FINAL REPORT

Introduction

For the past four (4) years, the Kentucky Oral Health Program (KOHP) utilized State Oral Health Collaborative Systems funding to: conduct an oral health strategic planning partnership workshop; develop, publish and distribute the Kentucky statewide oral health strategic plan, *Healthy Kentucky Smiles: A Lifetime of Oral Health*[1]; develop, implement and analyze a statewide children's oral heath surveillance system; complete a workforce development study, *Kentucky Dental Provider Workforce Analysis: 1998-2006*[2]; and update computers and software for KOHP staff.

Purpose

To support Kentucky's efforts to develop, implement or otherwise strengthen State oral health collaborative systems (infrastructure) that increase access to oral health services for Kentucky's children.

Goal

Project Goal: The goal for funding requested under the State Oral Health Collaborative Systems Grant for the past four years was to improve the oral health of Kentucky's population through the following venues:

1) Development and implementation of a five-year Oral Health Strategic Plan.
2) Development and implementation of the Children's Oral Health Surveillance System.
3) Development of a Supply and Demand Dental Workforce Study for Kentucky.

Progress Toward Goals

1. Strategic Planning:

Objective 1: Convene oral health strategic planning partnership workshop, with representatives from public health, private providers, consumers and other partners by May 1, 2004.

---

[1] *Healthy Kentucky Smiles: A Lifetime of Oral Health: Statewide Oral Health Strategic Plan*, The Commonwealth of Kentucky: 2006. http://chfs.ky.gov/NR/rdonlyres/69AA0FAC-4479-49D4-8B5F-BD350C4E7594/0/262366UofKRoundIII.pdf

[2] *Peterson, M.* Kentucky Dental Provider Workforce Analysis: 1998-2006. Louisville, KY, University of Louisville School of Dentistry, 2007.

Objective 2: To develop and publish a five-year statewide strategic plan to address increased access to and utilization of care for all citizens of Kentucky in the area of oral health by September 2004.

Discussion: Strategic Planning

Kentucky implemented the following approaches to a statewide strategic planning process: electronic survey, a one-day "Visioning Summit" with key oral health leaders in Kentucky where draft vision, mission and value statements were created; a two-day "Strategic Planning" Meeting, where the participants critiqued and finalized the Mission and Vision Statements, reviewed the electronic input (SWOT Analysis) and identified sub-committees which would form and continue to work on the Strategic Plan; and the 2006 publication of the strategic plan, *Healthy Kentucky Smiles: A Lifetime of Oral Health.* Detailed information regarding the strategic planning process, the strategic plan and specific committees are included in *Healthy Kentucky Smiles: A Lifetime of Oral Health.*

The KOHP's first step for strategic planning was to identify partners for the strategic planning meeting and encourage them to provide their comments to the KOHP via a website survey. Over one hundred and fifty people were invited to participate in this process on a web-page set up by the University Of Kentucky School Of Public Health (UKSPH). Participants were requested to answer the following open-ended questions.

1. What are the strengths in the provision of oral health services in Kentucky?
2. Are there other additional factors that would help us have a positive impact on the achievement of oral health?
3. What can Kentucky do to improve oral health for all citizens?
4. What can Kentucky do to influence the negative factors affecting oral health?
5. What is your vision of oral health in Kentucky?
6. What do you think the purpose or calling of the oral health initiative in Kentucky should be?
7. What are your beliefs, values, or judgment about oral health regarding what is worthy, important or desirable?

Electronic submissions for these questions were collected for approximately one month. Tabulation of the survey was completed through the UKSPH. Approximately fifty individuals anonymously completed the survey. This electronic input from the survey assured inclusion from a variety of community leaders throughout the Commonwealth.

On April 16, 2004, the KOHP convened key oral health leaders in the state for a one-day "Visioning Summit". The Oral Health Strategic Planning Executive Committee met to create draft vision, mission and values statements which were

presented to participants at Kentucky's initial Oral Health Strategic Planning Meeting.

On May 20 - 21, 2004, Kentucky's initial Oral Health Strategic Planning Meeting was held at the Hilton Suites of Lexington Green. Individuals invited to participate in the strategic planning meeting were the same group invited to participate in the web-based survey. Participants in this two-day event were representatives from the provider community, academics, business leaders, the faith community and consumers, as well as state and local public health staff. In all, over 100 individuals attended the two-day event.

The primary purpose of this event was for participants to critique and finalize the Mission and Vision Statements, to review the electronic input (SWOT Analysis) and to identify sub-committees, which would form and continue to work on the Strategic Plan.

At the conclusion of the two-day meeting, eight subcommittees formed:

Oral Health Strategic Planning Sub-Committees

• Partnerships and Collaborations	• Education
• School-based Collaboration	• Economic Development
• Prevention	• Workforce
• Funding	• Advocacy

Participants identified their preferred group and the meeting adjourned. The Mission and Vision Statements selected by the group follow.

Mission Statement: Assure Oral Health for Kentucky!
Vision Statement: Healthy Kentucky Smiles: A Lifetime of Oral Health

Following the meeting the Executive Committee met for several hours to draft the next steps for the completion of the Strategic Plan. A confirming email was mailed to all groups and their members and committee co-chairs were selected.

The strategic planning meeting continued as committee members provided additional input toward the development, publication and distribution of the strategic plan.

Strategic Planning Successes

The following activities and materials were developed during the strategic planning process: the electronic survey, visioning meeting, strategic planning meeting and 2006 publication of the strategic plan, *Healthy Kentucky Smiles: A Lifetime of Oral Health.*

Strategic Planning Challenges

The primary challenges were the time constraints with the coordination of the survey, strategic planning meeting, sub-committees and actual publication of the strategic plan.

2. Surveillance

Objective 1: Development and implementation of the Kentucky's Children's Oral Health Surveillance System, collecting data and monitoring the oral health of Kentucky's 3rd and 9th graders annually beginning September 2006.

Discussion: Surveillance

Kentucky's Children's Oral Health Surveillance System

In 2003, Kentucky began planning for a statewide children's screening and fluoride varnish application project using trained local health department registered nurses. During the timeframe, a sealant initiative was also developed in partnership with local health departments. These initiatives were targeted for implementation in pilot sites in early 2004. In order to measure the efficacy of these initiatives and to monitor the oral health of Kentucky children, the request for an on-going children's oral health surveillance system was submitted.

During this project, calibrated dental professionals (dentists and hygienists) ascertained the oral health status of children through a visual screening of school children across the state; data was collected using Personal Digital Assistants (PDAs) and downloaded into a secure server at the University of Kentucky for analysis by an oral health epidemiologist

Originally, the visual screenings of Kentucky school children were designed to take place on an annual basis. The target population was children in public schools in the 3rd and 9th grades. Funds were requested for analytical support, travel for abstractors, trainings for schools and abstractors, equipment (PDA's) and some administrative support.

The design and sample for the surveillance system were completed in the spring and summer of 2004. The task was accomplished by working with an oral health epidemiologist, Mike Manz, DDS, MPH with the University Of Michigan College Of Dentistry, and a partnership including representatives from the KOHP, the Kentucky Department for Public Health (KDPH), and the University Of Kentucky College Of Dentistry (UKCOD), Division of Dental Public Health.

Several meetings were held by the development team to identify scope of the system, ages to be screened, sample size, data collection and timeline for implementation. Drawing the sample and weighting by various regions of the state

were important to planners. Following is a description of the sampling design as provided by Dr. Manz.

The sampling was designed as a cumulative replicate sampling over three years. Each sample in each year was planned to be a representative sample of the state's 3rd and 9th grade children which would also allow for merging as a cumulative sample over the three years, allowing for more precise estimation overall, and for subpopulations. Implicit stratification was planned to be employed by sorting lists of schools containing 3rd and 9th grade students. Additionally, Body Mass Index (BMI) information was planned to be collected in order to provide agency health professionals with a statistically accurate sample of under/overweight for Kentucky 3rd and 9th graders.

Lists were sorted first by Area Development District (ADD). ADD geographical areas were believed to provide relevant division of the state by geographic, social, and economic factors, and were useful for gaining subpopulation estimates by ADD, for describing the state of oral health in the school age population and for program planning and implementation. The list was further sorted within ADD to ensure representation by distributing sample selections across other important factors believed to be related to oral health. Depending on the ADD, plans were to sort schools by urban/rural status, county and percentage of enrolled students eligible for the free/reduced lunch program.

Lists of data for selection were obtained from the Kentucky Department of Education and were from the 2000-2001 school year. Based on resources available for the surveillance project and enrollment distribution among ADDs, it was determined that 150 schools for 3rd grade children, and 96 schools for 9th grade children could be visited over the three year period of the surveillance project. Plans were to visit each of the required 50 schools for 3rd grade children and 32 schools for 9th grade children in each of the 3 replicate years. A slightly higher rate of sampling proportional to population size was to be employed in the smallest ADDs to ensure that one school is selected in each of the 15 ADDs in each year of the three-year period.

In the following years, three replicate samples were planned to be selected from the created and sorted lists. In the second and third years, new data was to be evaluated to determine if potential significant shifts in the population required adjustment to the original replicate samples in any of the ADDs. However, the opinion of the investigators was that the population distribution and school enrollments would remain sufficiently stable over a three-year period so that modifications to the sampling plan would not be required. Resampling with a similar design could be completed at three-year intervals for future continuation of oral health surveillance of Kentucky school children.

The planned sample was a visual sample and annual calibrations for screeners were scheduled; therefore, this data was expected to be accurate and could be

generalized to the total population of Kentucky 3rd and 9th graders. While screening for additional grades (particularly 6th graders) would be desirable, initial years were planned to only include the aforementioned grades.

The sample was of sufficient size to be weighted to five Kentucky regions (North, West, Central, East and Jefferson area) annually and to the fifteen ADDS in every third year, the resulting information should recognize subpopulations of the state not previously examined.

Surveillance Successes

Personal Digital Assistants (PDA) Software

The PDA survey software was developed for the project and has the capacity for national utilization for data collection in surveillance system, which was demonstrated at an Oral Health Collaborative Systems Meeting in Washington. This PDA system allows for immediate data entry by screeners and is based upon the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey Tool, in a user-friendly system that was pilot-tested for ease of use. Further, the PDA's can be downloaded from any PC while screeners are in the field. This would provide KOHP analysts immediate receipt of the data. This system is now available to other states.

Surveillance Challenges

Kentucky's Children's Oral Health Surveillance System (KCOHSS)

A pilot project study was completed with a number of school children screened. The PDA's were tested and changes were made to the programming due to lessons learned from the pilot project.

The implementation of the KCOHSS faced numerous challenges. Although careful planning was involved in designing the surveillance system, a combination of four challenges (staffing changes, Institutional Review Board (IRB) revisions, PDA programming and school scheduling) prevented in-school screenings throughout the project. Due to these challenges, the surveillance system did not achieve the expectations foreseen by either the UKCOD or KDHP.

Perhaps the greatest challenge for this project was the attrition of dental faculty within the UKCOD. Changes over the past years for the project principal investigator (PI) have been numerous and have included retirement, promotions and relocation out of state. The learning curve on a project of this complexity was steep and time was necessary after each change to familiarize the new individual with project details.

A second challenge was the need for IRB approval of data collection methods which were different from the original proposal. The survey collected parent information through an opt-out survey (the parents indicate if they did NOT want their children to participate) which also served to collect dental access information for each child. Due to privacy reasons, the survey did not have a child's name recorded.

During the pilot project phase, screeners expected the parent survey would be given to the screener by the child at the time of the clinical screening. However, this was not the case. Children turned their signed surveys into a teacher who provided the grouped surveys to the screening team; thus, no parent survey could be associated with any particular student. Consequently, the critical link between dental access and resulting clinical findings was lost to the study and needed to be remedied through IRB revisions.

After IRB approval for changes to include a child's name on the initial parent survey was received, the modification necessitated the PDA acquired for this project be reprogrammed so these changes could be accommodated thus delaying the project again.

Schools could only be approached at certain times of the year due to restrictions during the winter (numerous snow-days particularly in the mountainous regions of Eastern Kentucky) and spring testing days. Fall was an ideal time for these screenings to take place and missing this "window of opportunity" significantly decreased the number of schools willing to participate.

Although careful planning for the surveillance project, creation and revisions of software and training dental professionals for the surveillance system were executed, the original objectives were not met due to the challenges encountered during the implementation of the surveillance system. UKCOD Public Health attempted to increase the number of school visited and children screened; however, the current methods to reach the target audience for screening will need to be altered to reach the project's full potential. Currently, the UKCOD Public Health and KDPH are trying to rectify the problems encountered.

3. Dental Workforce Study

Objective 1: Development of a Dental Workforce Study, completed by estimating demands for oral health services for the next ten years, using historical state-specific dentist supply numbers from the past decade. Areas of imbalance will be determined based upon estimated supply and demand at both state and regional levels, with completion by September 2007.

Discussion: Dental Workforce Study

Dental Workforce Study: *Kentucky Dental Provider Workforce Analysis: 1998-2006*

Since oral health access had been identified as a critical factor in the strategic planning process, in 2006 the KOHP contracted with the University of Louisville to complete a workforce development study. Of particular concern was Kentucky's aging workforce and the Kentucky dental school graduates (particularly 2002-2006 graduates) staying in the Commonwealth to practice dentistry. Both of these factors would compound access to oral health care for Kentuckians.

The Kentucky Workforce Development Study was loosely modeled after the study on the dental workforce in Wisconsin by Beazoglou et al[3], which showed actual state level data for practitioners and estimated demand for services based on national historical utilization rates compared to derived estimates for supply and demand for services. The workforce study design was refined through research of other similar projects throughout the country.

In May 2007, the University Of Louisville School Of Dentistry (ULSOD) completed a *Dental Workforce Study, Kentucky Dental Provider Workforce Analysis: 1998-2006*.[4] An overview of results of the report follows:

- "Kentucky has 5.6 practicing dentists per 10,000 population, which is below the ADA's national projection of 6.0 professionally active dentists per 10,000 population.
- Statewide, the number of dentists per 10,000 population from 1998-2006 increased from 5.3 to 5.6.
- Ranking by the five 1987 stratified survey districts used for the Kentucky Oral Health Survey, the Louisville District has the most dentists per 10,000 population at 8.3, followed by Central Kentucky (7.6 per 10,000), Northern Kentucky (4.6 per 10,000), Western Kentucky (4.1 per 10,000) and Appalachia (3.8 per 10,000).
- Using the Urban-Rural Continuum Codes, the increase in the number of dentists per 10,000 population from 1998-2006 has occurred in the metro areas (6.6 to 7.0) and remained unchanged in the non-metro areas at 3.7 dentists per 10,000 population.
- Forty-five percent of respondents accept Medicaid/KCHIP and 39% are accepting new Medicaid/KCHIP patients.

---

[3] Beazoglou, T., Bailit, H. and Heffley, D. 2002. *Dental Workforce in Wisconsin*; J. Amer. Dent. Assoc. 133:1097-1104.

- More respondents in the Appalachian District serve and accept new Medicaid/KCHIP patients, followed by the Western, Central, Northern, and Louisville Districts, respectively.
- More respondents in the Appalachian and Central Districts serve migrant farm workers and routinely offer free care to children and adults."

With information from the *Dental Workforce Study, Kentucky Dental Provider Workforce Analysis: 1998-2006,* and oral health surveys of Kentucky's children, adults and elderly, it was apparent there is a disconnect between oral health education, access and services, particularly in the rural counties of Eastern and Western Kentucky.

Dental Workforce Successes

The information gained through the *Dental Workforce Study, Kentucky Dental Provider Workforce Analysis: 1998-2006,* and the publication of the document will allow oral health professionals as well as state and local policymakers to utilize data-based information when addressing dental workforce shortage areas, dental school enrollment, oral health needs assessment and access to care.

Dental Workforce Challenges

During the initial phase of the workforce development study, historical state-specific dentist supply numbers for the past ten-year period were to be reviewed and used to estimate the supply of dental practitioners for the next ten years. Kentucky Board of Dentistry license data was to be used to build a historical model of the state's manpower over the time period.

A barrier was identified when only four (4) years of complete historic licensure data was found. As with many professional associations, data collection has been used to assure adherence to the licensure process rather than for the purpose of data analysis.

In an attempt to solve the issue of inconsistent historic data sets with regard to Kentucky Dental Licensure, planners developed the 2006 Kentucky Dental Workforce Survey. The intent of the survey was to have its' completion as a part of the requirement for licensure by Kentucky dental practitioners. However, the survey was not mandated as part of re-licensure but rather as a voluntary submission. Approximately 32% of Kentucky licensed dentists completed the survey.

Kentucky Oral Health Program Staff Changes

Staff changes during the project included the relocation of Lorie Chesnut, epidemiologists, and retirement of James C. Cecil, DMD, MPH, State Dental Director. Dr. Xiaowu Lu and Linda Grace Piker, MS, MPH, RD, LD, assumed

duties of the grant. In mid-July 2007, Julie W. McKee, DMD, was hired as the State Dental Director.

Presentations

- Williams, J. and Mundt, C. Poster Presentation Preliminary Review Of Results: the Kentucky Dental Workforce Study: 1999-2004. The American Dental Education Association Conference, Orlando, FL. March 2006.

Impact of Overall Project

State Oral Health Collaborative Systems funding provided support for Kentucky's efforts to develop, implement and strengthen Kentucky's oral health collaborative systems (infrastructure) to increases access to oral health services for Kentucky's children, particularly through the Kids Smile: Fluoride Varnish Program and the Kentucky Sealant Program.

Partnerships developed through the strategic planning process had a synergetic effect on oral health activities, awareness and oral health funding statewide. Examples of the impact of the strategic planning process and infrastructure development are development of faith based oral health clinics, requests for professional and public education presentations, requests by local media to meet with the KOHP to learn about the oral health needs of Kentucky and how media representatives can help with meeting the oral health needs of Kentuckians, the increased Medicaid/KCHIP funding for dental services, understanding changes in Kentucky's dental workforce and the extra $900,000 of early childhood tobacco settlement monies to provide additional oral health services to children during FY 08-10.

Although the following activities cannot be directly attributed to the State Oral Health Collaborative Systems Grant, the strategic planning process was likely an impetus for additional oral activities in Kentucky. Examples follow:

Partnerships Developed

A. **HANDS** The HANDS (Health Access Nurturing Development Services) Home Visitation Program stresses the importance of oral health to overall health for Kentucky's children and their families during HANDS services. HANDS is a voluntary, intensive home visitation program for first time parents designed to improve both health and social outcomes with the following goals: positive pregnancy outcomes, optimal child growth and development, children live in healthy/safe homes and family self sufficiency. In FY 06, HANDS services were provided to over 10,967 Kentucky families and completion of 137,230 (over 11,000 a month) home visits. (HANDS Handout 12/2006) In FY 08 the HANDS nurses will receive the KIDS

SMILE: Fluoride Varnish Training, fluoride varnish supplies, and dental education materials to utilize on home visits with eligible children. On quarterly home visits, the HANDS nurses will provide an oral exam, fluoride varnish applications, preventive oral health messages, and if necessary, referral to a dentist for children of families enrolled in the HANDS Program.

B. **Cross-Training** The need for increased partnerships and cross-training opportunities are critical for providing oral health care to children in Kentucky. Examples of the cross-training are: the fluoride varnish program now in local health departments; the inclusion of oral health training for residents through the Pikeville School of Osteopathic Medicine; and as a topic under discussion, the role of a mid-level practitioner for service provision in dental health professional shortage areas. The KOHP was invited to exhibit at an August 2007 Kentucky Chapter of the American Academy Of Pediatrics (Kentucky Pediatric Society) Continuing Medical Education Meeting and becoming partners with Kentucky Pediatricians in an oral health program, *Healthy Teeth for Tots*, which will train nurses to apply fluoride varnish in pediatrician's offices.

C. **Oral Health Education** Local health department nurses, dental hygienists, health educators and dentists educate caregivers and children about the importance of oral health to overall health, the importance of primary teeth and how to properly care for children's teeth. For the past three years, the Kentucky's Children's Librarians have partnered with the KDPH to provide oral health education during National Children's Dental Health Month. Educational activities have included visits by dentists and the Tooth Fairy, demonstration of proper brushing and flossing, oral health information, "story hour" with dental themes and activities and distribution of toothbrushes and toothpaste for children attending an oral health education program at the libraries. As a consequence of the librarians' participation in oral health programs, additional oral health books, videotapes, and DVDs are available for children to enjoy all year long.

D. **Kentucky Oral Health Specialty License Plate** Staff of the KOHP and the Kentucky Dental Association (KDA) initiated the specialty license plate project, which was designed by KDA staff. The KDA adopted the specialty license plate project to promote oral health in Kentucky. By the end of 2007, these license plates are expected to be produced and displayed wherever Kentucky license plates are sold. Funds produced from the license plate will be donated to the Kentucky Dental Foundation to help support community service projects.[5]

[4] Kentucky Dental Association. *6/21/07* *http://kyda.org/cgi-local/htmlos.cgi/003.1.030553361211422945*

E. **Family Violence: Guidelines for Reducing Liability in Your Practice Workshop** Kentucky's Strategic Plan identified a special initiative by the KDPH to develop and implement a continuing education program and resource materials to increase dental professionals' recognition of domestic violence. In 2005 and 2006, with support from the Kentucky Justice and Public Safety's Violence Against Women Act (VAWA) funds, the KDPH and the UKCOD collaborated with the Centers for Research on Violence Against Women, KDA, Kentucky Domestic Violence Association, Kentucky Division of Child Abuse and Domestic Violence Services, Department of Aging, Department of Community Based Services, Family Violence Prevention Fund and the Kentucky Injury Prevention Center's Intimate Partner Violence Surveillance Project, to provide efforts to reduce the barriers for Kentucky dental professionals in identifying victims of domestic violence via a three-hour continuing education course offered at the 2005 and 2006 KDA Conference and as well as a Domestic Violence Toolkit. In addition to approximately 500 dental professionals receiving the training, further trainings were held for UK dental students and participants at domestic violence conferences.

Identify considerations for improvement of results for such activities in the future

Additional methods for children's oral health surveillance need to be developed to allow for effectual continuation of the surveillance system. Discussion with the UCOD Public Health Director and epidemiologist indicated several scenarios are under consideration to improve the surveillance system.

In September 2007, the KOHP received funding through the Targeted State MCH Oral Health Service Systems Grant Program (TOHSS) to support the State's capacity to expand preventive and restorative oral health services for Medicaid and State Children's Health Insurance Programs (SCHIP) eligible children, and other underserved children and their families. The TOHSS Grant will provide funding for the KOHP to addressed needs identified through surveillance, community and partnership development, the workforce development study and the strategic planning process. The grant will allow the KOHP to build upon the infrastructure developed during the past four years of the State Oral Health Collaborative Systems funding.

Discuss any non-federal funding support that will allow you to continue the project you have worked on these past 4 years

On October 2, 2007, the KOHP was notified of additional early childhood tobacco funding in the amount of $300,000 per fiscal year for FY 08-FY10 and has been designated for oral health activities. These funds will be used to serve uninsured children from birth through 5 years of age. Preventing ECC by training and supporting health professionals to screen, apply fluoride varnish to the baby teeth, provide oral health care information and make appropriate referrals to local dentists can result in a dramatic decline in the prevalence of this disease. This program will promote community-based oral health preventive services to address primary and secondary preventive strategies. Providing these services at a total cost of about $700 per patient per budget year could save between $5,000 to $10,000 per child in restorative care and hospitalization when the disease progresses toward losing the teeth. If unfunded, the result would be increased societal costs associated with hospitalization and restorative care that can easily and inexpensively be prevented by enhancing the clinical skills of nondental personnel (nurses, physicians and others) to include the mouth, head, and neck in routine physical examinations and assessments at health departments and other public agencies; as well as assure access to care through the control of acute pain and disease by contracted dentists.

Materials Developed and Publications

Burklow, C. Kentucky Oral Health Surveillance Program: PDA Training
A digital data collection system was developed for this project which will allow screeners to collect screening data by using a Personal Digital Assist (PDA)

Chesnut, L. *Leading Kentucky's Oral Health Program – A Profile and Activity Update,* Kentucky Epidemiologic Notes and Reports, Jan-Feb 2005.

Healthy Kentucky Smiles: A Lifetime of Oral Health: Statewide Oral Health Strategic Plan, The Commonwealth of Kentucky: 2006.

Mayer, L. and Mundt, C. *Oral Health in Kentucky: A View from the National Behavioral Risk Factor Surveillance System: 1999-2004*. University of Louisville, June 2006.

Peterson, M. Kentucky Dental Provider Workforce Analysis: 1998-2006. Louisville, KY, University of Louisville School of Dentistry, 2007.

White, J. *The Training Manual for Standardized Oral Health Screening Schoolchildren – Kentucky Children's Oral Health Surveillance Program*: 2005.

Kentucky Oral Health Collaborative Systems Grant
Federal Assurance FWA00005155
CFDA #93.110; Grant #H47MC01940
Final Report 14

Appendix

Kentucky Strategic Plan
Strategic Initiatives Progress

Advocacy

1. Funding for the Kentucky Oral Health Program (KOHP) increased.
2. Kentucky Medicaid fees have increased for usual and customary fees. In 2006, the Kentucky General Assembly increased Medicaid reimbursement rates for dental services to Kentucky children by approximately 30 per cent.

Economic Development

1. The KOHP and the KDPH, Health Access Branch, are working together to increase the number of designated health professional shortage areas in Kentucky.
2. The workforce development study was completed and published in 2007.

Funding

1. The KOHP received an additional $900,000 early childhood tobacco settlement monies to provide added oral health services to children during FY 08-10.
2. In September 2007, the KOHP received funding for the Targeted MCH Oral Health Service Systems (TOHSS) Grant.
3. Medicaid funding has increased for the usual and customary fees for oral health services.
4. Medicaid has added additional oral health services for their participants.

Partnerships and Coalitions

1. Faith based oral health clinics have opened in Lexington, Frankfort and Bardstown.
2. Oral health/domestic violence continuing education course and toolkits were offered at the Kentucky Dental Association's (KDA) Annual Conference in 2005 and 2006. Additional trainings have taken place at the dental schools and domestic violence conferences.
3. The KOHP has enlisted a variety of community partners (Family Resource Centers, State Children's Librarians, local media, KDA, local health departments, Health Education through Extension Leadership) to provide oral health programs and materials during National Children's Dental Health Month.

4. KOHP and community partners have coordinated oral health efforts statewide with the oral health screening, varnish/sealant application and education at the Kentucky State Fair and the Special Olympics.
5. Oral health curriculums are being offered for the provision of basic oral health education, screening techniques and referral skills for non-dental professionals in Kentucky such as second year students at the Pikeville School of Osteopathic Medicine and KIDS SMILE: Fluoride Varnish Training for nurses. The KOHP and the Kentucky Chapter of the AAP (Kentucky Pediatric Society) are currently developing a continuing medical education meeting and an oral health program, *Healthy Teeth for Tots*, which will train nurses to apply fluoride varnish in pediatrician's offices.
6. The collaboration, known as the Kentucky Dental Public Health Partnership, was awarded the American Public Health Association/Glaxo SmithKline Partnership for Healthy Children Award at the 2006 American Public Health Association's 13th annual meeting. This award recognizes and supports community-based collaborative efforts to improve the health of children.
7. Staff of the KOHP and the KDA initiated the specialty license plate project, which was designed by KDA staff. The KDA adopted the specialty license plate project to promote oral health in Kentucky. By the end of 2007, these license plates are expected to be produced and displayed wherever Kentucky license plates are sold. Funds produced from the license plate will be donated to the Kentucky Dental Foundation to help support community service projects.

Prevention and Treatment

1. Faith based oral health clinics have opened in Lexington, Frankfort and Bardstown.
2. The KOHP has increased the number of children receiving fluoride varnish and sealants by partnering with the KDA, UOLSOD and UKCOD, local health departments, Family Resource Centers, Area Health Education Centers, Kentucky Pediatric Society and the Pikeville School of Osteopathic Medicine. Currently 23 local health departments provide sealants for their constituents.
3. In 2007, the Kentucky Medicaid Oral Health Benefits included preventive services for the prevention of preterm births.
4. The UKCOD developed and implemented *Centering Pregnancy with Smiles* at the Women's Health Center at the Trover Clinic in Madisonville, Kentucky and at the University of Kentucky. This new model provides prenatal education and care for expectant mothers in small groups. When fully implemented, over 1,000 women and their families will be included annually. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the new March of Dimes Program of the KDPH.

5. James C. Cecil, DMD, MPH, was featured in "A Question of Life or Meth," a two-part series aired on the A&E Classroom channel, which won a 2007 Daytime Emmy for Outstanding Special Class Special by the National Academy of Television Arts & Sciences.
6. The UKCOD participates annually, in cooperation with the KOHP, in "Seal Kentucky" activities, including traveling with first-year student dentists and faculty to selected rural counties for the application of sealants for children who might not otherwise see a dentist. Traditionally scheduled in October, this activity is mutually beneficial for children and residents alike, with many residents noting that this opportunity was one of the highlights of their graduate experience.