Executive Summary:

The 2016 Texas Oral Health Metrics Summit

August 18, 2016
J.J. Pickle Commons Learning Center
Austin TX

Presentation One: Building a Strong Oral Health Surveillance System
Ms. Genelle Lamont, MNOHSS Coordinator

Ms. Lamont highlighted the Minnesota State Oral Health Plan and the Minnesota Oral Health Burden Document as the vision for creating the Minnesota Oral Health Surveillance System (MNOHSS). The ultimate goal of MNOHSS was to create a unified source of health data, including oral health, that could be accessed in a single location. While creating MNOHSS, the goals were to create oral health awareness in the state of Minnesota; provide accurate, accessible, understandable, and actionable data; identify health disparities and at-risk populations in Minnesota; and support state and local program planning, evaluation, and policies. Ms. Lamont explained tailoring aspects of MNOHSS to audiences like researchers, oral health professionals, media, etc.

When reviewing MNOHSS, a goal was to get a “bite” of data, or a take-home point that could be used and understood easily. A “snack” took longer to “digest” or understand, which included drilling down into the charts and graphs. A “meal” was a comprehensive review of the charts, graphs, and required more elevated statistical analytics. Each type of data is available on MNOHSS. MNOHSS provides data to be queried and viewed on the website or downloaded and analyzed by the user. Mobile use and access of the data was carefully considered while building MNOHSS.

Compared to the construction of a house, a solid foundation built upon strategic planning and collaboration is necessary. A diverse group of reviewers, stakeholders, and users are engaged in the strategic creation of processes, roles, responsibilities, and protocols, which are key when considering data visualization, benchmarks, outcomes, and evaluation.

Presentation Two: An Update from the State Surveillance Committee
Mr. Jesse Simmons, St. David's Foundation

The State Surveillance Committee (SSC) was created by Dr. David Cappelli and Dr. Vy Nguyen following the 2014 Texas Oral Health Metrics Summit to support oral health metrics and surveillance initiatives in the state of Texas. Three areas of support were identified for the committee in this capacity: exploring surveillance systems in other state, reviewing existing data and identifying gaps, and strengthening the existing network of oral health partners and stakeholders across Texas. The most recent initiative of the SSC was to administer a statewide survey to community dental programs assessing the type of services provided, type of data collected, data collection methods, and interest in contributing to an oral health data repository in Texas. Programs indicated early childhood populations were the largest area of services while non-senior adults (ages 19-59) were the smallest area of service. Approximately 70% of programs are entering data into some sort of electronic database, either directly or using paper and entering into an electronic source after collection. Programs indicated lack of manpower, lack of appropriate tools, and delay in getting data from partners hinder data collection in their organization. More than 80% of programs signified interest in contributing to a data repository if it was easy and the data remained secure.

Presentation Three: The Texas Health Improvement Network (THIN): Achieving the Triple Aim in Texas
Dr. Jay Morrow, Director of THIN

The Triple Aim as described by the Institute for Healthcare Improvement includes three key aspects: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. This process are designed to improve public health using system-level metrics including specific population health outcomes (mortality, health status, life expectancy, etc.), the disease burden, and the behavioral and physiological factors of the individual (smoking status, alcohol use, BMI, etc.) As such, the Academic Health System has adopted the use of this Triple Aim in the Third Curve.

The goal of the Academic Health Systems is to advance population health using nominal resources. This is achieved through three “curves”: Individual patient care, population health management, and cross-sectoral partnerships. The third curve, cross-sectoral partnerships, is of particular importance as it utilizes the social determinants of health to improve the health of all individuals in a population and thus extends to an entire population receiving services as opposed to just patients seeking care or managed patients. In realizing this Third Curve, health behaviors, social and economic factors, and physical environment must be considered. Within the UT System, several initiatives have been developed to reach this Third Curve (UT Consortium for Population Health Innovation and Improvement (Co-PHII), It’s Time Texas, THIN, etc.)

The Texas Health Improvement Network (THIN) was developed to establish a network of academic and health science institutions whose mission is to improve the health of Texans with the goal of achieving the Triple Aim (Third Curve). THIN partners include the Texas Collaborative for Healthy Mothers and Babies, Safe Babies, UT-CoPHII, Behavioral Health, and Tobacco Use. There are currently no partners for oral health. The presentation concluded by emphasizing the importance of cross-sectoral data sharing and warehousing in repositories like ROHDEO is a key aspect of meeting the Triple Aim both in Texas and nationally.

Presentation Four: An Introduction to ROHDEO
Dr. David Cappelli, UT Health Science Center at San Antonio

The Repository of Oral Health Data for Evaluation and Outcomes (ROHDEO) was first conceptualized and introduced at the 2014 Metrics Summit and is now funded through the Health Resources and Services Administration (HRSA) Grants to Support Oral Health Workforce. The initial target contributors are community oral health programs. The goals of ROHDEO are threefold: 1.) To create a repository of Basic Screening Survey summary data from oral health program across Texas to be collectively shared and utilized 2.) To keep the process of data contribution utility simple and understandable for all users and 3.) To support standardized data collection throughout Texas. ROHDEO is currently in the design phase and will be hosted on the UT Health Science Center San Antonio's server.

There are three components to ROHDEO: individual data collection, summary data collection, and a public website displaying aggregated data. Summary data will be aggregated by county and age which in turn requires programs to collect and summarize on those levels. Programs will submit a summary report for each county and age group. Tentatively, the contribution period will be from June to August annually.

For programs needing a data collection tool, a completely optional health screening tool will be provided beginning in Fall 2017 which will allow for data collection of de-identified, non-personal health information. Data to be collected on this platform includes demographic, Basic Screening Survey indicators, and access to care questions. There will be no program identification on the website for either summary or individual data collection.

The ROHDEO website will be similar to other publically available repositories like Behavior Risk Factor Surveillance System, National Oral Health Surveillance System, MNOHSS, etc. Data will be presented in charts, graphs, maps, etc. and will be available for raw download. A demonstrative version of ROHDEO will be available in early spring 2017 and will include pilot data. Summer 2017 will begin the first summary level data contribution period. Individual data collection will begin in Fall 2017 (but is optional).

OPEN SPACE BOOK OF PROCEEDINGS

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Name the issue/focus of Conversation:
Sustainability: What happens when the grant ends?

Convener: Shailee Gupta

Notes-taker: Becki Hale

Other Members:
Celia Aviles, Peggy Timothe, Johanna DeYoung

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- HRSA grant is for 3 years
- Having a familiar domain may promote hits on the website
- ROHDEO itself with help with grant renewal with HRSA but also for grant writing for looking for further funding
- Will San Antonio maintain the website? After grant?
- Agencies that are using ROHDEO that are having positive outcomes showing their needs and trends are getting funding that could then show utilization of ROHDEO – which would in turn
- Could agencies maintain a dashboard using the ROHDEO data? – ongoing support
- We don't want to charge anyone for accessing our data but show how they are using it, but what about private funders – what private funders would be able to benefit from the data? Foundations such as Dell, RWJ?
- Should there be independent contributors to ROHDEO that could provide financial support – private funders
- Who would oversee sustainability? Should there be a committee for sustainability?
- What role would Texas Dental Association play in ROHDEO?
- Minnesota didn't mention organized dentistry's involvement? Why?
- Would there be any ADA funding?
- Networking will be very important because in order to sustain we need a large, robust database, which means many contributors. We need to reach those organizations that have access with a lot of data – dental schools. Can they extract the BSS data from their detailed data collection from pediatric patients and adult patients in the dental schools?
- Sustainability Committee will be crucial – sustainability can very easily fall through the cracks without intention
- What structure will be in place – will there be a ROHDEO Board with subcommittees
- Could we utilize data interns? Bioinformatics students? Workforce development

Name the issue/focus of Conversation:
Barriers and Solutions to Data Collection

Convener: Diana Montalvo

Notes-taker:
Kila Johnson

Other Members:
Jodie Hostetter, Jennifer Bankler, Raonna Thompson, Anita Albert, Genelle Lamont, Analisa Heck

- Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/next steps:
- What type of agreements need to be in place – MOA, MOU, DUA?
- Direct data entry very time consuming vs importing data from an excel data base – some data could be retrieved from the school as opposed to recollecting the data during the screening
- Lack of time
- Clarity of questions and thoroughness of parental response i.e. race/ethnicity, birthday
- Electronic data collection – access to electronics
- HIPAA & FERPA compliant
- A lot of us do the surveillance as a part of care delivery but are not specifically performing surveillance
- Difficult for those trained in dentistry to unlearn what we already know
- Challenge: take what is there all of the volumes of data – what do we do with it?
- Evolution of current data collection practices may eventually be able to be extrapolated to private practice models
- No universal way to capture data
- Future we may have CDT codes to align with the data
- How do you modify different scopes into a common practice?
- Hard to keep data separate – need a way to collect the BSS data vs what we may want to report to the parent based on our training and what we are driven to do based on a more thorough examination
- Concern about the disease progression as it relates to action that may or may not occur based on what we've reported if we are focused on BSS results
- Lots of differences between each person's urgent vs non-urgent – each person's determination is based on their own set of principles – how do we make this consistent amongst such a wide group?
- How do we align more closely to the national standards?
- How can we change our internal process to be in line with the BSS? Challenging
- How do we standardize what a cavity is and what it isn't?
- Information from the parent could completely change what you think you are looking at, an oral cavity could be presented as 4 restored molars, hx of caries vs 4 sealants, no hx of caries. Lack of parent input is a large variable
- Underreporting is very prevalent due to conservative evaluations
- Is there any reason we can't start with a Texas standardization to help standardize and eventually go to the BSS (national format)?
- Money/funding – huge deterrent for surveillance programs

- Claim data in Texas would be limited to Main Home dentist only

- Difficult to measure the outcome of interventions without claims data
- Difficult to monitor care children received due to the lack of data
- Building in security, if we start BSS and incorporate it will we be able to secure the data, transmit it safely
- Data collection for some programs current has been extremely challenging – often data managers don't have a dental background which is an additional challenge
- Some programs are checking retention and more extensive details that are not required by BSS
- Paper to electronic can by time consuming – but some people feel that direct data entry in real time is not feasible
- How much data do we need to be statistically significant?
- Best way – captured with your daily billings but so many of us are not billing i.e. we utilize grants
- How will the data that is collected be used?
- People want to do with they are comfortable with – you have to be able to be flexible and report it in the way they want the data reported
- BSS is a surveillance tool not as an assessment tool

Name the issue/focus of Conversation:
Mining existing data to make comparable

Convener: Nana Lopez

Notes-taker: Tonya Fuqua, DDS

Other Members: Sowmya Renuka, Ensy Atarod, Elodie Levy

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

1. How do individual programs collect their data to be comparable or uploaded into ROHDEO?
2. Need to have an app or program that is designed to help all the programs to easily collect data
3. The use of a technology oriented system
4. Future access to Medicaid/CHIP data
5. How is the format going to work (so that existing data collected in individual programs can be easily uploaded into ROHDEO)?
6. ROHDEO needs to potentially have a user friendly format that any program could respond with this new repository
7. Cost effectiveness to collect this data
8. Would like this to be utilized for children and adults
9. How to get non-BSS data uploaded or a part of ROHDEO that may be useful for dentistry, programs and state initiatives.
10. Would be great to utilize the data to further education of the public and other health care providers

Name the issue/focus of Conversation:
INTEGRATION vs. DUPLICATION, so many tools out there

Convener: Jesse Simmons

Notes-taker: Jesse Simmons

Other Members:
Magda A. de la Torre
Caesar Collazo
Ellie Coplin
Teresita Ladrillo
Sondra McDonald
Debra Saxton

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

We don't want this to turn into another website that no one uses. Observation: The available data currently out there isn't being used!

- Adult through BRFSS
- Child through YRBS
- Cancer Data & CDC

Regional level is the distinguishing factor – that's what's needed. State-wide not as useful.
Are fact sheets the way to go? More digestible. Easier for policy makers.

- Challenge is it becomes out of date. Dashboards that easily update?

Disconnect between available data and making program decisions.
What questions do you want to answer with this data?
Incentives (role of philanthropy) to incentivize districts (others) to participate.
Are we over surveying – people getting tired of it. So many surveys use phones that is becoming not the way to go.
Training nurses to do it and then pull straight from the district databases.
Important: It will probably need more than just count data. Individualized (de-identified) will be important to do cross-tabs, slice in different ways, etc.
Will also need to collect how people collect their data because when doing comparison, that will be important. Data Quality is important – Idea: Send pretty report back to the group entering, that they can look at and make sure it's correct.
Benchmarking for certain Population. Always helpful for program decisions.
Convening the groups with good data practices and good outcomes to share best practices.
Added benefit, take off the workload on the program for trend analysis, etc. by having the data repository doing it for you.
Is the vision **One-Stop-Shop**? Where do people go now. Explain through dashboards or fact sheets what all is out there. If a new initiative is starting, what info do they need to consider.
We've had success in adding oral health questions to existing surveys (YRBS, PRIMS, etc.). Should that live in the data repository.
Have to start somewhere. Then you learn what data you actually didn't need and what additional you do. Starts peaking curiosity.
Has to be visual – "people are afraid of data". Must be easy. Geared to the community.

Name the issue/focus of Conversation:
How are going to use the data to improve oral health

Convener: Debra Saxton

Notes-taker: Becki Hale

Other Members:
West Ficken, Sandra McDonald, Dr. Anita Albert, Rhonda Stokely, Roana Thompson

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- Assuming what we have is quality data, how would we use it?
- Information from the database be proactively sent out, take a proactive approach to disseminating it
- School nurses may by interested in it
- Data sent to local health authorities for them to use to enhance, change, structure, adapt their programs
- How do we answer the questions that are the most important to those who would use the data?
- Local hospitals that would be able to use it – then giving proper referrals to those individuals showing up in the ER with dental pain
- How can we use this data for one of the ultimate goals which is to get people into a dental home – of course this is a challenge
- We don't know just yet what the data is going to look like so it's difficult to accurately say how we can use this to improve oral health
- Will there be quality checks, will the data be a high enough quality and if it is – what is going to be done with it… other than using it for grants – and if we are underreporting, how is that really going to make a difference.
- Is it beneficial to record more that the BSS? However this would bring up calibration issues.
- How much of a loss of validity will there be with inputting
- Has there been a data sharing agreement drawn up? We need those prior to imputing our data into ROHDEO.
- It could possibly improve standards.
- The data could be used for process improvement within individual programs
- **How does ROHDEO plan to get feedback from users/contributors, etc. on a regular basis?**
- Is the data we're being presented with going to have an explanation of uses? What you can and can't say about it?
- Have we thought it through that this data could also be used against the cause? Anti-fluoridation groups could use this. The data could be taken out of context. Are contributing groups aware of this and are they comfortable with this?
- What really is the end goal of the repository? We haven't been told just yet.
- We just don't want to be collecting it to collect it.
- Could there be a pilot or base before letting everyone starts dumping their data in the repository?
- Is this count information going to be enough? Are people really going to be able to use it appropriately and in a way that can improve oral health?

Name the issue/focus of Conversation:

How do we define and evaluate the quality of data?

Convener: Ankit Sanghavi

Notes-taker:
Kila Johnson

Other Members:
David Cappelli, Annalise Cothron, Madge Vasquez

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- How are we ensuring the quality of the data the programs submit, since there may be multiple programs from the same county?
- Are we combining the data to make "county" data – i.e. City of Houston, Harris County & Memorial Hermann are all in Harris County should these three agency's get together to make sure they are not duplicating patients and thus data. How are we identifying "unique" data only?
- No way around duplication – you can't combine it, just report 3 different data sources. They stand alone – three sources. You would never know who it was.
- Report as a range – not one flat number
- Data is a sample of a specific population group – not a representative sample of a particular state or city
- Not a reflection of any particular county
- How can we ensure it is generalizable date? None of the data will be generalizable to any one county
- The state does a representative sample every 5 years of children but that is not the focus of RHODEO
- One capability is to compare data program to program because the program participation criteria is similar i.e. free and reduced lunch data
- Look at data to determine if we are meeting goals and to help set benchmarks
- What are national leaders doing that look like us – hard to tell without data?
- Data repository will eventually give us 5 year trend data
- How can we determine if a specific agency will commit for multi-year commitments and not skip years? Maybe incentives
- Are there any big data questions we want answered by the repository?
- As things develop we will have more questions inferred from the data
- BSS data collection is not a requirement of FQHC's – missed opportunity to collect adult data
- All questions will be based on the BSS plus a few additional supplemental questions (i.e. preventive care provided, insurance status)
- Opportunity to figure out how to collect BSS data at nursing homes – currently that data is collected by anyone available (MDS data)
- Important to integrate oral health questions into health surveys
- Physicians just don't look in the oral cavity – they are not trained to - therefore when we talk about what data to collect oral health is not on the list for the medical community
- Dental hygienists can't do the basic screening but nurses can
- How can content experts in the field of oral health support non-oral health practitioners?

- Data shines a bright spot on gaps
- Why aren't you taking care of these people and where is the data that says they are not being taken care of?
- TEA & SHAC are more likely to be successful championing Medicaid reform through the legislature – by linking up with a legislative partner
- Vulnerable population carve out is needed in Texas for community based programs
- Parent accompaniment rule is very restrictive in Texas
- Texas Health Institute works closely with TMA and maybe that can be leveraged to influence TDA
- Medicaid enrollment vs utilization in Texas, the data can be used to map out the services being provided and not compensated and map out the community programs
- Since the programs are submitting data based on BSS – so how are we going to make sure of the accuracy of the submissions – we will try standardization but there is no way you can calibrate across the state, there will be inherit differences between the data
- We are going to standardize people but not calibrate
- There must be some way to vet the data
- There will be variability
- At this time there is not data at all but this repository will provide a baseline – a place to start
- Most people are using the BSS in some way and are following the guidelines
- Plan to stratify data by county and by age
- The more layers you add, the more difficult the process becomes on the back end
- What were lessons learned from other organizations that attempted repositories and maybe had issues with sustainability

Name the issue/focus of Conversation:

Teledentistry as a possible way to gather info for BSS

Convener: Nana Lopez

Notes-taker: Dr. Sowmya Renuka

Other Members: Dr. Nana Lopez, Dr. Griffin, Dr. Timothé, Dr. Daneil Jones, Dr. Gursimran Aurora

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

Envision "Non institutionalized adults" or " School children" use photo to collect BSS.

Advantage of Tele dentistry: It can be done by non-dental background
Barriers: Generalizability, smaller sample size

Idea 1: Start a pilot project with small sample size for compliance to using photographs in BSS surveillance.

Primary Aim: Estimate the disease for a target population (surveillance)

Recommendations:

1. Can be used for medically compromised patients
2. Due to compliance issues of the patients willing to take a picture, it is suggested that it should be part of other general questions like tobacco….
3. Photos can be utilized to those patients who cannot travel long distances for specialist opinion or referrals.
4. For teaching people self examination
5. For oral cancer patients

Questions & Barriers:
Is it defined in the dental practice act?
Do you need a consent form for taking non- identifiable picture?

Idea 2; Calibration of examiners for BSS:
Compare Inter rater reliability of 20 **Adult** patients examined through photographs to 20 **Adult** patients examined in person?
- Idea for "Summer research projects for dental students".

Name the issue/focus of Conversation:
How can we integrate oral health data with public health data?

Convener: Ankit Sanghavi

Notes-taker: Ankit Sanghavi

Other Members: Dr. Collard, Rhonda Stokley, Verne LaGrega, Annalise Cothron

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- Contracting with vendors to integrate different sourcs
- Look for funding to support common interface
- UDS report card that FQHCs fill out
- FQHCs all aready in the process of adding behavioral health measures
- Adding oral health questions to UDS
- Role of Dental Schools in RHODEO
- Phase III – looks at integration of existing
- HRSA has a plan to add questions to UDS
- Utilizing patients as data source

Name the issue/focus of Conversation: Standardization and uniformity of data collection

Convener: Mamatha Pasala

Notes-taker: Lex Ohlendorf

Other Members:

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- The biggest challenge is to get people to not over think it. Dental professionals want to find it and fix it. With the BSS we want to over think rather than marking and moving on
- Another challenge is knowing the difference between documenting the BSS and completion of the take home sheet. The information on the BSS and the take home information/referral sheet will not always line up
- Some programs have criteria that they must meet due to funding and the requirements that are necessary. Can we meet the BSS criteria and follow the requirements imposed by funding organizations?
- The BSS is used in all states so it is great to have comparative data between all states
- Using professionals outside of oral health is very helpful. Holding a calibration clinic helps with uniformity.
- Standardization – making sure that we are all collecting the same information. In the care of the BSS examples would be untreated decay, treated decay, existing permanent sealants.
- Having another group of BSS providers would be helpful. These people would need to learn the standard information and be calibrated
- Following the BSS these patients would be referred for care
- Calibration – have a group of BSS providers do a BSS on the same group of patients to ensure that they are documenting/identifying the information similarly
- The BSS is like other data collection in that it is a snap shot in time

Name the issue/focus of Conversation: Measures to enable ease of accessibility to website use
Convener: Mamatha Pasala
Notes-taker: Malatha Pasala
Other Members: Elodie Levy, Ensy Atarod, Yana Kushner, Shailee Gupta, Annilisa Heck, Stephen Collard, Abby Menke
Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps: • Training is a critical phase (website training) • Look at best practices – as different successful data programs • First part of the question – who does the data serve? • Once website is accessed, how will it hold the attention of users?

Name the issue/focus of Conversation: State Models
Convener: Johanna DeYoung
Notes-taker: Johanna DeYoung
Other Members: Genelle Lamont, Celia Aviles, Annalise Cothron
Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps: • Ohio might be a good model • WI COWSS Program is also on line

Name the issue/focus of Conversation: Adult BSS

Convener: Beth Stewart

Notes-taker:
Lorie Jones

Other Members:
West Ficken, Donna Warren-Morris, Lorie Jones, Nancy Cline, Sandy Tesch, Sarah Dirks, Madge Vasquez, Lori Cofano

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

TMF - Texas medical foundation working on a grant where they are wanting to get people in to nursing homes to perform BSS. Utilizing dental hygienists to go out and train nurses to perform the BSS

DADS is wanting to improve the quality of oral health and is utilizing TMF to do that.

Need buy in from the nursing home - TMF would need to provide an incentive to get the nursing home to buy in to this project

What's the outcome objective?

We need Policy Enforcement for the nursing home oral health requirement. There is some barriers on the part of the nursing homes that proposes challenges for the dentist to go in.

Older collected data - for adult BSS - where is that data going to go?

Dental hygienists doing the training to he nurses at the home, nurses do the BSS and input data into Smilesmaker.

Utilizing a teledentistry aspect would be overkill since there is not diagnosing and treatment planning

How to do calibration for this project? Hygienists calibrate on the BSS and than hygienists train the nurses - to be accurate need to get nurses together to calibrate.
What is the minimum number of patients that are needed to establish calibration?
How many nurses from each location are calibrated?

Calibration, Standardization under the umbrella of quality assurance...reaching that Triple Aim

What deliverables are we trying to get?

Big Mouth - national repository of dental data

IT support come from TMF? Nurse fills out data on either paper or digital, hygienist will either input or review data and coalate data.

TMF grant proposal is due at the end of the month. 2-4 year project.

Can oral health be part of the nursing home scorecard?
The nurses already has to be doing the minimum data set however it has been highly inaccurate.

Need to have a referral mechanism in place to send those that are in need. And a caseworker?
How to provide the follow up care? TMF needs technical assistance.

Moving into Adult BSS data

Ways to get adult data for BSS??

Using patient adult BSS data from community clinics or private practice in Practice Based Research Network (PBRN).

Name the issue/focus of Conversation:
How to "activate" the data so its used for program improvement

Convener: Elodie Levy

Notes-taker: Lex Ohlendorf

Other Members:

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

- How do we know the data is clean and standardized? Are well all capturing the standardized BSS data? Once the data exists, how do the programs use it? Do we need a facilitator that could explain the data to the programs?
- Getting together to discuss all of the data that is garnered
- Who would be in charge of activating the data? Is UTHSCSA capable of also activating the data?
- Knowing who is involved in BSS could help identify the plan behind activation

Name the issue/focus of Conversation: Raising awareness and encouraging participation of different community programs

Convener: Josephine Wolfe

Notes-taker: Josephine Wolfe

Other Members:

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

Raise Awareness

- Engaging state dental associations
- Social marketing
- Work through the TxOHC to connect with community dental programs to directly connect with programs

Encouraging Participation

- Make it “Sexy”
- Having a concise model that is easily replicated in different settings
- Showcase examples of success
- Help programs understand how data can help support policy change to increase funding
- Offer technical support

Name the issue/focus of Conversation:
Workforce utilization for BSS

Convener: Lorie Jones

Notes-taker: Lorie Jones

Other Members: Beth Stewart, Sarah Dirks, Sandy Tesch, Nancy Cline, Lori Cofano, Josephine Wolf

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

Who can perform the BSS?
Dental hygienists going into nursing home for 6 months, can the BSS be a delegated procedure by the dentist?
Need a rule clarification on what dental professionals can do them?
Retired dental hygienists?
Inactive licensed hygienists
Nurses
School nurses
Caseworkers/social workers
Speech Pathologists
Pharmacists
Registered Dieticians

Standard Delegated Order - BSS for dental hygienists

Dental Hygienists CAN do BSS under Rule 112 Visual Dental Health Inspection

Name the issue/focus of Conversation:
. How can we engage organizations, community programs, etc. to participate and learn about ROHDEO?

Convener: Magda de la Torre & Teresita Ladrillo

Notes-taker: Laura Hernandez & Leticia Santos

Other Members: Laura Hernandez, Teresa Hines, Leticia Santos, Teresita Ladrillo

Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps:

Can highlight a program or clinic in the meeting to entice them to join ROHDEO. Promote their program.

Have a form to query data. Make it user friendly

Who should be here that is not here: Dental Society, ADA
AHEC Model, develop a more formal structure to capture the various interest's
Start from the top down, making a commitment in having them participate which lends to funding streams, financial resources

Leadership rotates to participate other members within their perspective programs

Silos developing repositories, how do we get everyone to share

Legislative designates a representative a term which is mandated for a time period, as well the governor's office who holds a health liaison that continues to keep legislation informed

Regional locations, THIN parameters having them host the meetings at various UT Campuses. May not be able to reach all areas or all counties. There are limitations.

Name the issue/focus of Conversation: How can we build the repository so that it can be used for timely intervention?
Convener: Tess Ladrillo & Magda de la Torre
Notes-taker: Laura Hernandez & Leticia Santos
Other Members: Laura Hernandez, Teresa Hines, Leticia Santos, Teresita Ladrillo
Discussion notes, key understandings, outstanding questions, observations, and if appropriate to this discussion – action items/ next steps: Data must be entered in a timely manner. Entered more than once a year. Can the repository find a way to analyze trends. Have data management analyst to analyze data. Web site should have the ability to query for trends.

TEXAS
ORAL HEALTH
METRICS SUMMIT

August 18th, 2016
J.J. Pickle Commons Learning Center
Austin, TX

7:30 – 8:15 AM	Registration and Breakfast	
8:15 – 8:30 AM	Welcome	Drs. Cappelli, Stokley, Gupta
8:30 – 9:30 AM	Presentation: Building a Strong Oral Health Surveillance System	Ms. Lamont
9:30 – 9:45 AM	Presentation: Updates from the State Surveillance Committee	Mr. Simmons
9:45 – 10:00 AM	Break	
10:00 – 11:00 AM	Presentation: The Texas Health Improvement Network: Achieving The Triple Aim in Texas	Dr. Morrow
11:00 – 11:30 AM	Presentation: An Introduction to ROHDEO	Dr. Cappelli
11:30 – 12:00 PM	Introduction to Open Space	Ms. Flanagan
12:00 – 1:30 PM	Lunch	
1:30 – 2:30 PM	Open Space Session One	All Attendees
2:30 – 2:45 PM	Break	
2:45 – 3:45 PM	Open Space Session Two	All Attendees
3:45 – 4:15 PM	Reflection	Ms. Flanagan
4:15 – 4:30 PM	Closing	Dr. Cappelli

TEXAS ORAL HEALTH METRICS SUMMIT

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Genelle Lamont, MPH, PhD Candidate
Minnesota Oral Health
Surveillance System Coordinator
Minnesota Department of Health,
Oral Health Program

Genelle Lamont is the Oral Health Surveillance Coordinator at the Minnesota Department of Health (MDH) responsible for developing an oral health web-based data portal. She also leads MDH's Center for Health Promotion Health Literacy Advisory Group. Ms. Lamont received her master in public health from the University of Minnesota where she is a PhD Candidate in the Occupational Health Services Research and Policy program. She holds past fellowships with the Directors of Health Promotion and Education, Centers for Disease Control and Prevention, and the Great Lakes Inter-Tribal Council. Her research interests include oral health, chronic disease, environmental and occupational health, health disparities, GIS mapping and health literacy.

Jay Morrow, DVM, MPH
Director, Texas Health Improvement Network
The University of Texas System

Dr. Morrow is Program Director for the Texas Health Improvement Network (THIN), on the Population Health team in Health Affairs at UT System. He was most recently Research Manager for the Health Disparities team at the Dell Medical School at the University of Texas at Austin, following his service as Research Program Manager for Internal Medicine at UT Southwestern Medical Center in Dallas, Texas. He brings over 16 years of experience serving at academic medical centers in public health, health services, community-based, and health disparities research, in addition to providing clinical and informatics support, and teaching medical students, graduate students, and residents in research methods and electronic communication skills.

Dr. Morrow graduated with a degree in Economics from The University of Texas at Austin, earned his Doctorate in Veterinary Medicine from Texas A&M University, followed by a Masters in Information Science from the University of North Texas, and a Master of Public Health degree from the University of Texas at Austin. Dr. Morrow is a native of Corpus Christi, Texas. His current duties include fostering a collaborative population health network among the UT System components and major partners from academia, local, state and national government, public interest non-profits, and industry.

David L. Lakey, MD
Chief Medical Officer and
Associate Vice Chancellor for Population Health
The University of Texas System

David L. Lakey, M.D., serves as the Associate Vice Chancellor for Population Health for the University of Texas System, and the Senior Vice President for Population Health and Isadore Roosth Distinguished Professor at the University of Texas Health Science Center in Tyler (UTHCT). He is the Center Director for the UT Northeast Center for Rural Community Health and Dean of the School of Community Health and Health Professions at UTHCT. Dr. Lakey serves on a federal public health advisory committee for the Centers for Disease Control and Prevention and the Defense Health Board.

Dr. Lakey served as Commissioner of the Texas Department of State Health Services from January 2007 to February 2015. During his tenure as Commissioner, Dr. Lakey served as president of the Association of State and Territorial Health Officials (ASTHO) in 2011-2012, and received several national awards including the AMCHP President's Award, the March of Dimes President's Public Health Leadership Award, and the Arthur T. McCormack Award. Dr. Lakey was awarded the 2015 HHS Innovates award as part of a collaboration that also included ASTHO, the Association of Maternal and Child Health Programs, CityMatCH, March of Dimes, HRSA's Maternal and Child Health Bureau, CDC, and CMS for their partnership on the CoIIN to Reduce Infant Mortality.

He earned a Bachelor of Science in chemistry, graduating with high honors from Rose-Hulman Institute of Technology in Terre Haute, Indiana, and received his medical degree with honors from Indiana University School of Medicine.

Mary Flanagan, MSW, LMSW-AP, CTF
Facilitator
Strategy & Leadership, LCC

Strategy and Leadership, LLC provides group facilitation, consultation and training to businesses and organizations. Strategic and project planning, organizational development, team building and leadership effectiveness are common topics of client engagements. The company has offices in Nashville TN and San Antonio TX.

Mary's work with Strategy and Leadership began in 2003 and builds on 25 years' prior experience in planning, project development, fund raising, coalition building, board governance, leadership development and management in the non-profit arena.
Mary holds a Masters degree in Social Work from the University of Houston Graduate School of Social Work with a focus on community & organizational development, and a BA with Honors from the University of Texas at Austin. She is licensed as an Advanced Practitioner of Social Work in Texas (LMSW-AP). She is a Mentor Trainer through the Institute of Cultural Affairs, and has been awarded master facilitator status and carries a national certification, Certified ToP Facilitator (CTF). She has served on numerous professional and community committees and boards, and continues to lead in such capacities.

TEXAS
ORAL HEALTH
METRICS SUMMIT

Goals

- Achieve standardization of the metrics needed to measure oral health in Texas.
- Develop strategies to address obstacles related to data collection and contribution.
- Empower the network of advocates within communities to enhance and increase effective communication about the sharing of oral health data.
- Support oral health data collection to identify oral health disparities, target unmet needs among underserved, influence policy change, and illustrate the oral health landscape in Texas.
- Identify what it will take to build and use ROHDEO to improve oral health in the state of Texas.

ROHDEO
Repository of Oral Health Data Evaluation & Outcomes

What are the questions we want/need to explore in order to move forward with the establishment of an Oral Health Data Repository for the State of Texas?

ROHDEO Goals:

- To create a repository of Basic Screening Survey summary data from oral health programs across the state that will be collectively shared and utilized in Texas and the United States.
- To keep the process of data contribution and data utility simple and understandable for all users.
- To support standardized data collection and contribution throughout the State of Texas.

ROHDEO Use:

- To more accurately and comprehensively illustrate the oral health landscape in Texas.
- To tell the ‘oral health story’ of Texas, examining current data and, eventually, changes and trends observed in longitudinal data.
- To identify existing oral health disparities so that targeted intervention may be more effective.
- To research emerging trends in oral health across the state, including opportunities to secure funding for such research.
- To use data to influence and introduce policy changes.
- To target unmet needs among underserved regions and populations.
- To develop a centralized resource where comparisons of oral health indicators can be made on the local, regional, state, and national level.

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Resource List

Visit the resources below to find more information on oral health indicators, evaluation and surveillance methodology, and best practice guidelines for oral health data collection. Note: These will be available electronically when summary materials and evaluations are distributed after the Metrics Summit.

- Oral Health in Texas 2008 Report:
  http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=29473&id=8589983239&terms=oral+health+in+texas+2008
- Texas Oral Health Surveillance Data Chart Book:
  http://www.dshs.state.tx.us/dental/tohss.shtm
- Texas Oral Health Surveillance Plan:
  http://www.dshs.state.tx.us/dental/tohss.shtm
- U.S. National Oral Health Alliance Leadership Colloquium: Metrics for Improving Oral Health Summary:
  http://usnoha.org/content/metrics-improving-oral-health-november-15-16-2012
- Center for Disease Control Healthy People 2020 Initiatives for Oral Health:
  http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32
- The Minnesota Oral Health Surveillance System:
  https://apps.health.state.mn.us/mndata/oral-health
- A State of Decay Volume III by Oral Health America:
  http://toothwisdom.org/pages/a-state-of-decay
- The American Dental Association's Health Policy Institute:
  http://www.ada.org/en/science-research/health-policy-institute/publications/research-briefs
- The Association of State and Territorial Dental Directors:
  http://www.astdd.org/a-z-topics/