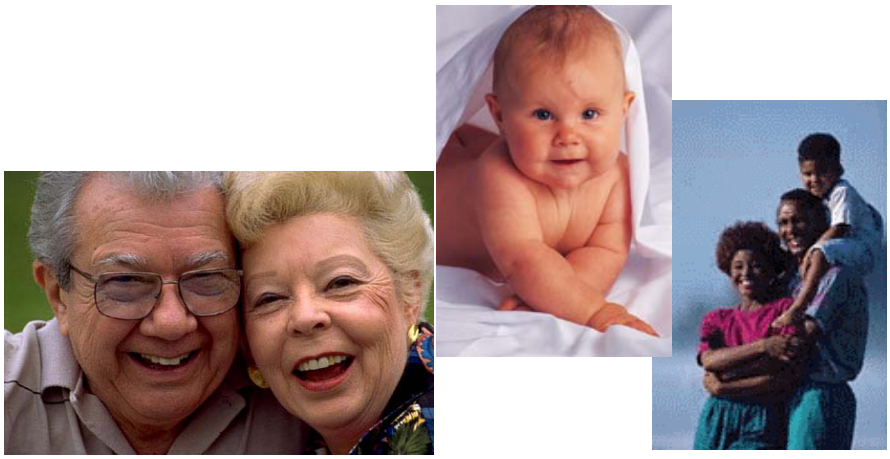
An Oral Health Plan for Nevada

Strategic Meeting of Oral Health Stakeholders
January 24, 2002



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" You are not healthy without good oral health "

Dr. C. Everett Koop, Surgeon General of the United States, 1981-1989

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Summary

On January 24, 2002, the Nevada State Health Division (NSHD) convened a Strategic Meeting of Oral Health Stakeholders to evaluate the Nevada State Oral Health Program and to plan for the future. Participants represented a diverse group of stakeholders. Funding for the meeting was provided by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Division of Medicine and Dentistry. The meetings were held to gather information and community input, to be used in the planning and establishment of an Oral Health Program and an Oral Health Advisory Committee, and to aid in the development of an updated Oral Health Plan for Nevada. The goal of the strategic meeting was to discuss and determine issues pertaining to establishing, strengthening, and expanding the capacity of Nevada to plan, evaluate and implement oral disease prevention and health promotion programs as outlined in *Oral Health in America: A Report of the Surgeon General* and by Healthy People 2010. The objectives of the strategic meeting were to identify gaps in oral health in Nevada, develop a vision for the NSHD Oral Health Program, develop a plan addressing infrastructure building, population based services, enabling services and direct health services and to identify potential Oral Health Advisory Committee members. Prior to the meeting, participants were provided with a brief summary of current Nevada oral health data, existing programs, and the Healthy People 2010 objectives. Participants were asked to utilize this information as they went through the process of identifying gaps, developing a Vision Statement, establishing goals and objectives for the NSHD Oral Health Program, and developing evaluation criteria. Stakeholders made specific recommendations for the areas of Infrastructure Building, Population Based Services, Direct Health Services and Enabling Services.

Infrastructure Building

Develop an Oral Health Program, an Oral Health Advisory Committee and community-based oral health coalitions to establish policy.

Develop and implement a systematic and ongoing surveillance system including baseline data.

Identify target populations and the barriers to achieving optimum oral health that they encounter.

Population Based Services

Develop educational programs relating oral health to total health.

Increase utilization of proven, science based preventive measures such as water fluoridation and dental sealants.

Direct Health Services

Develop and implement regional dental care plans.

Implement a basic care network targeting specific populations such as schools, seniors, rural and underserved populations, utilizing portable equipment.

Enabling Services

Develop a screening instrument to evaluate client needs.

Develop a standardized format for evaluating client information related to eligibility, waivers etc.

Develop a resource directory.

Recruit providers.

Inform clients and providers about federal requirements and the resources available to meet them.

Background

The NSHD, through the Maternal and Child Health Block grant has promoted oral health for many years. Until 1998, the NSHD had a small Children's Dental Program (CDP) which paid for dental treatment for eligible children to age 19. As the eligibility for the CDP mirrored the eligibility for the state's Child Health Insurance Program, the CDP was discontinued when Nevada Check Up was implemented in October 1998. In addition, for a number of years, the NSHD, Bureau of Family Health Services (BFHS) partnered with the Community College of Southern Nevada Dental Hygiene Program and the Southern Nevada Dental Society to conduct quarterly dental clinics in Las Vegas where children were provided with free preventive and restorative dental services. Since 1997, funding from the Centers for Disease Control and Prevention (CDC) and the Human Resources and Services Administration (HRSA) has been utilized for fluoridation education. In 1998, the Governor's Maternal and Child Health Advisory Board, Oral Health Subcommittee developed *An Oral Health Action Plan for Nevada.* The *Action Plan* contained a series of recommendations for both the public and private sector. A number of recommendations from the action plan have been actualized, including an increase in the percent of population with access to fluoridated community water systems and an increase the percent of third graders with at least one dental sealant on a permanent molar. In 1999, the Nevada State Legislature, recognizing the importance of oral health and the lack of programs and services to address the state's needs, authorized a one-time redirection of unobligated Maternal and Child Health block grant funds to establish a State Oral Health Initiative with a prevention and education focus. The Oral

Health Initiative funded the development and implementation of the Healthy Smile – Happy Child, Early Childhood Caries Prevention program and provided funding to private and public entities to provide oral health education and preventive services. In July of 2001, the NSHD was awarded a five-year, cooperative agreement from CDC. The purpose of the cooperative agreement is to establish, strengthen, and expand the capacity of Nevada to plan, implement and evaluate oral disease prevention and health promotion programs, targeting populations and disparities as outlined in *Oral Health in America: A Report of the Surgeon General.* The cooperative agreement outlined the following goals: establish a State Oral Health Program staffed with a State Dental Health Officer, Health Program Specialist II (HPS II), Health Resource Analyst II (HRA II), and an Administrative Assistant II (AA II), establish a State Oral Health Advisory Committee, develop a State Oral Health Plan, establish an oral health surveillance system, increase the number of children with dental sealants through public/private partnerships, develop a state oral health public education campaign and develop an oral health curriculum that may be utilized by school districts. In September of 2001, the NSHD held four community-based oral health stakeholder meetings throughout the state. The September meetings identified general support from a diverse group of stakeholders for the following:

- Increase access particularly for Medicaid and Nevada Check Up clients, the uninsured, the undocumented, pregnant women and seniors.
- Emphasize prevention.
- Develop a central source for information sharing and dissemination.

- Develop a coordinated, targeted education campaign on oral health for the public, the medical community and policy makers.

The intent of the Strategic Meeting of Oral Health Stakeholders was to build on the findings generated from the September 2001, Oral Health Stakeholder meetings. Information gathered at the Oral Health Stakeholder meetings and the Strategic Meeting of Oral Health Stakeholders will be used to establish the State Oral Health Advisory Committee, develop the State Oral Health Plan, and design and implement the goals outlined in the CDC Cooperative Agreement.

Past Oral Health Assessments

"A silent epidemic" of oral diseases is affecting our most vulnerable citizens---poor children, the elderly, and many members of racial and ethnic minority groups..."

Oral Health in America: A Report of the Surgeon General

The last statewide oral health needs assessment of Nevada's children was done in 1992 by Cristman Associates under contract with the NSHD. The needs assessment found:

- 67 percent of children examined had experienced decay in permanent or primary teeth.
- Active tooth decay in primary or permanent teeth requiring routine dental treatment was found in almost half (48.6 percent) of first graders and more than half (51.0 percent) of sixth graders.
- Approximately 18 percent of first graders and 12 percent of sixth graders were found in need of some form of urgent care because of active caries that could lead to pain or infection.
- About 5 percent of first graders and 3 percent of sixth graders needed immediate attention due to severe pain and infection.

In 1999, the NSHD contracted with Cristman Associates to conduct an oral health needs assessment of Nevada seniors. The needs assessment found the following in residents of long term care/skilled nursing facility (LTC/SNF):

- 13 percent reported chewing problems.

- 13 percent reported swallowing problems.
- 2 percent reported mouth pain.
- 8 percent have an oral health problem that affects the ability to eat.
- 51 percent have either dentures or a removable bridge.
- 25 percent have lost some of their natural teeth, but do not use dentures or a partial.
- 8 percent have lost all natural teeth, but do not use dentures.

The needs assessment found the following in Nevada seniors residing in the general community:

- 14 percent have broken, loose or decayed teeth.
- 6 percent have inflamed and swollen or bleeding gums.
- 3 percent have infection, ulcers or rashes in the mouth.
- 6 percent have lost all natural teeth, but have no denture.
- 23 percent have lost some natural teeth, but do not have a partial denture.
- 58 percent have dentures or a removable bridge.

More recently, on October 26, 2000, the Southern Nevada Dental Hygienists' Association conducted a "Dental Fitness Check" in 23 Southern Nevada Elementary Schools. 9958 children were screened. 4390 children (44%) were referred to a dentist due to the presence of visible, untreated decay. 695 of them needed immediate care due to the presence of pain and/or swelling. From July 1, 2000 through June 30, 2001, Saint

Mary's Take Care A Van screened 1583 children in 31 Washoe County schools. 400 (25%) were referred to a dentist due to the presence of visible untreated decay. From July 1, 2000 through June 30, 2001, Saint Mary's Take Care A Van screened 798 children in 15 rural schools. 215 (27%) were referred to a dentist due to the presence of visible untreated decay.

Identified Gaps in Oral Health in Nevada

Participants at the Strategic Meeting of Oral Health Stakeholders identified existing gaps in oral health in Nevada. Identified gaps included lack of support from policy makers, an inadequate number of dental schools, lack of capacity, lack of incentives to provide dental services to the underserved, inadequate infrastructure, gaps in education, lack of collaboration, coordination and partnership, and language and cultural barriers.

Stakeholders believe that policy makers do not establish priorities based on actual dental public health needs. Examples included, lack of support for optimal fluoridation statewide, lack of state funding for an oral health program, inadequacies in the current Medicaid and Nevada Check Up systems (particularly lack of adequate coverage for adults), and inadequate coverage from private insurance companies (including the need to reimburse medical providers for oral health screening and fluoride treatments). Funding for proven, science based, preventive strategies such as fluoridation and sealants need to be provided so these strategies can be used consistently and on a wide-spread basis.

Stakeholders also believe that there are an inadequate number of dental schools to meet the current and future needs of the population. In addition, existing dental schools have conflicting roles such as educating students and providing services in their communities while also having to seek funding in order to be able to meet their expanding roles.

Stakeholders recognized that Nevada is also experiencing a lack of capacity – dental health professionals and facilities in which they can practice. There are only 35

dentists to every 100,000 of the general population, the worst ratio in the nation. There are an insufficient number of specialists, particularly pediatric dentists. Some areas of the state are experiencing a shortage of support staff needed to effectively provide dental services - dental hygienists and dental assistants. In addition, programs for the underserved frequently lack practice management and case management support. Licensing issues have also contributed to the state's lack of capacity. Nevada does not participate in any of the regional dental exams and does not have reciprocity with any other states. Some dentists with loan repayment obligations have experienced difficulty in obtaining a license to practice dentistry in Nevada. Those who do obtain licensure in Nevada frequently prefer to pay their loan back monetarily rather than through service to the underserved.

In addition, Nevada does not have adequate incentives for dentists to take care of the needs of the underserved. Dentists do not feel that reimbursement rates for Nevada Check Up and Nevada Medicaid adequately compensate for the cost of services. Dentists perceive that paperwork for these programs is overly cumbersome and payment is delayed. This has resulted in a shortage of practices willing to accept the clients of these programs. There is also a lack of recruitment and retention programs designed to funnel dentists into underserved communities. Community service is not mandated, and there is no organized system in place to educate providers on the importance of, and the need for, service to underserved and special populations.

During the 2001 session, the Nevada Legislature recognized licensing issues as a barrier to increased capacity, and passed legislation creating several new licensure by

credential options. This has resulted in increased interest in practicing in rural and underserved communities from dentists licensed in other states. However, stakeholders strongly recognized the lack of Federally Qualified Health Centers (FQHC), non-profit clinics, and rural clinics in which these dentists can practice. Nevada currently has only one FQHC that provides dental services. Capital is needed to establish new and expand existing facilities that serve rural, underserved and special populations.

Nevada is also experiencing gaps in oral health education. Schools do not effectively integrate oral health education into existing health education. School administrators are reluctant to take valuable class time for oral health education, prevention or treatment. School-based programs to educate and screen children are few. The general population does not receive effective oral health education either. Recognizable and credible experts on oral health are lacking. Much of the general population does not value oral health. They do not believe that oral health is essential to general health or that oral health is important throughout the lifespan - from birth to death. They do not recognize that prevention is life-long and that problems need to be identified before it is "too late". Finally, the general population needs to be educated to take personal responsibility for their oral health.

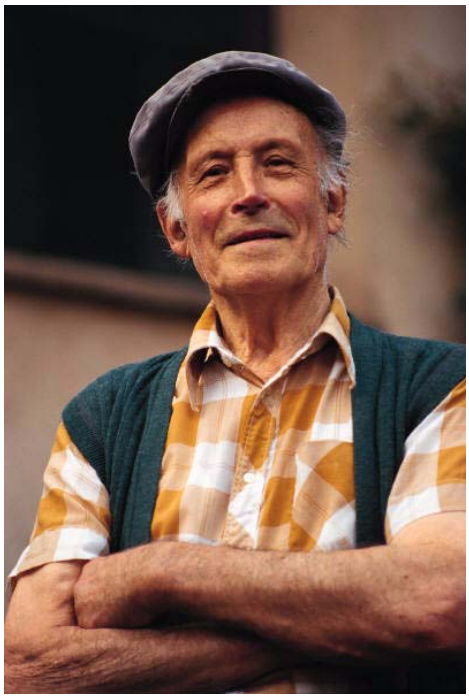
Stakeholders also identified a lack of collaboration, coordination and partnership. Existing programs, services and funding need to be coordinated. Applications for funding need to include more and better partnerships. Coordinated education, prevention and treatment partnerships need to be established. In particular, a lack of coordination and collaboration between the medical and dental communities was identified. Health

care providers need oral health education so they can recognize oral health problems and promote oral health with their clients. Childcare providers should also be targeted for education and collaboration.

Additional barriers to care identified include language, cultural, transportation, and case management issues.

Vision Statement

Stakeholders developed a vision statement for the Nevada State Health Division Oral Health Program.



The Vision of Nevada's Oral Health Program Is That All Nevadans Achieve Optimal Oral Health.

Developing a Plan

Stakeholders self-selected into workgroups to develop goals and objectives addressing one of the following topics: Infrastructure Building, Population Based Services, Direct Health Services or Enabling Services.

The first action recommended by the Infrastructure Building workgroup was establishment of a formalized Oral Health Program that is fully staffed with qualified individuals. The role and function of each position needs to be defined. Providers, consumers, educators, media, legislators, and the medical community should be consulted. This will require funding, partnerships and the support of the Nevada State Health Division. The Oral Health Program should be staffed within 3 months. The Infrastructure Building workgroup also recommends establishment of an Oral Health Advisory Committee. The first step will be to identify potential members of the Advisory Committee. The Advisory Committee should reflect a diverse group of stakeholders and the selection process should involve providers, consumers, educators, media, legislators, and the medical community. Establishment of an Advisory Committee will require funding, partnerships and the support of the NSHD. The Advisory Committee should be established within 3 months of the establishment of the fully staffed Oral Health Program. The third action identified by the Infrastructure Building workgroup was to identify baseline resources and capacity, and to conduct a needs assessment. This will involve collection and analysis of existing data. In addition, focus groups and surveys should be conducted as part of the needs assessment. After data collection, analysis and the needs assessment are completed; an ongoing surveillance

system should be designed and implemented. This will involve the Advisory Committee, staff and partnerships. After the data analysis and needs assessment are completed and the Oral Health Program and the Advisory Committee are established, the NSHD will have the infrastructure and capacity to establish data driven policy and programs.

The first action recommended by the Population Based Services workgroup was to determine what the barriers are to achieving optimum oral health. Specific populations such as specific age, ethnic, socioeconomic groups, geographic communities, and special-needs populations should be surveyed to determine what the existing barriers are to achieving optimal oral health. This should involve a diverse group including ethnic related service groups, Centers for Independent Living, mental health groups, Family Resource Centers, senior centers, the state demographer, school districts, and public health nurses. Resources needed include staff, funding and partnerships. This should be completed within 3 months of establishment of the Oral Health Program. In addition, the highest risk groups should be identified. This will involve the NSHD, the Division of Health Care Financing and Policy (DHCFP), professional associations, health care providers, safety-net providers, and school districts and can be accomplished using existing data and surveys. A third action would be to create community-based coalitions to promote oral health. The first step will be to identify partners and invite them to participate. This should include all of the groups mentioned previously. Once barriers and high-risk groups are identified and community-based oral health coalitions are established, targeted educational programs should be developed. These programs should include information about the relationships that exist between oral health and general

health, prevention, intervention and maintenance. Existing curriculums should be researched. The development of educational programs should include marketing strategists, school districts, dental and dental hygiene schools and the NSHD. This will require staff and funding. Research should start immediately and curriculums should be ready to implement in 18-24 months.

The first action recommended by the Direct Health Services workgroup was the development of regional dental care plans. The first step would require needs assessment of populations and providers and an assessment of existing capacity and potential for expansion. This will require involvement of the State Dental Health Officer, staff of the Oral Health Program, the Office of Rural Health, UNLV School of Dentistry, school districts, city and county governments, safety-net providers and community-based organizations. After regional dental care plans have been developed, a basic care network targeting specific populations should be implemented. The first steps involved will be to seek funding from public, private, non-profits and foundations. This will require partnerships between all of the organizations named above.

As a first action, the Enabling Services workgroup recommended development of a screening instrument to evaluate client needs. This will require input from providers, clients, and community-based organizations representing populations with special needs. The screening instrument itself will then be designed by staff of the Oral Health Program. Development of the screening instrument should be initiated as soon as the qualified staff is in place. In addition, a standardized format for evaluating client information related to eligibility, waivers, etc. should be developed. The first step would be to create a flow

chart that identifies the resources clients may be eligible for. This will involve Medicaid, Medicare, dentists, and safety-net providers. As soon as the qualified staff is in place, the staff of the Oral Health Program should develop the flow chart. A third action recommended by the workgroup is the development of a resource directory. Key service providers should be identified by the Oral Health Program, the DHCFP, dentists, and safety-net providers. When qualified staff is hired, the Oral Health Program will then develop the resource directory. Strategies and a marketing plan for recruitment of providers willing to see Medicaid, Nevada Check Up, and special-needs clients should be developed. The Oral Health Program, DHCFP, Nevada Dental and Dental Hygiene Associations, and community-based organizations representing special-needs populations should be involved. This will require staff and funding. A fifth action should be to develop a system to inform clients and providers of the federal requirements related to specific needs of clients (i.e. language, Americans with Disabilities Act) and the resources available to meet these requirements (such as the ATT language bank and hearing impaired phone lines). The requirements and resources need to be identified. A standardized curriculum should be developed. Trainers need to be identified and trained. The information should be shared by holding periodic in-service for private and safety-net dental providers. Continuing education credit should be provided for the training. This will involve a multi-agency task force including the Nevada Dental Association and local societies. Finally, a mobile delivery system for rural and underserved areas needs to be developed. Existing systems statewide need to be identified. The effectiveness of existing systems needs to be evaluated. A survey of providers to determine who is willing to participate should be conducted. A map of areas of need and inventory of

existing services should be developed using this information. Funding to establish a mobile delivery system for rural and underserved areas can then be investigated, including lobbying the legislature in 2003 for support for a collaborative effort and public and private grants. This should be initiated by a multi-organization task force including the NSHD, safety net providers, rural clinics, and school-based providers.

Infrastructure Building

Goal Statement: To develop an Oral Health System in Nevada.

Outcome/Measurement: Development of oral health leadership for the State.

Action	First Steps	Who to Involve	Resources / Help Needed	When
Establish an Oral Health Program.	Define role and function.	Providers, consumers, educators, media, legislators, medical community, health plan providers.	Funding, staff, partnerships.	Qualified staff hired within 3 months.
Establish Oral Health Advisory Committee.	Identify Advisory Committee.	Providers, consumers, educators, media, legislators, medical community, health plan providers.	Funding, staff, partnerships.	Advisory committee established within 3 months.
Identification of baseline resources and capacity. Develop needs assessment Develop community-based reporting system.	Review of existing data sources, focus groups, surveys.	Advisory Committee, staff.	Funding, staff, partnerships.	Initiated within 6 months of staff being hired. Ongoing.
Develop ongoing surveillance.	Complete needs assessment, establish priorities.	Advisory Committee, staff.	Funding, staff, partnerships.	Ongoing.
Develop policy.	Identify stakeholders, conduct focus groups, establish Advisory Committee.	Advisory Committee, staff.	Funding, staff, partnerships.	Ongoing.

Population Based Services

Goal Statement: To assure that all Nevadans achieve optimal oral health.

Outcome/Measurement: Population-based education and services for all populations.

Action	First Steps	Who to Involve	Resources / Help Needed	When
Determine the barriers to achieving optimum oral health.	Identify populations to be served such as certain age, ethnic, and socioeconomic groups, individuals with physical or mental disabilities, or specific geographic locations.	Ethnic related service groups, Centers for Independent Living, Mental Health groups, Family Resource Centers, Senior Service Centers, State Demographer, school districts, Public Health Nurses.	Staff, partners. Current data. Funding. Survey results.	Within 3 months of program being staffed.
Identify highest risk groups.	Determine what groups have already been identified by the Health Division, professional associations, Medicaid, school districts and non-profits.	The Health Division, professional associations, Medicaid, school districts and non-profits.	Staff, partners Current data.	Within 3 months of program being staffed.
Create coalitions.	Invite groups to the table.	All above groups send representative. Invite medical society.	Active players.	Start: Within 3 months of program being staffed. Accomplished within 6-9 months
Develop educational programs including information relating oral health to total health.	Program should include information on prevention, intervention, and maintenance. Example: how to maintain/care for partials and dentures.	Grant writers, marketing strategist, school districts, dental schools, Oral Health Program.	Information about existing curriculums, staff, funding.	Start investigation now. Implement in 18 – 24 months.

Direct Health Services

Goal Statement: To provide access to direct dental services

Outcome/Measurement: The number of patients, the number of encounters, the relative value units of the services provided, the number of referrals made, the number of cases completed.

Action	First Steps	Who to Involve	Resources / Help Needed	When
Develop regional dental care plans.	Do needs assessments of population and providers. Assess diagnostic and emergency capacity and potential for expansion.	State Dental Health Officer and staff, UNLV School of Dentistry, elected officials, stakeholders, schools, city and county governments, hospitals, private providers, safety-net providers, community-based organization such as senior programs.	Nevada State Health Division, partners, consumers, providers.	Within 1 year of program being staffed.
Implement a basic care network targeting specific populations such as schools, seniors, etc., utilizing portable equipment.	Seek funding from public, private, non-profits and foundations. Find sponsors and locations.	State Dental Health Officer and staff, UNLV School of Dentistry, Elected officials, stakeholders, schools, private providers, safety-net providers, community-based organization such as senior programs.	Funding, partners	Within 2 years of program being staffed.

Enabling Services

Goal Statement: To ensure that all Nevadans have access to treatment, have the ability to communicate with culturally competent providers, and the communication and delivery system between Medicaid and providers will be streamlined.

Outcome/Measurement: Treatment needs will be measured and met for all Nevadans

Action	First Steps	Who to Involve	Resources / Help Needed	When
Develop a screening instrument to evaluate client needs.	Design the screening instrument.	Department of Human Resources, providers, clients, community-based organizations representing special needs groups.	Staff of Department of Human Resources.	Immediately.
Develop a standardized format for evaluating client information related to eligibility, waivers etc.	Create a flow chart that identifies the resources for which the client is eligible.	Medicaid, Medicare, dentists, safety-net providers.	Staff of Department of Human Resources.	Immediately.
Develop a resource directory.	Identify key service providers.	Dentists, safety-net providers, Department of Human Resources.	Staff of Department of Human Resources.	Immediately.
Develop strategies and a marketing plan for recruitment of providers.	Establish a multi-agency task force. .	Dentists, physicians, Department of Human Resources.	Staff of Department of Human Resources, Nevada Dental Association.	Within 6 months.

Inform clients and providers of federal requirements and resources available related to specific needs of clients (i.e. language, Americans with Disabilities Act).	Identify requirements and resources. Develop a standardized curriculum. Identify and train trainer. Share above information by holding in-service on a regular basis. Provide continuing education credit for training.	Department of Human Resources, Nevada Dental and Dental Hygiene Associations, community-based organizations representing special-needs populations.	Staff of the Department of Human Resources, funding.	Within 6 months.
Develop a mobile delivery system for rural and underserved area (reverse transportation - take services to patient)	Identify existing systems statewide. Evaluate effectiveness of existing systems. Do a survey of providers to determine who is willing to participate. Develop a map of areas of need and inventory of existing services. Investigate funding.	Multi-organization task force including the Nevada State Health Division, safety net providers, rural clinics, school-based providers.	Partnerships, funding.	Initiate immediately.

Issues that remain to be addressed

After reviewing the recommendations developed by each workgroup, participants discussed issues that were not addressed in the workgroups. Under Infrastructure Building, the Oral Health program needs to be a leading advocate. It needs to play a lead role in exploring funding opportunities and in insurance reform, particularly related to Medicaid, Nevada Check Up and Medicare. Licensing issues, including reciprocity, should continue to be addressed. Population Based Services need to include primary prevention, including oral health education of expectant and new parents and nutrition education for seniors and school age children. Population based services should also include increased access to community water fluoridation and dental sealants. Direct Health Services should establish quality of care measures. Continuing professional education on geriatric and pediatric care should be made available. Resources should be invested in existing services and funding from public and private sources for direct health services should be pursued. Enabling Services should include development of an adult version of Early and Periodic Screening Diagnosis and Treatment (EPSDT). Incentives should be provided to clients who access prevention and early care. Additional investment should be provided to existing enabling services. Individualized case management should be pursued. Private practice dentists and safety-net providers should be educated on existing enabling services and how to access them.

Issues that remain to be addressed

Infrastructure Building	Population Based Services	Direct Health Services	Enabling Services
Advocacy. Explore funding opportunities. Insurance reform / Medicaid, Nevada Check Up, Medicare Individualized case management for uninsured. Invest in existing services. Licensing/Reciprocity .	Primary Prevention. Education of expectant and new parents. Nutrition / schools and for seniors. Fluoridation. Sealants.	Establish quality of care measures. Develop continuing professional education / pediatric and geriatric. Pursue funding.	Use incentives. Invest in existing services. Increase utilization of enabling services by private practice dentists and safety-net providers. Develop adult EPSDT.

Evaluation of goals and objectives - "How will we evaluate progress?"

Infrastructure Building can be evaluated by a number of criteria. Have the action steps been completed? Are policies addressing gaps? Health status indicators can be evaluated using a "report card" system. An assessment by stakeholders could be conducted. Population Based Services can be evaluated by the number of children with sealants and the percent of Nevada's population with access to optimally fluoridated community water supplies. In addition, the number of individuals reporting to emergency rooms for dental care can be evaluated. Are the community-based coalitions established and meeting regularly? Direct Health Services can be measured by the ratio of dentists to population and the number of dentists providing treatment to Medicaid and Nevada Check Up clients. The number of patients receiving services and the value of the services provided can be evaluated. The number of clinics in rural and urban areas, the capacity of these clinics, and clinic utilization can be measured. Client surveys regarding client care can be conducted. Finally, have regional plans been developed and implemented? One measurement of Enabling Services would be the number of clients and providers using interpretive services and the number of vouchers issued vs. the number of vouchers used. The number of Medicaid clients receiving EPSDT services would also be an effective measure as would the number of clients being served by mobile clinics, including the number of residents of long term / chronic care facilities receiving dental services.

Infrastructure Building	Population Based Services	Direct Health Services	Enabling Services
Completed action steps. Policies address gaps. Health status indicators -report card. Stakeholders' assessment.	Number of children with sealants. Percent with access to optimally fluoridated community water supplies. Number of individuals reporting to emergency rooms for dental care can be evaluated. Are the community-based coalitions established and meeting regularly?	Ratio of dentists to population. Number of dentists providing treatment to Medicaid and Nevada Check Up clients. Number of patients receiving services. Value of services provided. Number of clinics in rural and urban areas Capacity of clinics. Clinic utilization. Client surveys. Regional plans developed and implemented.	Number of clients and providers using interpretive services. Number of vouchers issued vs. vouchers used. Number of Medicaid clients receiving EPSDT services. Number of clients being served by mobile clinics. Number of residents of long term / chronic care facilities receiving dental services.

Where do we go from here?

Participants were then asked, "Where do we go from here?" Participants want to meet the staff of the Oral Health Program. They want continued communication, collaboration and coordination between stakeholders and the Oral Health Program. They want the Advisory Committee formalized and any necessary subcommittees established. Recommendations from the Strategic Meeting should be incorporated into an Action Plan that can be utilized by the Oral Health Program and other stakeholders. The report from the Strategic Meeting of Oral Health Stakeholders should be posted on the Nevada State Health Division web site. An e-mail list serve for oral health stakeholders in Nevada should be developed. Finally, stakeholders want to be informed of legislative timeframes and advised when to initiate necessary action.

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