to integrate bi-directional oral health and primary care into provider education curricula
- Identify and build partnerships with insurance companies and health plan administrators to incorporate of oral health

STATE TACTICS
- Engage local and state-based integrated care organizations to test models, including metrics, financing, and practice reform
- Support the integration of oral health into state Medicaid ACO models
- Engage PCAs in the promotion of integrated care delivery in safety net settings
- Engage dental providers and associations in design of state PCMH, ACO, and other payment reforms
- Promote state adoption of regulation and policy
- Identify and build partnerships with insurance companies and other health plan administrators to promote the incorporation of oral health

COMMUNITY TACTICS
- Test care model integration in community sites
- Engage a broad range of community partners to develop local and state alignment around effective models, promotion of equity, and improvement of oral health literacy
- Integrate oral health into community and economic development efforts
- Engage local providers, care coordinators, and consumer advocates to build relationships, support, and champion oral health integration
- Conduct ongoing community needs assessments to support person-centered, integrated care

Tactics, as they are implemented, will help to achieve milestones, Tactics happen at multiple levels, and often simultaneously, across the network.

ON THE ROAD TO THE GOAL:

IMPROVE THE PUBLIC PERCEPTION OF THE VALUE OF ORAL HEALTH TO OVERALL HEALTH

ORAL HEALTH FOR ALL 2020℠

At the end of the journey the vision becomes **reality.**

TARGET

ORAL HEALTH IS INCREASINGLY INCLUDED IN HEALTH DIALOGUE AND PUBLIC POLICY.

GOAL

IMPROVE THE PUBLIC PERCEPTION OF THE VALUE OF ORAL HEALTH TO OVERALL HEALTH.

Milestones are markers along the road to reaching a target, and can happen in the network in any order, and even at the same time.

2018 MILESTONES

Twenty five states have legislative committees of jurisdiction with oral health as a priority in their health policy agenda

The Oral Health 2020 Network has consensus policy priorities that promote the achievement of the 2020 targets

Engagement of congressional champions has resulted in all committees of jurisdiction having oral health as a priority in their health policy agendas

All oral health 2020 network members are delivering framed messages in their oral health communications

NATIONAL TACTICS

- Continuously assess social and new media for opportunities for effective engagement
- Include oral health-related questions in national surveys/polls to monitor public perception
- Build partnerships with and assess and influence attitudes of national policy makers to support policy change
- Build partnerships with key national organizations and champions with the position, clout, and influence to support policy change at the national level
- Continuously monitor and contribute to national dialogue on oral health in media and social media
- Develop appropriately framed messages and share and implement framed messages with partners and broader public

STATE TACTICS

- Build partnerships with and assess and influence attitudes of state policy makers to support policy change
- Support state and local organizations to engage administration and legislative champions
- Continuously monitor and contribute to state dialogue on oral health in media and social media

COMMUNITY TACTICS

- Expand support for broad range of community partners to serve as advocates to engage partners that influence policy change
- Continuously monitor and contribute to local dialogue on oral health in media and social media
- Collect community level oral health data that demonstrates impact on overall health outcomes to drive legislative decisions
- Adapt framed messages to be culturally and linguistically appropriate for different communities
- Build power through authentic community engagement that mobilizes the public to advocate for change

Tactics, as they are implemented, will help to achieve milestones, Tactics happen at multiple levels, and often simultaneously, across the network.

WITH A CLOSING OF DISPARITY GAPS, 85% OF CHILDREN REACH AGE 5 WITHOUT A CAVITY

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess, **with a closing of disparity gaps, 85% of children reach age 5 without a cavity.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. 15 percentage point increase in the number of children receiving oral health preventive services from any healthcare provider on an annual basis by age two.	• In your state, what percentage of children ages 2 and under eligible for Medicaid or CHIP Medicaid Expansion programs, enrolled for at least 90 continuous days, received a preventive dental service in 2017? • How did that compare to the percentage in 2014?	• FFY 2016 CMS-416 data on medicaid.gov. FFY 2017 data will be released soon. • Dental and Oral Health Services in Medicaid and CHIP February 2016 (FFY 2014).	• Target Team will obtain data. No data request of state/ grassroots reps.
2. A detailed understanding of which populations have the lowest percentage of children reaching age five without a cavity in each state will have been developed.	• What percentage of children ages 5 and younger were screened with evidence of decay, broken down by race/ethnicity, geography, income level, and any other demographic factors captured in your state?	• National Data: Healthy People 2020 Data (NHANES data). Proportion of Children ages 3-5 with Dental Caries Experience & Proportion of Children aged 3 to 5 years with Untreated Dental Decay in their primary teeth years 1999 to 2014. Includes breakdown by sex, race/ethnicity, family status: Also, 2015-2016 brief. • State-level surveillance data/public health agency data. • School entrance oral health assessment data.	
3. Number of fluoridated communities increased by 10 percent and no communities currently fluoridated eliminated fluoridation.	• How many communities in your state had fluoridated water in 2014? • How many communities in your state have added fluoridation since 2014? • How many communities in your state have eliminated fluoridation since 2014?	• State oral health coalition. • State oral health programs • CDC (e.g., list of water systems) • EPA Safe Water Drinking Information System • CDC: My Water's Fluoride • ASTDD Basic Screening Surveys	
4. 15 percentage point increase in the number of non-dental providers that have delivered preventive services, anticipatory guidance, education, and/or referral for continuous care for children under age five.	• What percentage of children ages 5 and under received fluoride varnish application by a non-dental provider in 2017 compared to 2014? • What percentage of non-dental providers delivered these services in 2017 compared to 2014?	• CMS 416 data - Line 12f • State Medicaid Data	• AAP conducting survey of fellows on whether pediatricians are doing this more frequently compared to a few years ago; however, data will not be ready in time for this assessment.

5. The U.S. Preventive Services Task Force includes an oral health strategy for prospective parents and primary caregivers.	• Explore strategic plans of U.S. PSTF to see whether there is any strategy or other language pertaining to engagement of prospective parents and primary caregivers around oral health. If yes, what is the strategy? • Does the Task Force include an oral health strategy for prospective parents and primary caregivers?	Children Birth through Age 5 Pregnant women - inactive	• Target Team will obtain data. No data request from state/grassroots reps.
6. 65 percent of children under age five have access to consistent, evidence-based oral health care.	• In your state in 2017, what percentage of children ages 5 and under received: • Any Dental Service • A Preventive Dental Service • Dental Treatment Services • Dental Diagnostic Services • Sealants, Ages 6-9 • Any Dental or Oral Health Service	• State Medicaid Data, CMS 416 data • National Data: CDC, Percent of children aged 2-17 years with a dental visit in the past year	• Target Team will obtain data. No data request from state/grassroots reps.
7. 90 percent of early childhood programs will deliver oral health education and prevention to the children they serve.	• What percent of children enrolled in Head Start and Early Head Start in your state are up-to-date on a schedule of age-appropriate preventive and primary oral health care according to the relevant state's EPSDT schedule? • What percent of children enrolled in Head Start and Early Head Start in your state received preventive care since last year? • What percentage of Head Start and Early Head Start in your state provide oral health education and prevention service to program participants in 2017?	• National Center for Early Childhood Health and Wellness • ECCS - Early Childhood Coordinating Services (?) • State level Head Start Assoc.l, coordinates standards for early health systems, head start program data • National Maternal and Child Oral Health Resource Center • Head Start Program Information Report (C.17-C.21 report dental health)	• Target Team will obtain data. No data request from state/grassroots reps. • Ask Amy Requa or Nancy Topping Tailby for input • EHS and HS have standards we could look into to help define education and prevention.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: 15 percentage point increase in the number of children receiving oral health preventive services from any healthcare provider on an annual basis by age two.		
Measurement Questions	**Findings**	**Data Source(s) Used**
In your state, what percentage of children ages 2 and under eligible for Medicaid or CHIP Medicaid Expansion programs, enrolled for at least 90 continuous days, received a preventive dental service in 2017?		
How did that compare to the percentage in 2014?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 2: A detailed understanding of which populations have the lowest percentage of children reaching age five without a cavity in each state will have been developed.		
Measurement Questions	**Findings**	**Data Source(s) Used**
What percentage of children ages 5 and younger were screened with evidence of decay, broken down by race/ethnicity, geography, income level, and any other demographic factors captured in your state?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

Milestone 3: Number of fluoridated communities increased by 10 percent and no communities currently fluoridated eliminated fluoridation.		
Measurement Questions	**Findings**	**Data Source(s) Used**
How many communities in your state had fluoridated water in 2014?		
How many communities in your state have added fluoridation since 2014?		
How many communities in your state have eliminated fluoridation since 2014?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: 15 percentage point increase in the number of non-dental providers that have delivered preventive services, anticipatory guidance, education, and/or referral for continuous care for children under age five.		
Measurement Questions	**Findings**	**Data Source(s) Used**
What percentage of children ages 5 and under received fluoride varnish application by a non-dental provider in 2017 compared to 2014?		
What percentage of non-dental providers delivered these services in 2017 compared to 2014?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 5: The U.S. Preventive Services Task Force includes an oral health strategy for prospective parents and primary caregivers.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Explore strategic plans of U.S. PSTF to see whether there is any strategy or other language pertaining to engagement of prospective parents and primary caregivers around oral health. If yes, what is the strategy?		
Does the Task Force include an oral health strategy for prospective parents and primary caregivers?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 6: 65 percent of children under age five have access to consistent, evidence-based oral health care.		
In your state in 2017, what percentage of children ages 5 and under received:		
• Any Dental Service		
• A Preventive Dental Service		
• Dental Treatment Services		
• Dental Diagnostic Services		
• Any Dental or Oral Health Service		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 7: 90 percent of early childhood programs will deliver oral health education and prevention to the children they serve.		
Measurement Questions	**Findings**	**Data Source(s) Used**
What percent of children enrolled in Head Start and Early Head Start in your state are up-to-date on a schedule of age-appropriate preventive and primary oral health care according to the relevant state's EPSDT schedule?		
What percent of children enrolled in Head Start and Early Head Start in your state received preventive care since last year?		
What percentage of Head Start and Early Head Start in your state provide oral health education and prevention service to program participants in 2017?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess whether **the 10 largest school districts have incorporated oral health into their systems.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. X% of schools in districts are delivering oral health services in the 10 districts.	• How many schools are in the target school district in your state? • How many schools and which grades in the school district offer access to oral health education services? • How many schools and which grades in the district offer access to preventive oral health services (screenings, cleaning/prophylaxis, sealants, and/or fluoride varnish)? • How many schools and which grades in the district offer access to restorative oral health services? • How many schools and which grades in the district offer access to oral health case management/ case navigators? • How are oral health care services provided (e.g., permanent operation, mobile, linked, telehealth, other)?	• School-Based Health Alliance (SBHA) • State/local school-based health organizations • State oral health coalitions • State health department • School district health office	• The target school districts are: New York (NY), Los Angeles (CA), Chicago (IL), Clark County (NV), Miami-Dade (FL), Broward (FL), Hillsborough (FL), Houston (TX), Hawaii, and Puerto Rico. • "Access" in the measurement questions can be defined as providing the service directly, or making a referral to it somewhere else and facilitating completion of the referral.
2. National learning collaborative has created measurable district-wide improvement in cross-cutting policy barriers in the 10 districts.	• Quantitative assessment of learning collaborative participants • Output document of lessons learned	• Consent Conundrum • Quantitative assessment conducted by Schools Target Team led during SBHA check-ins with school district teams.	• Target Team will answer. No additional data request of state/ grassroots reps.
3. The Oral Health 2020 Network has adopted the defined parameters of oral health integration into primary education.	Questions to ask of key organizations operating within the space of school oral health, ask: • Are you aware of this framework? • How if at all have you incorporated this into your work? • What are the reasons you have not incorporated these parameters further?	• Framework for School Oral Health • Target Team to determine which organizations to survey (could pose to subscribers of Socious Schools page).	• Parameters were established in collaboration with a number of national partners with input from the Network at the Schools Target Convening in September 2016. • Target Team will answer. No additional data request of state/ grassroots reps.

4. All 10 districts include oral health in their wellness policy.	• Is oral health in the Wellness Policy?
	• If so, which of the five school oral health parameters are covered?
	  ○ Oral health education
	  ○ Oral health screening
	  ○ Preventive oral health care
	  ○ Care coordination and linkage to community-based health care
	  ○ Oral health treatment in schools
		• Hallways to Health: Creating a School-Wide Culture of Wellness
		• Tracking doc (draft)
		• State/local school- based health organizations
		• SBHA
		• State oral health coalitions
		• State health department
		• School district health office
			• Parameters referenced are from SBHA's Framework document in Milestone 3.

5. Consent rates for student participation in oral health programs in the 10 largest school districts has increased by 20 percentage points.	• For oral health services provided in the district, which services require consent?
	• For services requiring consent, what populations are served in the district?
	• For services requiring consent, what are the consent rates for the following school years (please provide data for all years available):
	  ○ 2014-2015
	  ○ 2015-2016
	  ○ 2016-2017
	  ○ 2017-2018
		• SBHA
		• State oral health coalitions
		• State health department
		• School district health office
		• State/local school-based health organizations
			• SBHA has consent baseline and current data for districts participating in SBHA's program.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: X% of schools in districts are delivering oral health services in the 10 districts.		
Measurement Questions	**Findings**	**Data Source(s) Used**
How many schools are in the target school district in your state?		
How many schools and which grades in the school district offer access to oral health education services?	_____Schools Grades (check): ○ Kindergarten ○ First ○ Second	
	○ Third ○ Fourth ○ Fifth ○ Sixth ○ Seventh ○ Eighth ○ Ninth ○ Tenth ○ Eleventh ○ Twelfth	

How many schools and which grades in the district offer access to preventive oral health services (screenings, cleaning/prophylaxis, sealants, and/or fluoride varnish)?	_____Schools Grades (check): ○ Kindergarten ○ First ○ Second ○ Third ○ Fourth ○ Fifth ○ Sixth ○ Seventh ○ Eighth ○ Ninth ○ Tenth ○ Eleventh ○ Twelfth	
How many schools and which grades in the district offer access to restorative oral health services?	_____Schools Grades (check): ○ Kindergarten ○ First ○ Second ○ Third ○ Fourth	
	○ Fifth ○ Sixth ○ Seventh ○ Eighth ○ Ninth ○ Tenth ○ Eleventh ○ Twelfth	
How many schools and which grades in the district offer access to oral health case management/ case navigators?	_____Schools Grades (check): ○ Kindergarten ○ First ○ Second ○ Third ○ Fourth ○ Fifth ○ Sixth ○ Seventh ○ Eighth ○ Ninth ○ Tenth ○ Eleventh ○ Twelfth	
How are oral health care services provided (e.g., permanent operation, mobile, linked, telehealth, other)?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 2: National learning collaborative has created measurable district-wide improvement in cross-cutting policy barriers in the 10 districts.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

Milestone 3: The Oral Health 2020 Network has adopted the defined parameters of oral health integration into primary education.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Questions to ask of key organizations operating within the space of school oral health, ask: ● Are you aware of this framework? ● How if at all have you incorporated this into your work? ● What are the reasons you have not incorporated these parameters further?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: All 10 districts include oral health in their wellness policy.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Is oral health in the Wellness Policy?		
If so, which of the five school oral health parameters are covered? ● Oral health education ● Oral health screening ● Preventive oral health care ● Care coordination and linkage to community-based health care ● Oral health treatment in schools		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 5: Consent rates for student participation in oral health programs in the 10 largest school districts has increased by 20 percentage points.		
Measurement Questions	**Findings**	**Data Source(s) Used**
For oral health services provided in the district, which services require consent?		
For services requiring consent, what populations are served in the district?		
For services requiring consent, what are the consent rates for the following school years (please provide data for all years available): ● 2014-2015 ● 2015-2016 ● 2016-2017 ● 2017-2018		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

3. Stories Illustrating Progress Toward the Milestones

Here, state and grassroots reps are encouraged to share any stories uncovered during their outreach and data collection that illustrate how stakeholders have pursued the target's milestones, and those that describe the achievement of greater equity for the target. Stories illustrating the impact on students and families of having (or not having) oral health care services available in schools are of particular interest. Stories are not expected for each milestone, but are welcome.

AT LEAST 30 STATES HAVE AN EXTENSIVE MEDICAID ADULT DENTAL BENEFIT

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess, **at least 30 states have an extensive Medicaid adult dental benefit.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. Four states increase the level of covered services for all Medicaid-eligible adults.	● Was there an increase in covered services in the Medicaid adult dental benefit since 2014? ● If so: ○ What services were covered in 2014? ○ What services are covered in 2018? ○ Were there any interim changes between these two years? ○ Is an expanded set of services covered by one or more contracted MCOs, or is all coverage under the Medicaid state plan?	● State oral health coalitions ● State Medicaid agency website ● www.Medicaid.gov ● www.cms.gov ● www.healthcare.gov	
2. Four states enhance the oral health benefit offered to specific eligibility categories in their Medicaid program.	For the Medicaid eligibility categories of pregnant women, adults with an intellectual/ developmental disability (I/DD), the elderly, and Medicaid expansion populations: ● Which of these groups had an increase in Medicaid dental benefits since 2014? ● For those that did have an increase in benefits: ○ What services were covered in 2014? ○ What services are covered in 2018? ○ Were there any interim changes between these two years? ○ Is an expanded set of services covered by one or more contracted MCOs, or is all coverage under the Medicaid state plan?	● State oral health coalitions ● State Medicaid agency website ● www.Medicaid.gov ● www.cms.gov ● www.healthcare.gov	For pregnant women with Medicaid benefits, how long did the benefits extend post-partum?
3. No states have rolled back Medicaid adult dental coverage.	● Is your state's Medicaid dental coverage for the general Medicaid adult population today less extensive than it was in 2014?	Target Team has a draft table maintained by the ADA, with information on both 2014 and 2017/2018 coverage.	● No additional data request of state/ grassroots reps. Target Team will derive information from data provided in milestone #1, and from ADA table. ● The information currently being gather by the adult dental Medicaid rubric survey should help with this determination. ● Note that "less extensive" is subjective as a state may have gained in one area of adult coverage, while losing ground in another.

4. The Oral Health 2020 Network adopts a definition of an extensive Medicaid adult dental benefit.	• None needed -- status known.		• No additional data request of state/ grassroots reps.
5. A comprehensive set of resources and supports exists for any state to implement an advocacy campaign to increase coverage.	• What resources (e.g., templates, talking points, newsletter articles) or supports (e.g., funding, advising) are available in the state to support state-level advocacy campaigns around increasing Medicaid dental coverage? When was each resource last updated? • Given what is available in the state, what resources are missing? For example, resources on a specific topic, in a specific format, or for a specific audience.	• State oral health coalition • State primary care association • Other advocacy organizations in a state • Findings of the adult dental Medicaid rubric.	• State/grassroots reps to answer both bulleted questions. • In addition, Target Team will identify resources available from national organizations, including the ADA's Medicaid Provider Reference Guide & Advocacy Toolkit, Why Dental Coverage Matters: A Tool-Kit, and Families USA.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: Four states increase the level of covered services for all Medicaid-eligible adults.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
Was there an increase in covered services in the Medicaid adult dental benefit since 2014?		
If yes: • What services were covered in 2014? • What services are covered in 2018? • Were there any interim changes between these two years?		
Is an expanded set of services covered by one or more contracted MCOs, or is all coverage under the Medicaid state plan?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 2: Four states enhance the oral health benefit offered to specific eligibility categories in their Medicaid program.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
For the Medicaid eligibility categories of pregnant women, adults with an intellectual/ developmental disability (I/DD), the elderly, and Medicaid expansion populations: • Which of these groups had an increase in Medicaid dental benefits since 2014?		
For those that did have an increase in benefits: • What services were covered in 2014? • What services are covered in 2018? • Were there any interim changes between these two years?		

Is an expanded set of services covered by one or more contracted MCOs, or is all coverage under the Medicaid state plan?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 3: No states have rolled back Medicaid adult dental coverage.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
Is your state's Medicaid dental coverage for the general Medicaid adult population today less extensive than it was in 2014?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: The Oral Health 2020 Network adopts a definition of an extensive Medicaid adult dental benefit.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
None needed -- status known.		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 5: A comprehensive set of resources and supports exists for any state to implement an advocacy campaign to increase coverage.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
What resources (e.g., templates, talking points, newsletter articles) or supports (e.g., funding, advising) are available in the state to support state-level advocacy campaigns around increasing Medicaid dental coverage? When was each resource last updated?		
Given what is available in the state, what resources are missing? For example, resources on a specific topic, in a specific format, or for a specific audience.		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

3. Stories Illustrating Progress Toward the Milestones

Here, state and grassroots reps are encouraged to share any stories uncovered during their outreach and data collection that illustrate how stakeholders have pursued the target's milestones, and those that describe the achievement of greater equity for the target. Especially useful would be any personal stories or quotes about/from patients that illustrate the challenge and impact of not having access to dental care in Medicaid. Stories are not expected for each milestone, but are welcome.

MEDICARE INCLUDES AN EXTENSIVE DENTAL BENEFIT

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess whether **Medicare includes an extensive dental benefit.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Note that any milestones that are shaded in gray DO NOT require any information to be provided by state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. The Oral Health 2020 Network has adopted a consensus Medicare dental benefit design.	• We know that this has not happened.	• Oral Health America will describe status and the facilitative/ hindering factors.	• No data request of state/grassroots reps.
2. Dental benefit in Medicare is part of the mid-term election discussion	• Are state-level stakeholder organizations including Medicare dental benefits in their mid-term advocacy efforts? • Are safety net providers including Medicare dental benefits in their mid-term advocacy efforts? • In your state, how many candidates running for the U.S. Senate or House in the mid-term election have public positions on dental coverage in Medicare?	• Websites of state AARP chapters, Departments of Aging, and PCAs to see if they include any information about dental coverage for seniors and/or in Medicare. • Online searching of state candidates' web sites and local media to identify published positions on dental Medicare. An organization in your state may track this.	• State and grassroots reps should NOT contact candidates' offices directly for this information, as there is no benefit design to share yet.
3. Senate committee of jurisdiction holds hearing on benefit.	• Has the state legislature ever introduced any resolutions on a Medicare dental benefit?	• Target Team will obtain this from ADEA.	• No data request of state/grassroots reps.
4. A consensus advocacy agenda and approach have been adopted by a critical mass of key influencers with position and clout to support passage of a bill.	• Does the state oral health coalition have a Medicare dental benefit as a priority and/or is it doing work around Medicare awareness? If yes, please describe. • Does the state oral health plan have a program or approach for older adults? • Which national organizations, if any, have drafted an advocacy agenda and/or approach?	• State oral health coalitions for bullets #1 and #2. • Target Team will obtain data for bullet #3 from Oral Health America.	• State/grassroots reps only need to answer bullets #1 and #2. • Target Team will answer bullet #3.
5. There is a 15 percent increase in the number of Medicare-eligible people that are aware of and actively advocating for this coverage.	• How has this changed compared to findings of previous research performed?	• Target Team will obtain data from Marketing for Change via Oral Health America.	• No data request of state/ grassroots reps.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

Milestone 1: The Oral Health 2020 Network has adopted a consensus Medicare dental benefit design.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Has the Oral Health 2020 Network adopted a consensus Medicare dental benefit design?	There has not yet been adoption of a consensus Medicare dental benefit design. However, Oral Health America recently published a paper written collaboratively by a diverse group of stakeholders, illustrating diverse support for the approach. The next step is to vet this further with the Network.	
Factors facilitating achievement of the milestone:		
Factors hindering achievement of the milestone:		
Milestone 2: Dental benefit in Medicare is part of the mid-term election discussion.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Are state-level stakeholder organizations including Medicare dental benefits in their mid-term advocacy efforts?		
Are safety net providers including Medicare dental benefits in their mid-term advocacy efforts?		
In your state, how many candidates running for the U.S. Senate or House in the mid-term election have public positions on dental coverage in Medicare?		
Factors facilitating achievement of the milestone:		
Factors hindering achievement of the milestone:		
Milestone 3: Senate committee of jurisdiction holds hearing on benefit.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Has the state legislature ever introduced any resolutions on a Medicare dental benefit?	-NJ introduced a bill each session since 2014/15-2018/19 RE: Memorializes Congress to provide Medicare coverage for eyeglasses, hearing aids, and dentures. -HI introduced a bill 18/19 RE: Urges Congress to require adult dental coverage under Medicare and Medicaid.	ADEA-resolutions since 2014
Factors facilitating achievement of the milestone:		
Factors hindering achievement of the milestone:		

Milestone 4: A consensus advocacy agenda and approach have been adopted by a critical mass of key influencers with position and clout to support passage of a bill.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Does the state oral health coalition have a Medicare dental benefit as a priority and/or is it doing work around Medicare awareness? If yes, please describe.		
Does the state oral health plan have a program or approach for older adults?	Have no SOHP in 2017: AK, AR, DE, FL, HI, MA, MD, ME, MT, NE, NJ, NV, OH, TX, WA, WY Have SOHP in 2017, but does not mention older adults: AZ, KY, UT Have SOHP in 2017 and mentions older adults: GA, ID, IL, IN, LA, MI, MN, MS, NC, NH, OK, OR, PA, RI, SC, TN, VA, WI, AL, CA, CO, CT, IA, KS, MO, ND, NY, SD, VT, WV	State Dental Directors Survey conducted by Oral Health America in October and November 2017 via Survey Monkey.
Which national organizations, if any, have drafted an advocacy agenda and/or approach?	Oral Health America, Families USA, Justice in Aging, Santa Fe Group, Center for Medicare Advocacy	OHA
Factors facilitating achievement of the milestone:		
Factors hindering achievement of the milestone:		
Milestone 5: There is a 15 percent increase in the number of Medicare-eligible people that are aware of and actively advocating for this coverage.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
How has this changed compared to findings of previous research performed?	Since 2015 OHA with behavior change firm, Marketing for Change, have worked toward building a consumer campaign to engage and motivate adults 50+ to advocate for a dental benefit in Medicare. While we do not have a true national baseline to measure percent increase in awareness and advocacy, through our 2018 state pilots in Iowa, Michigan and Tennessee we are able to measure engagement through google trends and market penetration. In Iowa, our campaign reached 171,000 adults 60+ via Facebook, resulting in a 33% market penetration during the four campaign months. Michigan: reach of 158,000; 30% market penetration (currently active, ends in Sept.) Tennessee: reach of 122,000; 20% market penetration (currently active, ends in Oct.) With regards to Google trends, there is a high, sustainable search of the keywords 'Medicare dental' during the campaign. Supplemental PPT slides are available if needed.	OHA/Marketing for Change State Pilots, 2018 Iowa Campaign-May-August Grand Rapids/Lansing Campaign-June-Sept. Knoxville/Chattanooga Campaign-July-Oct.
Factors facilitating achievement of the milestone:		
Factors hindering achievement of the milestone:		

A NATIONAL AND STATE-BASED ORAL HEALTH MEASUREMENT SYSTEM IS IN PLACE

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess whether **a national and state-based oral health measurement system is in place.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. Forty percent of states are collecting data aligned with the recommendations of the Oral Health 2020 Network.	● Does your state collect oral health measures that align with the following guidelines: provides information about oral health status, utilization, access, prevention, and oral health across the lifespan? Answer yes or no for each. For those with a yes, what measures are they tracking? ● For any they are not tracking, note if any plans are in place to do so in the future.	● State office of oral health in the department of health, particularly the epidemiologist. ● State oral health reports ● National Oral Health Surveillance System	● Read the measurement brief, "Making Oral Health Count: Toward a Comprehensive Oral Health Measurement System," released by CDHP and ASTDD (available on Socious), particularly the appendix, to identify the consensus recommendations of the network. This white paper was the culmination of a multi-year consensus- building process among data consumers and agencies that collect and analyze data. If your state does not collect data that align with all of the guidelines, please indicate which guidelines the state does adhere to in the findings section.
2. Consensus recommendations for a core set of measures with sufficient granularity and a measurement and reporting strategy have been adopted by the Oral Health 2020 Network.	● Are consensus measures with sufficient granularity developed, and have we established consensus around them ?		● Target team will answer. No data request of state/ grassroots reps.

3. Thirty percent of care delivery settings using EHRs have integrated medical and dental records.	• What percentage of care delivery settings have fully integrated EHRs? • What percentage of care delivery settings have some interoperability between medical and dental records? Please describe what functions they offer. • What national efforts are taking place to improve integration?	• State PCAs, AAP chapters, state hospital association, National Primary Care Association, payers.	• Care delivery settings may include private providers' offices, ED's, community health centers, and others. • State/grassroots reps are only asked to respond to bullets #1 and #2. • Target team will answer bullet #3.
4. Key federal agencies, policymakers, and the Oral Health 2020 Network are aligned around a core set of measures with sufficient granularity and a measurement and reporting strategy.	• Are consensus measures with sufficient granularity developed, and have we established consensus around them?	This may also be asked of the Policy NRT - is this a goal they are engaging with the network? What does that engagement look like?	The target team will respond to this milestone. No data request of state/ grassroots reps.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: Forty percent of states are collecting data aligned with the recommendations of the Oral Health 2020 Network.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Does your state collect oral health measures that align with the following guidelines: provides information about oral health status, utilization, access, prevention, and oral health across the lifespan? Answer yes or no for each. For those with a yes, what measures are they tracking?		
For any they are not tracking, note if any plans are in place to do so in the future.		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone :		
Milestone 2: Consensus and recommendations for a core set of measures with sufficient granularity and a measurement and reporting strategy have been adopted by the Oral Health 2020 Network.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Are consensus measures with sufficient granularity developed, and have we established consensus around them?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

Milestone 3: Thirty percent of care delivery settings using EHRs have integrated medical and dental records.		
Measurement Questions	**Findings**	**Data Source(s) Used**
What percentage of care delivery settings have fully integrated EHRs?		
What percentage of care delivery settings have some interoperability between medical and dental records? Please describe what functions they offer.		
What national efforts are taking place to improve integration?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: Key federal agencies, policymakers, and the Oral Health 2020 Network are aligned around a core set of measures with sufficient granularity and a measurement and reporting strategy.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Are consensus measures with sufficient granularity developed, and have we established consensus around them?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

3. Stories Illustrating Progress Toward the Milestones

Here, state and grassroots reps are encouraged to share any stories uncovered during their outreach and data collection that illustrate how stakeholders have pursued the target's milestones, and those that describe the achievement of greater equity for the target. Stories are not expected for each milestone, but are welcome.

ORAL HELTH IS INTEGRATED INTO AT LEAST 50% OF EMERGING PERSON-CENTERED CARE MODELS

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess whether **oral health is integrated into at least 50% of emerging person-centered care models.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. Oral health is included in key national accreditation standards for person-centered care.	• Are oral health standards included? • Are they mandatory or optional? • Are there other standards under development?	• NCQA • Joint Commission • AAAHC	• Target team will collect this data. No additional data request of state/ grassroots reps.
2. Twenty-five states have oral health incorporated into their person-centered care policies.	• Does the state include oral health in its regulatory guidance around person-centered care that is delivered by publicly funded programs (such as Medicaid)? • For public programs, does the state have guidance about oral health in its person-centered care policy? • Does the state have any policy related to private payers that regulates oral health inclusion in person-centered care?	• State Medicaid agency • Oral health office in the department of public health • Office of chronic disease management • State primary care association (i.e., Patient-Centered Medical Home Initiative) • MCO contracts	
3. Quality metrics for oral health care integration have been developed by key national stakeholders.	• Do key national stakeholders have quality metrics that focus on interprofessional care?	• HRSA, MCH, DQA, NNOHA, PHAB	• Target team will collect this data. No additional data request of state/ grassroots reps.
4. Oral Health 2020 Network is aligned around a definition of integrated person-centered care.	• Does a representative organization in your state from each of the following four buckets do work or have policies aligned with the definition of person-centered care: advocacy organization, public health organization, provider organization, and a community program?	• Ask an organization from each of the four categories. Examples include: advocacy (coalition); public health (primary care association); provider organization (dental association); community program (Head Start).	• The definition we are using is: "Person Centered Care can be defined as a health care delivery system where all aspects of patient care between healthcare providers—for example dental, medical and behavioral care and community resources—are integrated and coordinated, that are valuable and meaningful to the patient, with the goal of improving health care quality and outcomes and lowering health care costs."

5. A diverse set of pilot programs that serve as a model for fully integrated person-centered care and are reimbursed based on health outcomes have been launched.	• Has a pilot been launched that is testing an innovation in where, who, or how care is delivered either at the state level or as part of a national effort; and is it coupled with a reimbursement mechanism? Note whether or not it reimburses based on health outcomes.	• State departments of health • Primary care associations • School-based health centers • Accountable care organizations (managed care organizations) • Dental schools • Research institutions	• The pilot may be focused on one or more aspects or elements of a person-centered care model. Please share which aspects of person-centered care on which it is focused and its name.
6. Twenty percent of provider education and training programs include a focus on oral health and interprofessional care.	• Do provider education programs in your state address interprofessional care? • If yes, does the program educate provider types together in a multidisciplinary setting, or are they offered interprofessional education (IPE) in individual professions?	• Dental, medical, and community provider schools in your state. • ADEA.	• We deliberately excluded "and training programs" because the work required to capture that information would be prohibitive. We are asking whether providers receive IPE or not. Please note how many provider education schools there are, and how many include IPE in their curricula.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: Oral health is included in key national accreditation standards for person-centered care.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Are oral health standards included?		
Are they mandatory or optional?		
Are there other standards under development?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 2: Twenty-five states have oral health incorporated into their person-centered care policies.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Does the state include oral health in its regulatory guidance around person-centered care that is delivered by publicly funded programs (such as Medicaid)?		
For public programs, does the state have guidance about oral health in its person-centered care policy?		
Does the state have any policy related to private payers that regulates oral health inclusion in person-centered care?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

Milestone 3: Quality metrics for oral health care integration have been developed by key national stakeholders.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Do key national stakeholders have quality metrics that focus on interprofessional care?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: Oral Health 2020 Network is aligned around a definition of integrated person-centered care.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Does a representative organization in your state from each of the following four buckets do work or have policies aligned with the definition of person-centered care: advocacy organization, public health organization, provider organization, and a community program?		
Factors facilitating achievement of milestone:		
Factors hindering:		
Milestone 5: A diverse set of pilot programs that serve as a model for fully integrated person-centered care and are reimbursed based on health outcomes have been launched.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Has a pilot been launched that is testing an innovation in where, who, or how care is delivered either at the state level or as part of a national effort; and is it coupled with a reimbursement mechanism? Note whether or not it reimburses based on health outcomes.		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 6: Twenty percent of provider education and training programs include a focus on oral health and interprofessional care.		
Measurement Questions	**Findings**	**Data Source(s) Used**
Do provider education programs in your state address interprofessional care?		
If yes, does the program educate provider types together in a multidisciplinary setting, or are they offered interprofessional education (IPE) in individual professions?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

3. Stories Illustrating Progress Toward the Milestones

Here, state and grassroots reps are encouraged to share any stories uncovered during their outreach and data collection that illustrate how stakeholders have pursued the target's milestones, and those that describe the achievement of greater equity for the target. Stories are not expected for each milestone, but are welcome.

ORAL HEALTH IS INCREASINGLY INCLUDED IN HEALTH DIALOGUE AND PUBLIC POLICY

TEMPLATE: 2018 Network-Wide Project: Data Collection for Target Milestones

This document is a template for the Target Team focused on milestones that assess **oral health is increasingly included in health dialogue and public policy.** The Target Team completed Section 1, which provides guidance around collecting data to assess each milestone under the target. State and grassroots reps should complete Sections 2 (Data Reporting) and 3 (Stories). Milestones that are shaded in gray DO NOT require any information from state and grassroots reps in Section 2.

1. Guidance for Data Collection

Milestones	Measurement Questions	Suggested Data Sources	Notes
1. Twenty-five states have legislative committees of jurisdiction with oral health as a priority in their health policy agenda.	• Which committees (or caucuses, or legislative commissions) in the state legislature explicitly mention oral health in their documentation/website?	• State legislatures website • Public health lobbyists or other advocates (organizations) that are at the state capitol lobbying for health-related topics • Legislature documentation • Look at current policies they are advocating for • ANOHC list of states with oral health caucuses	• A legislative committee of jurisdiction means it has authority over issues that impact health policy.
2. The Oral Health 2020 Network has consensus policy priorities that promote the achievement of the 2020 targets.	• Does the network have written policy priorities that promote the achievement of the 2020 targets? • Has the network agreed on the priorities, and if yes, through what mechanism? • Do any of the priorities link/map to the seven network targets and if yes, which ones, and how?	• The network's Policy NRT • The network's Data/Measurement NRT • Harder & Company	• Milestone is referring to the OH2020 targets. • Target Team will collect this data. No ask of state/ grassroots reps.
3. Engagement of congressional champions has resulted in all committees of jurisdiction having oral health as a priority in their health policy agendas.	• What are the names and affiliations of legislative and congressional champions of health in your state? • What types of awareness and education activities and materials do organizations in your state use in order to elevate awareness of oral health among legislative stakeholders? (e.g., visiting the state capitol, employing a lobbyist, etc.)	• Public health lobbyists or other advocates (organizations) that are at the state capitol lobbying for health-related topics • National Conference of State Legislatures • Oral Health America • Community Catalyst • State-level oral health legislative committee	
4. All Oral Health 2020 Network members are delivering framed messages in their oral health communications.	• Are you aware of the work of the FrameWorks Institute? • Have you attended a network meeting where FrameWorks provided training? • Have you asked for framing technical assistance? • Have you used the FrameWorks messaging guidance to create new, or update existing, communication materials? • What keywords do you use to search/ google for oral health information? • Where and how is oral health showing up in social media? • How are people using search engines to find oral health information and what are related search terms?	• Network members from all levels: Grassroots, Grassmiddles, Grasstops • Member survey • FrameWorks website use metrics • Requests for FrameWorks TA (via Comms request form) • Analytics in social media and google searches pertaining to oral health and analyzing web trends in general	• Target Team will collect this data. No ask of state/ grassroots reps.

2. Data Reporting

State and grassroots reps should complete the "Findings" and "Data Source(s) Used" columns. Use rows adjacent to the "Factors Facilitating Achievement of Milestone" and "Factors Hindering Achievement of Milestone" to describe any such organizational, community, state, or national-level factors impacting the milestone in your state. **Cells shaded in gray do not have to be completed by state/grassroots reps.** If your state has data on additional measures that illustrate progress toward the given milestone, please add rows to capture that data (optional).

State: _____

Milestone 1: Twenty-five states have legislative committees of jurisdiction with oral health as a priority in their health policy agenda.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
Which committees (or caucuses, or legislative commissions) in the state legislature explicitly mention oral health in their documentation/website?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 2: The Oral Health 2020 Network has consensus policy priorities that promote the achievement of the 2020 targets.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
Does the network have written policy priorities that promote the achievement of the 2020 targets? (Yes/No)		
Has the network agreed on the priorities, and if yes, through what mechanism?		
Do any of the priorities link/map to the seven network targets and if yes, which ones, and how?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 3: Engagement of congressional champions has resulted in all committees of jurisdiction having oral health as a priority in their health policy agendas.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
What are the names and affiliations of legislative and congressional champions of health in your state?		
What types of awareness and education activities and materials do organizations in your state use in order to elevate awareness of oral health amongst legislative stakeholders?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		
Milestone 4: All Oral Health 2020 Network members are delivering framed messages in their oral health communications.		
Measurement Questions:	**Findings**	**Data Source(s) Used**
Are you aware of the work of the FrameWorks Institute?		
Have you attended a network meeting where FrameWorks provided training?		
Have you asked for framing technical assistance?		
Have you used the FrameWorks messaging guidance to create new, or update existing, communication materials?		
What keywords do you use to search/google for oral health information?		
Where and how is oral health showing up in social media?		
How are people using search engines to find oral health information and what are related search terms?		
Factors facilitating achievement of milestone:		
Factors hindering achievement of milestone:		

3. Stories Illustrating Progress Toward the Milestones

Here, state and grassroots reps are encouraged to share any stories uncovered during their outreach and data collection that illustrate how stakeholders have pursued the target's milestones, and those that describe the achievement of greater equity for the target. Stories are not expected for each milestone, but are welcome.

ACKNOWLEDGEMENTS

This monumental effort to assess progress toward the Network's 2018 milestones would not have been possible without the time and dedication of countless Network members. On behalf of the Network, sincere appreciation for these efforts is expressed to:

- All state and grassroots representatives
- Members of the seven target teams
- Members of the Network's Stewardship and Learning Workgroup
- Members of the Network's Health Equity Workgroup
- Senior advisors to the DentaQuest Foundation: Marcia Brand, Patrick Finnerty, and Laurie Norris
- Executive director of the DentaQuest Foundation, Michael Monopoli
- The Network Support Team

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