A collage of a collage of a health plan

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**State Oral Health**

**Improvement Plans**

**ASTDD Toolkit**

**August 2024**

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# FOREWARD

***This is meant to be a living document with links to resources. It is an informal document that is written so many people can use it.***

It is not a stand-alone history, list of resources, a best practice approach report, issue brief, instruction sheet, or series of QR codes. It has been developed through 1) reviewing and summarizing the history that created and changed state oral health plans, 2) creating, reviewing or reading all U.S. state oral health plans, 3) fielding questions and gaining feedback from those who made the effort to create, implement and evaluate plans, and 4) soliciting input from professionals who have provided consultation and technical assistance around plans. The toolkit is a collection of ideas and examples that have been suggested or tried. It is meant to be a story that is read once through and then selected strategies are highlighted for further use as tools. Several links are included to documents, worksheets or pages rather than posting everything on an ASTDD webpage or recreating resources. The links will be checked, updated, and new ones added as plans or other resources appear. Resources without links to other sites are included on the [State Oral Health Improvement Planning webpage](http://astdd.org/state-oral-health-improvement-planning-and-needs-assessment). State staff are encouraged to ensure their state’s plan is current and available through the State pages on the ASTDD website. This document does not directly address U.S. territorial and freely associated states oral health plans as they function somewhat differently than state programs. We will be developing a separate document if funding is available that more adequately addresses their needs, but the same basic concepts can be used in developing their plans.

Although state oral health program staff are the primary audience, anyone involved in oral health plans is encouraged to use this document. Communication issues are important and are specifically addressed. States are also encouraged to support other health plans or those for local jurisdictions or specific populations to achieve oral health equity.

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# INTRODUCTION AND RATIONALE

## What Are State Oral Health Improvement Plans and Why Are They Important?

Several U.S. national initiatives and coordinated efforts since 2000 have recognized that state oral health plans and collaborative planning efforts are essential for improving the population’s oral health. Such plans can also serve as a focal point for cross-sector engagement and partnerships and as an overarching direction or roadmap, enabling an integrated approach to meeting oral health needs and positioning the state to document needs, better compete for scarce resources, and demonstrate the value of collaborative partnerships.

The [*National Oral Health Call to Action to Promote Oral Health*](https://www.ncbi.nlm.nih.gov/books/NBK47472/#:~:text=The%20National%20Call%20To%20Action%20To%20Promote%20Oral%20Health%2C%20referred,actions%20to%20achieve%20the%20goals.) emphasized the need for action plans with monitoring and evaluation components to improve oral health at the state level. The report also noted that oral health plans should be developed with the intent of incorporating them into existing general health plans. Recent events such as the opioid crisis and the coronavirus pandemic demonstrate how public health agencies, academic, and the public/private oral health workforce are impacted by changing science, policies, climate, funding priorities, and public perceptions. Without previous plan development and implementation, or a current plan to follow or adapt, leveraging coordinated support for policies and programs to improve oral health may be difficult.

Various definitions exist for what constitutes a state oral health plan or oral health improvement plan. Earlier references used the term “state oral health plan,” but people more recently have incorporated the word “improvement” to increase emphasis on the measurement, monitoring and final outcomes of a plan—improvements in oral health status, access to oral health care, quality of life, and health equity, including the resources needed to help make the improvements a reality for the state.

***A State Oral Health Improvement Plan (SOHIP) is a public health strategic plan developed to systematically define and reduce specific burdens of oral diseases and enhance the oral health of populations residing in the state by promoting oral health and preventing oral diseases through collaborative efforts. Ideally, the plan is based on oral health needs assessment and surveillance findings at the state and local levels, uses SMARTIE (Specific, Measurable, Achievable, Relevant, Time-framed, Inclusive, Equitable) Objectives and evidence-based interventions, and includes an evaluation and quality improvement component. A SOHIP should serve as an umbrella to local or district oral health improvement plans.***

A SOHIP is not to be confused with a State Oral Health Program Strategic Plan, which is a roadmap for the state oral health program but not for more comprehensive efforts of many organizations to address the oral health needs of the various populations in the state. State oral health programs are a unit of state government, usually in the public health agency. They partner with other state and community groups to perform the essential public health core functions of assessment, policy development and assurance. This includes reporting dental disease rates and improvements in the state’s population; developing and implementing policies and programs to prevent or minimize diseases; establishing and recognizing standards for defining access, quality, or health equity; and assuring that laws and regulations are in place to keep the public safe and healthy. State oral health programs can play an integral role, often the lead or coordinating role, in oral health needs assessment and SOHIP development, dissemination, implementation, and evaluation. They can serve as a state’s authoritative source of guidance and recommendations for dental public health issues. Therefore, they may need to develop a Program Strategic Plan before developing a SOHIP to organize their thoughts, resources, and strategies before recruiting partners to a larger process. A Strategic Plan is one way to involve health agency leadership and other programs early on to start the health integration process.

## Why Did ASTDD Develop This Toolkit?

Despite long-time acknowledgement of the importance of SOHIPs, there currently are no accepted comprehensive guidelines for developing, disseminating, implementing, evaluating, or updating comprehensive oral health needs assessments or SOHIPs. There has never been a Healthy People national oral health objective addressing state oral health improvement plans, although many states developed separate Healthy People plans that included oral health.

***This toolkit will provide information useful for planning, developing, disseminating, implementing, and evaluating SOHIPs.***

Assessment Model

ASTDD has gathered information on state oral health plans since the 1960s during annual meetings or via electronic methods as they became available via email or online platforms. Input from 43 states in a 1999 ASTDD survey identified ten essential elements that would build infrastructure and capacity to achieve HP 2010 Oral Health Objectives, outlined in the report, [*Building Infrastructure and Capacity in State and Territorial Oral Health Programs*.](https://www.astdd.org/docs/infrastructure.pdf) Among the top ten elements was development and maintenance of a state oral health plan. At that time, only 16 states had a state oral health plan. A 2012 ASTDD report, [*State Oral Health Infrastructure and Capacity: Reflecting on Progress and Charting the Future*](https://www.astdd.org/docs/infrastructure-enhancement-project-feb-2012.pdf)*,* revealed progress as 29 states had oral health plans, while 15 states had no identified plan, 7 had other types of plans, and 3 listed plans in process. However, few state oral health plans addressed the diverse oral health needs of their populations nor did they evaluate how successful they had been at accomplishing the objectives in their plan. Starting in 2016 (2014-15 data), ASTDD added a question to the *State Synopses of Dental Public Health Programs* asking whether states had a comprehensive state oral health plan and what years were covered. The 2024 *State Synopses*, reporting FY2022-23 data, noted 39 states with plans, 10 without plans and 2 states didn’t respond.

A 2021 analysis of SOHIP revealed several similarities and differences.

* SOHIP similarities:
  + *target populations* included the most vulnerable and at-risk groups
  + *intervention levels* and *settings* were focused at the local community or state policy level, often among schools, community centers, or Federally Qualified Health Centers.
* SOHIP differences:
  + *funding source:* federal, state, local, private, or public
  + *plan duration period*: ranging from 1 to 10 years
  + *extent of* *stakeholder engagement*: number and types of partners, roles and responsibilities, involvement at different implementation stages
  + *availability and use of epidemiological data* to inform overall plans and guide its sections
  + *presence or absence of outcome measures*, including if they were linked to specific strategies or activities.

Operational definitions and description of processes were inconsistent. Plans also varied among activities and implementation, and whether they were scalable, sustainable, or impactful. Disconnects between goals or objectives and strategies or activities made tracking accomplishments and determining effectiveness or success difficult. Several factors may contribute to the variability of SOHIP content and rigor including state and local oral health program capacity, authority, resources, and partnerships as well as state laws, funding for oral health programs, and the structure and function of state government agencies.

***This toolkit will address ways to define and manage many of these issues and suggest ways to make SOHIPs more comparable for tracking national progress.***

# OVERVIEW OF IMPORTANT ELEMENTS OF STATE PLANS

## What are Important Elements of a State Oral Health Improvement Plan?

Over the years, several resources have identified important elements. The ASTDD *State Oral Health Plans and Collaborative Planning Best Practice Approach Report* written in 2008 (now archived) noted that the development of a State Oral Health Plan should include several elements. We have since updated these and used more contemporary language to contribute to the successful implementation of intervention programs and achieving goals:

1. Provide a vision for the future to enhance oral health;
2. Identify and enlist people and organizations that will collaborate and contribute to the plan’s implementation;
3. Acknowledge different roles of people and organizations;
4. Identify key issues within priority population groups and for oral health across the lifespan;
5. Identify existing oral health and general health plans and build upon these existing plans;
6. Assess and recognize existing and potential resources and develop strategies to leverage resources and obtain commitment of resources;
7. Establish long-term and short-term goals and measurable SMARTIE objectives based on needs assessment studies or surveillance data and priorities determined through consensus;
8. Review current evidence-based strategies and best practice information that can be replicated or adapted;
9. Select/develop implementation strategies that integrate interventions, maximize oral health in general health programs, establish strong collaborations and partnerships, and incorporate aspects for success such as building social value for oral health and ensuring cultural sensitivity and health equity in the delivery of services;
10. Establish evaluation for monitoring of measurable outcomes and impacts of plan implementation;
11. Create flexibility so the plan can be integrated and/or coordinated with other existing state and local health plans and policies;
12. Link the plan to national goals and objectives such as Healthy People;
13. Coordinate and identify additional resources needed to achieve objectives;
14. Establish accountability through monitoring, periodic assessment of progress, appropriate evaluation of outcomes achieved, and regular reporting to partners;
15. Assign responsibilities for implementation, monitoring and reporting;
16. Create a communication plan that covers key audiences, messages, dissemination and monitoring methods, and evaluation and improvement strategies;
17. Disseminate the plan widely and in formats to reach several audiences;
18. Periodically update the plan as new information becomes available and continuous feedback requires alignment of the plan to current environmental and emerging issues.

Other important elements include:

* A logic model
* A strong infrastructure or “backbone”
* Accessibility to current resources
* Current and relevant
* Definitions for measures
* Identified knowledge gaps in resources and recommendations for eliminating those gaps
* [Healthy People 2030: Oral Health Conditions](https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions)
* Identified priority populations and disparities in oral disease
* Identified partners with the ability to leverage resources
* A communication plan to address existing and new messages, populations, and pathways
* New evidence-based preventive dental services
* Wide dissemination using the communication plan
* Programs that address an array of oral health risk factors, diseases and conditions
* Integration of oral health into general health
* Oral health workforce issues
* Efforts to address infection control and safety in dental settings
* Evaluation activities at the beginning of the planning process, with recommendations for types of evaluation, and plans for monitoring outcomes related to plan implementation
* Identified best practices for replication of program implementation
* Products to be developed for disseminating and monitoring the plan
* Updated at least every five years
* A “maintenance plan” for the life of the plan that identifies who will update the plan and how often it will be updated.

## Where Can We View and Compare State Oral Health Improvement Plans?

Currently the most reliable place to view SOHIPs are the [*State Program Pages*](https://www.astdd.org/state-programs/) on the ASTDD website. They represent the latest versions of SOHIPs submitted by states; not all states have SOHIP and some may be outdated. Click on each state to view their SOHIP if one is posted.

Another continuously updated resource on the ASTDD website is the [State Oral Health Plan Comparison Tool](https://www.astdd.org/docs/state-oral-health-plan-comparison-tool-2023.xlsx). The [ASTDD State Oral Health Plan Comparison Tool Description](https://www.astdd.org/docs/state-oral-health-improvement-plan-tool-description.pdf) lists states with up-to-date plans that are on the tool, states with out-of-date plans that are on the tool, and states that do not have a state oral health improvement plan.

As requested by states over the years, history of plan comparison is important. Originally developed in 2006, the Children’s Dental Health Project (CDHP) developed a Comparison Tool to capture and provide an overview of state oral health plans, with a goal of facilitating comparisons across states and providing examples for developing or updating their own state plans; it was updated in 2010 and 2015. The Comparison Tool contained 22 content areas for specific topics, one miscellaneous category, and one for Healthy People Objectives. In 2018 CDHP transferred the Comparison Tool files to ASTDD to provide future updates. In 2021 it was reconfigured to match the 2021 [*Ten Essential Services to Promote Oral Health in the US*](https://www.astdd.org/docs/10-essential-public-health-services-and-10-esphs-to-promote-oral-health.pdf)and the three public health core functions based on revisions to the Public Health Accreditation Board (PHAB) [national framework](https://phnci.org/uploads/resource-files/EPHS-English.pdf) and used in the [2021 *ASTDD Guidelines for State and Territorial Oral Health Programs*](https://www.astdd.org/state-guidelines/)*.* Strategies were labeled with a key term and given an operational definition. Strategies, including emerging topics, were subsequently assigned into a conceptual framework with their most relevant category of core public health function and essential public health service to promote oral health.

***The Comparison Tool allows for cross-state comparisons and features descriptive information detailing the extent of each state’s oral health activities and relationship to one another. New and updated state plans will be added as they are completed and received.***

While allowing for unique differences among states, this type of structured framework and uniform wording and strategy indicators can be used for developing state oral health improvement plans, evaluating plan quality, comparing plans, sharing best practices, and tracking trends over time. A set of strategy indicators and operational definitions also provides clarity to better align goals and objectives with strategies and activities, prioritize activities, and reduce programmatic redundancy or inefficiency. Evaluation of the objectives, strategies, and activities is critical to inform a continuous quality improvement process. Robust and comprehensive measures can aid in routine data collection and contribute to better transparency, accountability, and evidence-informed programming.

Every State name is listed on the top bar and also on the tab at the bottom. You can find your state by clicking on either area. The Strategies are on the left side of the tool. The National Summary tab gives the compilation of all the states. The number identified across from the strategies shows whether a state has that indicator.

# CONCEPTUAL MODELS AND NATIONAL FRAMEWORKS AND INITIATIVES

## Are There National Conceptual Frameworks or Logic Models We Can Use?

Many states use several strategic frameworks but one useful conceptual model we have found, originally created by CDC, is now on the ASTDD website: [Conceptual Model of Comprehensive State Oral Health Plan Process](https://www.astdd.org/docs/conceptual-model-of-comprehensive-oral-health-state-plan-process.pdf).

Some state examples include [Pennsylvania’s Plan Logic Model (pg. 14)](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf), while [New Jersey (pg. 40)](https://www.astdd.org/www/docs/new-jersey-oral-health-plan-2023-2028.pdf) and [California (pg. 16)](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf) use CDC’s.

## Should We Consider Public Health Accreditation Criteria?

State Health Assessments (SHAs) and State Health Improvement Plans (SHIPs), along with the state health department’s organizational strategic plan, are prerequisites for state health departments that pursue national PHAB accreditation.

A discussion of these criteria are highlighted in the Association of State Health Officials (ASTHO) publication, [Developing a State Health Improvement Plan: Guidance and Resources](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf). Make sure you have reviewed your state health plan and know the accreditation status of your health department. A 2022 document, [Foundational Public Health Services (FPHS)](https://phaboard.org/center-for-innovation/public-health-frameworks/the-foundational-public-health-services/#:~:text=The%20Foundational%20Public%20Health%20Services%20(FPHS)%20define%20a%20minimum%20package,modernization%20of%20governmental%20public%20health.) published by the PHAB and partners, defines a minimum package of public health capabilities and programs no jurisdiction should be without. Several states are already using this framework to modernize their public health systems.

***To assure that State Oral Health Programs are perceived as integral to the State Health Department’s mission, we would recommend aligning with PHAB criteria and your state’s SHA and SHIP.***

## What Other National Initiatives or Frameworks Might We Consider?

[**Healthy People 2030**](https://health.gov/healthypeople) reflects health promotion and disease prevention priorities at the national level, emphasizing advancing health equity, increasing health literacy, and addressing social determinants of health in communities. Healthy People 2030 includes 359 core — or measurable — objectives as well as developmental and research objectives. Review the 11 Oral Health Objectives and the developmental objectives as well as others in the Health Conditions category, Health Behaviors category, Populations category, Settings and Systems category, or the Social Determinants of Health category that might be relevant. Also note the [Oral Health Leading Health Indicator](https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care/increase-use-oral-health-care-system-oh-08). Many states have created comparable Healthy People 2030 state plans. Find out if your state has such a plan or is working to develop one.

[**Health in All Policies**](https://pubmed.ncbi.nlm.nih.gov/25217354/)is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity. As a concept, it reflects the principles of legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government. In the summer or fall of 2024 NACCHO and ASTHO will launch their *Health in All Policies Toolkit*, so check back on their website or in the ASTDD Weekly Digest or *Roundup* newsletter for the framework and state and local examples.

[**HRSA Maternal and Child Health National Performance Measures**](https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures). Fifteen National Performance Measures (NPMs) across five population health domains were established for the Title V Maternal and Child Health (MCH) Services Block Grant program. Based on its identified priority needs, states select a minimum of five NPMs for programmatic focus. For each of these selected NPMs, states develop at least one related Evidence-based or –informed Strategy Measures (ESMs) to assess and demonstrate the impact of its State Title V strategies on the NPM. The oral heath NPM previously was NPM 13:

* 13.1. Percent of women who had a preventive dental visit during pregnancy.
* 13.2. Percent of children and adolescents, ages 1 through 17, who had a preventive dental visit in the past year.

In 2024, the MCH Bureau restructured the NPMs to eliminate the numbering system and 28 states and jurisdictions selected one or both parts of the NPM for oral health. Check the National Maternal and Child Oral Health Resource Center [(OHRC) webpage](https://www.mchoralhealth.org/titlevbg/index.php) or your state’s website to determine if your state has adopted one or both as state objectives. [Alabama’s plan](https://www.alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf) mentioned the NPM on pgs. 36-37 and 43.

[**Frieden’s Health Impact Pyramid**](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/) includes five tiers that describe the impact of different types of public health interventions and provide a framework to improve health. Interventions with the greatest potential impact are at the base of this pyramid. In ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, ongoing direct clinical care, and health education and counseling. Interventions on lower levels tend to be more effective because they reach broader segments of the population and require less individual effort. Implementing interventions at each level can achieve the maximum possible sustained public health benefit. [California used this pyramid with oral health examples](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf) (pg. 10).

[**Collective Impact**](https://collectiveimpactforum.org/what-is-collective-impact/) is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. It involves five conditions: 1) Start with a common agenda, 2) Establish shared measurements, 3) Foster mutually reinforcing activities, 4) Encourage continuous communications, 5) Have a backbone team. This model has been used extensively in public health arenas. [Colorado’s plan](https://coloradooralhealth.org/wp-content/uploads/2023/06/A-Framework-to-Advance-Oral-Health-Equity-in-Colorado-2023.pdf) is an excellent example.

# STATE RELATED CONSIDERATIONS FOR ALIGNMENT

## How Should Our SOHIP Intersect or Align with Other State Plans?

In addition to Healthy People plans, states may have several other types of plans focusing on chronic diseases, maternal and child health, wellness, health literacy, mental health, behavioral health, health equity, health financing, access to health services, and other timely crosscutting topics. Check to see if any include oral health objectives. As mentioned previously, ASTHO encourages all states to develop state health improvement plans; they have developed several resources such as [ASTHO Profile of State and Territorial Public Health dashboard,](https://astho.shinyapps.io/profile/) [State Health Assessment Guidance and Resources](https://www.astho.org/globalassets/pdf/state-health-assessment-guidance.pdf) and [Developing a State Health Improvement Plan: Guidance and Resources](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf) that are easily adaptable to develop SOHIPs. Examples from these are used throughout this document. [Vermont](https://www.astdd.org/docs/vermont-2022-oral-health-plan.pdf)’s SOHIP is modeled after several other state plans especially their [State Health Improvement Plan](https://www.healthvermont.gov/file/66226), which also includes an oral health focus area. [California](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf) modeled their SOHIP after the [state’s Wellness Plan](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/CaliforniaWellnessPlanImplementation.aspx). [Ohio](https://www.oralhealthohio.org/_files/ugd/a395ee_487c5836e9574df39de98c865508a04a.pdf) uses several state planning documents that outline priorities and action steps to improve healthy food access, poverty, and transportation in the state as oral health relates to all of them, and oral health professionals are generally unaware of these resources.

## What Laws, Regulations, and Policies Might Impact Our Plan?

Each state has enacted different health and oral health laws and policies that will influence the ability to create improvements or change systems. These might include state dental and medical practice acts, policies and benefits related to Medicaid or Medicare, public health department internal policies regarding hiring and contracting, policies for health professions education, taxes and policies on sales of tobacco or oral nicotine products and sugar sweetened beverages, licensing and implementation of mobile clinics and teledentistry, opioid prescribing reporting by dentists, application of preventive measures such as fluoride varnish by medical personnel, and reimbursement rates by insurance companies for dental services.

***Conducting an inventory of relevant laws, regulations and policies in the early stages of plan development will inform which partners to involve, what strategies will likely be successful and which ones won’t, and what timelines are realistic.***

## What are Some Emerging Topics that May Be More Prominent in Newer SOHIPs?

To make a SOHIP a living document, states should review other state plans and health issues to determine if there is a link with oral health and if there are evidence-based approaches and research to support addition in a SOHIP. As states vary in their focus and coverage, these topics may not apply to everyone.

* Teledentistry
* Dental Therapy, Public Health Dental Hygienists or Other Oral Health Workforce Models
* Medical/Dental Integration
* Minimally Invasive Care
* Opioids
* Medicaid Waivers
* State Mandatory Screenings
* Perinatal Medicaid Benefits
* Medicare Adult Dental Benefits
* Medicaid and Medicare Duel Eligible Integration
* Student Loan Repayment
* Human Papilloma Virus (HPV) and other vaccines
* Sugar & Tobacco/Vaping Taxes
* Vaping or Cannabis Use
* Antimicrobial Resistance
* Social determinants of health and oral health
* Health Equity

# IDENTIFYING PARTNERS, STRUCTURES, EXPERTISE, AND RESOURCES

## What/Who Is the Moving Force Behind Creating a SOHIP?

Is there a legislative mandate for a comprehensive plan to document oral health needs and plans to improve oral health? Is an oral health coalition wanting to address oral health disparities? Has the state oral health program decided to take the lead to facilitate partnership building to promote oral health equity? Most current SOHIPs were initiated by the state oral health program or an oral health coalition or advisory group, which assures there is a “backbone” group with some existing resources and the mission to improve oral health of the state’s populations by soliciting additional partners and resources. View [Ohio’s](https://www.oralhealthohio.org/_files/ugd/a395ee_26b2c6d818434a2e977d4af6d69c5fc2.pdf) process in one of their documents.

***Whatever the reason, some group will need to take a lead role to establish a structure and invite partners to join the effort.***

Partnerships can help to:

* Identify, secure, and share resources
* Identify, gather, and share data and information
* Identify and engage diverse populations including hard to reach or overlooked groups and perspectives
* Reduce the burden on individuals or groups
* Collaborate for systems or policy changes
* Increase effectiveness, timeliness, and efficiency of efforts.

Sustaining partnerships requires:

* A shared vision
* Perceptions of mutual benefits to the individuals and groups for participation
* Regular bi-directional communication and transparency
* Recognition and appreciation
* Frequent feedback and evaluation of functions and progress.

A comprehensive discussion of partnerships with best practice criteria, toolkits and guides, and specific examples is provided in ASTDD’s [Best Practice Approach Report: State and Territorial Oral Health Programs and Collaborative Partnerships](https://www.astdd.org/bestpractices/stohp-partnerships.pdf) with the associated descriptive reports. These cover several types of partnerships other than for SOHIPs.

This [Worksheet for Identifying Assets](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf) from [Developing a State Health Improvement Plan: Guidance and Resources](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf) (pg. 95) may be helpful to determine existing assets and potential new groups to pursue. Many of the SOHIP list their partners, so viewing some of these lists in the plans on the ASTDD State Program pages will be useful in making your own list. View the ASTHO [Stakeholder Wheel](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf) (Figure 1.4, pg. 18) that lists some potential partners. Each state has some “usual suspects” that work together on oral health issues, but there also are many that may be unique advocacy groups or businesses. Identify and engage people to assure the SOHIP addresses social, economic, and environmental determinants of health. [New Jersey’s](https://www.astdd.org/www/docs/new-jersey-oral-health-plan-2023-2028.pdf) plan (pgs. 10-13) lists contributors such as stakeholder organizations, executive planning and coordinating team, and committee and advisory work group members.

## What Structures Have Been Used for Partnerships to Create and Implement SOHIPs?

After the backbone organization/group has been formed, many states formed a steering committee with representatives from several sectors. This steering committee was then supported by work groups or other committees, each focused on different sets of strategies and indicators. Individuals with additional expertise were brought in for specific purposes. For a detailed look at one state’s process, view [California Partnership for Oral Health Plan](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/California_Partnership_for_Oral_Health_Plan_ADA_FINAL_6.15.2021.pdf) and also the [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf) plan.

With a diverse group of partners, it is critical to have a shared sense of purpose that can be referenced throughout the process. The first step is to develop clear and concise mission, vision, and values statements. This is an opportunity to collectively define the charge to the project team, committees, and work groups and will also be useful for outreach and engagement of new partners throughout the process. Another step is to establish regular methods, protocols, timelines for electronic and face-to-face communication and then to schedule them, oversee logistics, facilitate discussion, and create minutes and next steps for calls and meetings. [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf) includes a good overview of the development, discovery, and implementation process as does [North Carolina](https://www.astdd.org/docs/2020-2025-north-carolina-oral-health-plan.pdf) and [Pennsylvania](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf).

## What are Some Partner Roles and Skills/Expertise that Might Be Needed?

How the process is accomplished will depend on existing human resources, infrastructure, funding, policies, communication networks and support as well as additional resources that can be created. [Figure 1.4](https://www.astho.org/globalassets/pdf/state-health-assessment-guidance.pdf) (pg. 19) in one of the previously mentioned ASTHO documents outlines some roles and skills that might be needed and provides a grid to assess if people in your partnerships already exist with those skills or if you will need to identify new resources. You will need to develop a companion worksheet that allows you to identify existing assets.

***Developing a SOHIP is a complex process and requires expertise in several areas.***

## How Long Does the SOHIP Process Usually Take from Planning to Launch of the Plan?

Plans usually take one to two years, depending on several factors. These factors include:

* Existing partnerships and infrastructures
* Ability to engage new partners
* Existing expertise and resources
* Ability to acquire new expertise and resources
* Length of time and levels of bureaucracy for review and approval of drafts
* Agreement on priorities and strategies
* Efficiency of communication pathways
* Competing priorities for time and resources
* Unintended interruptions such as pandemics or other emergencies
* Changes in administrations or legislatures.

Creating anticipated timelines for each stage of the SOHIP process is helpful, along with backup plans for interruptions. See example in the [New Jersey plan](https://www.astdd.org/www/docs/new-jersey-oral-health-plan-2023-2028.pdf) (pg. 23).

## What Funding Mechanisms Have Been Used?

Many state oral health programs partner with state oral health coalitions. ASTDD can provide technical assistance, training, and this toolkit to all states but not funding. Oral health related activities are funded very differently across states, so each state will need to assess its assets in terms of public funds, private funds, and in-kind contributions. Administrators of the plan should carefully detail all anticipated expenses and income at the beginning to avoid any unnecessary delays or shortfalls. Partnerships are crucial for identifying commitments for multiple sources of monetary funding or other resources. In some cases, grant proposals to foundations or organizations may be needed. Coordinating all the resources may be challenging if funds need to be spent within a certain timeframe, especially if interruptions occur. If new contracts are needed, that process can be time-consuming and unpredictable, particularly if they need to go through state agencies such as health departments. Tap into local businesses and hospitals that have an interest or mandate for improving health care for diverse communities. [Tennessee](https://www.astdd.org/state-programs/Tennessee/) includes information about their funding and partners.

***Currently there are no federal or national sources of funding for SOHIPs in all states.***

In-kind contributions from partners such as meeting space, percentage of staff time, mailings or listserv postings, social media, meeting facilitators and recorders, graphic arts expertise, printing/copying, IT support, and other tasks are essential. Few states have acknowledged funding sources in their reports, but doing so would assist other states to brainstorm ideas. In a recent query of states, many used CDC or HRSA funding for some of their coordination activities, while others used a combination of CareQuest, private and state funding from different sources or programs, especially for meeting facilitation, health policy decisions, graphics, and printing. Try to identify special interest groups based on the priority interests and what resources they may have. If a state oral health program receives funding from multiple sources, then this may be easier. [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf) is a good example. Some state programs used their own Canva account for design and production. Evaluation of the plan was often done by volunteers, including graduate students from universities.

***Public acknowledgment of appreciation for these contributions is also crucial for successful partnerships.***

# NEEDS ASSESSMENTS

## Do We Have Any Recent Needs Assessments to Use?

***Needs assessments are ideally repeated/updated at least every five years.***

Several sources of information, both primary and secondary data, can be used to inform a SOHIP:

* Data included in a previous SOHIP
* National data for comparison purposes or to create goals, e.g., see [National Oral Health Data Portal](https://www.nationaloralhealthdataportal.net/)
* Regional data if geographic, economic, health access or other factors from neighboring states make this relevant
* State economic and health related data, especially by subgroups that would identify health inequities
* State oral health services data based on insurance information, health center or tribal clinic reporting or other tracking mechanisms or reports
* State oral health status data from Basic Screening Surveys, dental records, or other examinations
* County, city or community health and oral health data.

If current data are not available, decisions should be made about how representative the existing data are for planning purposes. One way to determine existing data and data gaps is through an environmental scan, a process that systematically surveys and interprets relevant data to identify external opportunities and threats that could influence future decisions. It is closely related to a [S.W.O.T. analysis](https://www.shrm.org/ResourcesAndTools/tools-and-samples/hr-qa/Pages/what-is-a-swot-analysis.aspx). When conducting an environmental scan, several methods should be used to collect data, including reviewing publications, conducting focus groups, interviewing leaders, and administering surveys. The MCH OHRC has used environmental scans for specific topics in several MCH related oral health projects in states. One [environmental scan tool](https://www.mchoralhealth.org/PDFs/NOHI-environmental-scan-tool.pdf) and the [resulting report](https://www.mchoralhealth.org/PDFs/NOHI-environmental-scan-chartbook-2023.pdf) may be helpful in creating your own environmental scan. ASTHO also performed environmental scans of states and territories in 2022 and displayed the resulting priorities in an [executive summary.](https://www.astho.org/globalassets/pdf/environmental-scan-executive-summary.pdf) [Ohio](https://www.oralhealthohio.org/sohp) has a separate section that outlines its strengths and challenges.

Another method that has been used by ASTDD and by states is the *Policy Consensus Tool* originally developed by the Children’s Dental Health project but transferred to ASTDD. ASTDD provides a facilitator for this tool that gathers partners while the state oral health program or the oral health coalition help plan and manage the process. No federal funding is currently available to ASTDD so states will need to request and pay for technical assistance to have an ASTDD partner. You can ask for technical assistance via the TA [Policy Consensus Tool TA Request Form](https://www.astdd.org/docs/policy-consensus-tool-ta-request-form.docx).

The ASTDD Basic Screening Survey (BSS) has been used for more than two decades to provide statewide information about oral health status primarily in Head Start/preschool, kindergarten, third grade and older adult populations. ASTDD tracks a [compilation of BSS surveys in each state](https://www.astdd.org/docs/states-with-bss-oral-health-data.pdf) by population group and years conducted. County data may only be available in some states via those state dashboards or reports. [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf) has included its oral health status and accomplishments in many areas while [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf) provides an historical overview of the state and the nation from 2000 to 2020.

Selected information about each state government oral health program is collected every year via the *ASTDD Synopses of State Dental Public Health Programs* for the previous calendar year. The reports with specific state data are available in the Members Only section of the ASTDD website or via special requests to [cwood@astdd.org](mailto:cwood@astdd.org). The [aggregated Synopses Summary report](https://www.astdd.org/docs/2023-synopses-summary-report.pdf) with no identifying state information and only selected questions is available on the ASTDD homepage.

## What is the Seven-Step Needs Assessment Model?

States are encouraged to conduct systematic oral health needs assessments to measure, identify, and prioritize the oral health care needs of the populations they serve. The [*ASTDD Seven Step Model*](https://www.astdd.org/docs/assessing-oral-health-needs-7-step-model-manual.docx) on the ASTDD website provides in-depth guidance for completing an oral health needs assessment. The Model covers all key steps starting with convening an advisory committee and identifying shared goals for conducting the needs assessment, to navigating identification of available data, necessary primary data collection, analyzing data, to synthesizing information and systematically prioritizing oral health needs. Ultimately, you are encouraged to use the Model as a guidance document, and make final determinations based on your state’s needs, budget, timelines, and other factors. Any needs assessments should consider systems approaches and frameworks as well as social determinants of health and an equity focus.

Several resources are available through ASTDD’s Seven-Step Model. The Needs Assessment Goals Table in the narrative will help you decide what you hope to accomplish with your needs assessment. [*The Oral Health Needs Assess­ment Planning Workbook*](https://www.astdd.org/docs/7-step-model-planning-workbook.xlsx) lists 35 data items drawn from a variety of sources including Healthy People 2030, the National Oral Health Surveillance System included in the National Oral Health Data Portal, and various standards put forth for oral health programs such as the[*MCH Title V National Performance Measures*](https://mchb.tvisdata.hrsa.gov/Home/FADDocuments). Indicators have further been prioritized based on their availability at the state level. Additional items are program related, while still others represent general types of information useful in needs assessment (e.g., public perceptions). Recogniz­ing that each state and local program has individual information needs, the model allows optional information elements to be added to the core set according to given needs. The Summary of Needs Assessment Methods table offers a comparison of various methods to help you select methods for the needs assessment and plan the work. Several other assessment mechanisms are available through the Model on the ASTDD website.

# ESTABLISHING PRIORITIES & IDENTIFYING ISSUES THROUGH PRIORITY SETTING

## What Process is Used for Developing Priorities?

Although states strive to achieve all roles and activities outlined in the *ASTDD Guidelines*, that is not often possible, and a staged prioritization process is needed. ASTDD has adapted ASTHO’s seven basic steps for this process that:

* Identify cross-cutting health, oral health, and strategic issues from the needs assessment
* Design a process that will work for everyone
* Determine facilitation needs and secure a facilitator who understands the players, the issues and the process
* Determine the vision and values for the process and how they inform the prioritization criteria and process
* Identify the criteria
* Conduct the process using the criteria
* Show flexibility in your final process to make sure vision and values are reflected, that all difficult decisions were made, that all stakeholders were involved, and that system issues were considered.

ASTHO used examples taken from Los Angeles County and New Hampshire in [Figure 4.1 as well as a generic worksheet in 4.2](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf) (pgs. 42-43) to show the following examples of criteria and considerations for a public health issue prioritization process that you can easily use:

* Magnitude of Public Health Issue
* Disproportionate Effects
* Importance of Public Health Issue
* Effectiveness of Potential Interventions
* Feasibility.

These considerations relate to size of the problem; seriousness of not addressing; feasibility of cost, time and resources; disparities; available expertise; importance to the community; comments, questions or additional thoughts. [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf) includes a Feasibility table in the Appendices. You will need to discover if you can realistically cover all age groups or other populations of focus. Are individuals with developmental disabilities a priority? People in rural areas? U.S. Veterans? [North Dakota](https://www.astdd.org/www/docs/north-dakota-state-oral-health-plan-2022.pdf) highlights their special population groups. Specific oral health issues can easily be woven into the public health issues. These can then be placed in a table for high and low priority, high and low need, and high and low feasibility. See the [Strategy Grid on pg. 47 and Figure 4.6](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf).

***Prioritization criteria and tools can help the SOHIP process be transparent and engaging for all partners.***

## How Should We Develop Objectives, Strategies and Measures?

***States need to decide how many objectives and strategies to realistically have and what measures are already available or need to be collected.***

ASTHO advises that discussion and decisions are needed on some important exploratory questions prior to developing objectives.

* What efforts are already in place to address each priority?
* What do we hope to accomplish in five years for each priority?
* How will we know if we are successful?
* How is this priority aligned with other state and national priorities?
* What opportunities exist that can be leveraged to address this priority?
* What barriers or potential threats may impact our ability to positively implement this priority?
* How can partners contribute to achieving the long-term goal(s)?
* Who should be engaged to address each priority issue?

ASTHO’s *Developing a State Health Improvement Plan* document contains a valuable section that reviews Goals, Objectives, Strategies and Measures starting on [pg. 62](https://www.astho.org/globalassets/pdf/accreditation/developing-a-state-health-improvement-plan-guidance-and-resources.pdf). The chapter also refers back to Frieden’s Model as well as logic models.

[Pennsylvania i](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf)ncludes a good visual of their prioroties and outcomes and the people involved but does not include quantifiable information. [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf) includes tables listing objectives and strategies followed by indicator tables that list objectives, indicators, data source, year, frequency and baseline data. [New Jersey](https://www.astdd.org/www/docs/new-jersey-oral-health-plan-2023-2028.pdf) includes a section on priority areas, goals, objectives, strategies, success measures, and key partners.

# COMMUNICATING THE PLAN

## What Are Some Key Processes and Resources?

***Communication is important throughout the planning process, especially when disseminating the final information.***

When developing the core of the plan, remember to use plain language rather than technical terms as much as possible as the document will have wide distribution among many people. A few links to plain language include: [plainlanguage.gov](https://www.plainlanguage.gov/), and [CDC Plain Language Materials and Resources](https://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html).

States should decide who should approve the final plan(s) and set the timelines as approval processes may be complicated and lengthy. Establishing a good relationship with the health agency’s Communication Office early on will be useful for the entire SOHIP process. The Office can identify timelines, suggest dissemination pathways and protocols, and help identify key messages for the leadership. The Office can review or respond to questions and answers from reporters or other interviewers. The Communication Officer can share your information with The [National Public Health Information Coalition (NPHIC)](https://nphic.org/) in their weekly newsletter. ASTDD has assembled a [Communication Plan Template](https://www.astdd.org/docs/communication-plan-template-for-a-goal-specific-project-or-document-and-year-at-a-glance-template-april-2018.docx) to assist in developing communication plan strategies, timelines, and evaluation methods for a project or a document. Some states have developed their own communication strategies and format for the SOHIP.

## What Formats are Useful?

### One document or a main document with a separate executive summary

***States need to decide how and when to target each audience, including policymakers and potential funders.***

Key questions to ask include:

* Will there be one SOHIP document with several stand alone documents such as infographics highlighting important priorities or geared to a particular group such as dental professionals, policymakers, or translated for those who speak another language?
* Will there be a separate executive summary in addition to the one in the main document?

Executive summaries are short, usually no more than one page and briefly cover:

* The history of the plan including the process used to develop it
* Key goals or focus areas
* Recent advances or challenges to oral health in the state that the plan builds on or addresses.

The executive summary may include plans for implementation. [Ohio](https://www.oralhealthohio.org/sohp) has divided their oral health plan into online sections rather than displaying the entire document.

### Introduction, Acknowledgments or Endorsements

Who will write the introductory message? Usually the introduction is written by the agency health director, oral health coalition director, or state dental director, often as a letter or message such as [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf). This supports the state oral health program and plan as well as the importance of oral health as part of overall health, acknowledges how SOHIP fits with other statewide plans, and invites participation from the public and contributors in implementing the plan. In some cases, plans are required every few years by the governor or legislature. Ideally, the introduction should be limited to one page.

A Table of Contents and sometimes a Glossary of key terms or acronyms are included after the introduction.

Acknowledgements can be at the beginning or end of the document, included in a general message or as a very detailed list of organizations and/or individuals by steering committee, advisory committee, workgroups, reviewers, etc. Sometimes the plan is dedicated to an individual who recently died but made significant contributions throughout their career such as [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf) honoring a previous dental director and ASTDD president, Dr. Greg McClure, DMD, MPH or [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf) honoring Dr. Amos Deinard, Jr MD, MPH for his lifetime commitment to oral health.

### Background and Resources

Various formats and content might include oral health data, historical information, accomplishments since the last plan, continuing challenges, the process used to develop the plan, and the purpose of the plan. Some states list their references and additional resources and appendices such as posters or survey results at the end of the document. Good examples of these elements are [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf), [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf), [Pennsylvania](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf), [North Carolina](https://www.astdd.org/docs/iom-transforming-oral-health-care-in-north-carolina.pdf), [Tennessee](https://www.astdd.org/state-programs/Tennessee/), [California,](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf) [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf), [Ohio](https://www.astdd.org/state-programs/North%20Dakota/).

### Foundational Elements or Guiding Principles, Strategic Framework or Public Health Concepts, and Basic Plan Framework

This may include overarching and crosscutting values and statements that guided the goals and priorities; the mission and vision statements; a conceptual model or logic model; overviews of needs assessments, goals, objectives, strategies, and measures with or without data sources or timeframes or rationales, built on themes or age groups or focus areas. Some examples include [California](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf), [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf).

### Disseminating, Implementing, Monitoring and Evaluating the Plan

Generally plans contain a mixture of narrative and graphics, audiences and vehicles for dissemination, workplans with steps and timelines to begin strategies, responsibilities for tracking and monitoring progress, reporting progress and determining any changes needed, celebrating achievements. View [Maryland,](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf) [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf), [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf), [Ohio](https://www.oralhealthohio.org/sohp).

## What Visual and Other Elements Did States Use?

This is a brief listing of some of them with examples:

***States used several visual and other elements to showcase their concepts.***

* Icons for partners: [Pennsylvania](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf)
* How strategic areas and oral health issues are interconnected: [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf), [Ohio](https://www.oralhealthohio.org/sohp)
* Scientific posters: [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf)
* Evaluation of previous oral health plans: [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf), [Idaho](https://www.idahooralhealth.org/wp-content/uploads/2022/03/2021-2026_improvement_plan.2022.pdf)
* Table of Focus Areas matched to Vision and Strategy for the plan: [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf)
* Summary of objectives, strategies, baseline and target data, data sources: [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf), [California](https://www.astdd.org/docs/california-oral-health-plan-2018.pdf)
* Summary of data sources: purpose, population, methods, and frequency: [Alabama,](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf) [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf)
* Call out boxes for key messages or perspectives: [Idaho](https://www.idahooralhealth.org/wp-content/uploads/2022/03/2021-2026_improvement_plan.2022.pdf), [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf), [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf), [Alabama,](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf) [Ohio](https://www.oralhealthohio.org/sohp)
* Infographics: [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf), [Tennessee,](https://www.astdd.org/state-programs/Tennessee/) [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf), [North Carolina](https://www.astdd.org/docs/iom-transforming-oral-health-care-in-north-carolina.pdf), [Kansas,](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf) [North D](https://www.astdd.org/www/docs/north-dakota-state-oral-health-plan-2022.pdf)akota
* Data graphs and tables: [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf), [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf), [Tennessee](https://www.astdd.org/state-programs/Tennessee/), [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf), [Pennsylvania](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf)
* Maps: [Illinois](https://www.astdd.org/docs/illinois-oral-health-plan-5.pdf), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf), [North Carolina](https://www.astdd.org/docs/iom-transforming-oral-health-care-in-north-carolina.pdf), [Tennessee](https://www.astdd.org/state-programs/Tennessee/), [Kansas](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf)
* Graphic of oral health and overall wellness: [Tennessee](https://www.astdd.org/state-programs/Tennessee/), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf)
* Photos and use of colors: [Michigan](https://www.astdd.org/www/docs/michigan-2025-state-oral-health-plan.pdf), [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf), [Minnesota](https://www.health.state.mn.us/people/oralhealth/docs/stateplan2020.pdf), [Alabama](http://alabamapublichealth.gov/oralhealthcoalition/assets/alsohp.pdf), [Kansas,](https://www.astdd.org/www/docs/kansas-state-oral-health-plan-2022-2027.pdf) [North Carolina](https://www.astdd.org/docs/iom-transforming-oral-health-care-in-north-carolina.pdf)
* Stakeholder survey findings using text and graphics: [Maryland](https://www.astdd.org/docs/maryland-state-oral-helaht-plan-2018-2023.pdf), [Pennsylvania](https://www.astdd.org/docs/pa-oral-health-plan-2020-2030.pdf)

Individuals want to read how and if the information applies to them or their community. Ideas for human interest stories can come from the oral health coalition or another group that may have used such stories in the past. Permission is needed if names or photos are used.

***Another important element is tying human interest stories to the key points in the plan or progress on an earlier plan.***

# IMPLEMENTING, MONITORING AND UPDATING THE PLAN

## What Infrastructure Should We Use?

California serves as one example of how they morphed during the plan into a new more formalized structure to monitor and promote the SOHIP. In 2020, the state dental director convened a workgroup to facilitate the transition of the Advisory Committee into the Partnership for Oral Health. Following a series of three planning workshops, the Partnership was officially formed in January 2021. See a description of the new [CA Oral Health Partnership](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/California_Partnership_for_Oral_Health_Plan_ADA_FINAL_6.15.2021.pdf). In addition, the Office of Oral Health started an [Oral Health Bytes Newsletter in July 2022 and a local oral health department grant program for 2017-22 and a new one from 2022-2027.](https://oralhealthsupport.ucsf.edu/moving-california-oral-health-forward-rfa-2022-2027)

As noted above, some group needs to take responsibility for monitoring and evaluating the SOHIP so it won’t sit on a shelf and be forgotten. [Ohio](https://www.oralhealthohio.org/sohp) presents a section where they list data as baseline, short-term and long-term outcomes as well as some data limitations. Dissemination needs to be broad and meaningful. Some states create interim workplans for a specific interval such as two years to update progress.

Everyone should be clear about how the plan will be monitored and updated including who is responsible, what funding is needed and the source, what human resources are required, and what timelines are realistic. Many states have created workgroups based on the priority areas or objectives, making sure that relevant expertise such as an epidemiologist or a communication specialist is available to the workgroups. Communication specialists are a key resource for dissemination.

***Areas such as health equity cross all workgroups or committees; that issue needs to be highlighted and coordinated.***

## How Can We Report Progress?

Using Key Indicators at a Glance is a concise visual way to display data on progress. Although this is important for professionals, it may not be an appropriate way to communicate with the general public unless plain language and familiar visuals are used. Simple Infographics linked previously may be more appropriate, especially in the languages of the primary audiences.

Dissemination methods vary across states, geographic areas, and communities and by who is disseminating the information. Possible vehicles include:

* TV or radio interviews
* Email distribution lists
* Online video conferencing or webinars
* Newspaper or newsletter articles
* Blogs
* Podcasts
* Websites
* Text messages
* Social media
* Town hall or community meetings
* Focus groups
* Listening circles
* Exhibits at meetings or health fairs
* Presentations or posters at conferences
* Mailed reports, and others
* QR codes linked to relevant documents or messages.

Sources need to be credible and trustworthy to the audience. Oral health champions or members of a specific community may be the best option as long as they understand the document, especially the key messages, and know where to find the documents.

***How the information is delivered is important and who delivers it is equally important.***

As the SOHIP is meant to be a compilation of information from several groups and individuals, ask individuals to promote the plan or portions of it formally and informally, especially to their friends, relatives and colleagues. Sometimes if government officials are the messenger, then the audience may think the plan is just for the government rather than a document created for everyone by a diverse group. If there are disparities noted for a group such as an American Indian tribe, then the process used to determine those disparities needs to be carefully outlined and feedback obtained from the tribe on how to improve the situation rather than dwelling on the disparities.

To track progress, [Ohio](https://www.oralhealthohio.org/_files/ugd/a395ee_51293804d84844b6b9e779c36cb87e55.pdf) uses a table that includes 8 SMART objectives (the indicator), baseline, short, intermediate and long-term targets, and priority populations.

## What Are Ways to Evaluate and Improve the Plan or Process?

The overall purpose of the evaluation is to determine whether the implementation of the SOHIP led to improvements in oral health partnerships, services, and oral health. A state that creates and evaluates a plan can determine what worked and what did not work and make mid-course adjustments. Evaluation of the *quality* of the SOHIP is important throughout the planning process but particularly before dissemination and at various intervals afterward.

***Evaluation results of SOHIPs can build evidence for the effectiveness of such plans and expand the knowledge base for all states.***

States should begin by referring back to their Logic Model and Conceptual Model to review the stated outcomes and create timelines to measure short-term, intermediate, and long-term outcomes.

Evaluation criteria might include:

1. Overall Quality
   1. The SOHIP is based on accepted assessment and elements of surveillance to establish goals and objectives and prioritize actions.
   2. It is developed through a collaborative process that includes key state and local representation and/or obtains several people’s input.
   3. The SOHIP has identifiable and measurable outcomes (intermediate and distal outcomes) and their evaluation is incorporated in the plan.
2. Implementation
   1. People commit time and resources in supporting the development, implementation, and maintenance of the SOHIP.
   2. Accountability, monitoring, periodic review, and reporting of progress are incorporated in the SOHIP.
3. Collaboration/Integration
   1. Linkages with people, including in local communities, are established for the development of the SOHIP.
   2. The SOHIP contains a core set of objectives that is easily customized to meet local needs/objectives as well as other organizations.
4. Objectives/Rationale:
   1. The SOHIP objectives reflect the broader vision for the state and are measurable in terms of oral health outcomes that can be linked to overall health outcomes where appropriate.

In addition,the evaluation of a SOHIP may involve sets of evaluation questions about Plan Implementation:

* Process – questions focus on the extent to which the activities to develop the plan occurred in ways likely to nurture the engagement of relevant partners and in ways likely to receive official endorsement and informal acceptance from those who must approve and/or implement it.
* Content – questions focus on the extent to which the plan contains necessary and/or recommended elements.
* Dissemination – questions focus on the extent to which the plan’s dissemination activities bring it to all relevant partners, decision-makers, users.
* Awareness – questions focus on the extent to which relevant partners, decision-makers, and other users recognize and understand the plan after it has been disseminated.
* Action – questions focus on the extent to which those who are supposed to take action based on the plan actually do take action.

Questions about Plan Outcomes could include:

* Achieving goals and objectives: questions could focus on the extent to which plan implementation achieved outlined goals and objectives, which programs and activities were implemented as planned, and barriers to implementation.
* Improving outcomes: questions could focus on measurable improvements in health outcomes.
* Partnerships: questions could focus on how plan implementation improved relationships among partners who implemented the plan and achieving goals and objectives related to health equity.

How should data to inform evaluation questions be collected? Face to face dialogue often is best to collect in depth information as it encourages two-way communication and an explanation of contexts or specific concerns and suggestions—qualitative information. This can be combined with quantitative data gathered from surveys or website “hits” or social media “likes.” Comparing BSS data for improvements in oral health in a population is one example. The information gathered can then be discussed by whatever structure is in charge of documenting and discussing progress. This information is particularly helpful if strategies have been delayed or changed such as by an epidemic, natural disaster, funding, staffing, a practice act, a law, or legislative representation.

States may want to review the following evaluation items to make sure they have addressed all elements.

***These items have been transformed into a*** [***checklist***](https://www.astdd.org/docs/evaluation-checklist-for-sohip.docx) ***on the ASTDD webpage for use and adaptability.***

* Key groups and individuals were involved throughout the plan development process.
* The *ASTDD SOHIP Toolkit*, the *SOHIP Comparison Tool* and the *Seven-Step Model* were used by the leadership prior to development of the plan.
* A structure to plan, implement and evaluate the plan is developed.
* Timelines for plan development, approval, implementation, evaluation, and updates on progress are outlined.
* A conceptual framework or logic model was used.
* State-level burden of oral health disease was described.
* Priority populations are based on needs assessment and epidemiologic data.
* Priorities are based upon assessment of existing infrastructure, resources, and gaps.
* Healthy People 2030 objectives are referenced or included.
* Priorities address core public health functions of assessment, policy development, and assurance.
* National or state frameworks are referenced.
* Plan addresses social determinants of oral health and oral health equity.
* Plan is based on state-wide goals and SMART objectives.
* Objectives/strategies are realistic and feasible.
* Plan goals and objectives integrate with other health areas.
* Objectives/strategies include identifying persons/organizations responsible for implementation.
* Objectives/strategies include identification of resources needed
* Plan addresses access to oral health services for those with oral health disparities.
* Plan addresses proven, evidence-based prevention strategies.
* Plan addresses education and/or awareness programs.
* Plan addresses policy and systems change.
* Plan addresses oral health surveillance.
* Tracking of progress and evaluation of the plan include identifying responsible persons/organizations, resources and timelines.
* Plan addresses issues and strategies for sustainability including funding.
* There is an embedded plan for communication.
* Plain language, human interest stories, and meaningful graphics are used to format the plan including other short documents targeted to particular audiences.
* Key messages are shared widely.
* Suggestions are included for how readers can use and promote the plan.
* Contributors to the plan and funding are acknowledged.
* Dissemination is accomplished in several formats via multiple modalities.
* Plan has identified evaluation strategies and measurable markers.
* Feedback on the Plan is collected from several individuals and organizations.
* Evaluation findings include progress, unintended outcomes, reasons for delay or changes, and strategies to manage the findings.
* Plan includes a system for using evaluation results to update plan strategies to promote oral health gains.

# CONCLUSION, ACKNOWLEDGEMENTS, AND FUNDING

## Conclusion

We hope this Toolkit is useful to readers and we welcome feedback and future suggestions. Please share any comments with [bev.isman@comcast.net](mailto:bev.isman@comcast.net) or [cwood@astdd.org](mailto:cwood@astdd.org).

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