Community and Partner Engagement Discovery Report

for the Colorado Oral Health Strategic Plan (COHSP)

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EXECUTIVE SUMMARY

The Colorado Department of Public Health and Environment (CDPHE) is embarking on the development of a comprehensive Colorado Oral Health Strategic Plan (COHSP) designed to address the systemic inequities that lead to poor oral health outcomes statewide. The goal of this work is to create a plan in close collaboration with underserved, poorly served, and never served communities to design a COHSP that helps tackle the systemic inequities that lead to poor oral health outcomes statewide.

To inform the strategic planning process, CDPHE's Oral Health Unit (OHU) sought feedback on the state of oral health in Colorado. CDPHE contracted with Joining Vision and Action (JVA) to facilitate a community and partner engagement process. The engagement process provided a better understanding of the current systems impacting oral health and identified potential areas for improvement and collaboration.

Informed by a mixed-methods research approach, data was collected through focus groups with community members, interviews with representatives of state agencies and partner organizations, and a survey administered to members of the Colorado Oral Health Network (COHN). The data presented in this report will provide an illustrative, not exhaustive, snapshot of the state of oral health in Colorado to inform the strategic planning process.

Summary of Key Takeaways

When the research findings are compared across sources, several common themes, as well as divergences, emerge. The findings outlined below will be relevant in the development of the COHSP:

Access to services is a key concern for all respondents. The overarching issue identified by all audiences is difficulty accessing care. Systemic barriers such as economic inequities, lack of transportation, geographic maldistribution of clinicians who address oral health, systemic racism, and other social determinants of health can make it difficult for some Colorado communities to take care of their mouths and access dental care. First and foremost, the current delivery system of dental services can be exclusionary. Lack of affordability of services was cited repeatedly throughout the data gathering process, including lack of insurance coverage. Affordability of clinical dental services is also the most common barrier cited by communities and key partners at a national level. Communities and partners also highlighted how current dental delivery systems do not meet the needs of many communities. Community members named specific examples of the system not meeting their needs, including lack of infrastructure for transportation, which can make it difficult to reach care; business models such as office hours that don't match community and workplace inequities; and care that lacks cultural responsiveness, as demonstrated by language or cultural differences. Flexible models are one way to address some of the logistical issues (teledentistry, use of promotores de salud, etc.), but partners relayed that these strategies can be difficult to

fund and replicate, as a result of silos and newness of models. Some focus group members also expressed skepticism regarding the usefulness of teledentistry.

Health equity relies on a strong workforce. It is also clear that one foundational piece of ensuring health equity is the workforce. Community members in focus groups indicated that they may receive care and education about taking care of their mouths from sources that do not look like them and do not share their background or understanding of their culture. There are many barriers to creating and sustaining a diverse and culturally responsive workforce, including the cost of education, burnout and limited opportunities for advancement. The burden of loans can be especially difficult for people from historically marginalized communities, and this inhibits individuals who would be representative of these communities from entering the dental workforce. Additionally, advances and innovations in the skills needed to provide oral health services in the modern era require additional cost and time (e.g., becoming certified to use teledentistry for placement of interim therapeutic restorations). The data showed that partners in particular felt that the lack of diversity in the current dental workforce requires funding, training, and oversight to enable more culturally responsive and trauma-centered care.

Data is critical for identifying and addressing health inequities. Data is vital to understanding the social and structural factors that impact Coloradans' oral health. Diverse and high-quality data can provide a more holistic understanding of the factors impacting oral health and the efficacy of current approaches. For example, demographic data can help ensure that programs are addressing inequities and evaluate whether programs are serving individuals representing their community. However, current datasets are often siloed, aren't comprehensive or high quality, are burdensome to collect, and/or are difficult to use. State-level partners discussed the lack of policies that other states have enacted to improve oral health datasets, such as mandated school oral health screenings to gauge school readiness. Several partners also cited the lack of inclusion of oral health strategies and oral health data in broader state health discussions and products. One partner cited several state reports that covered specific health topics impacted by oral disease but did not include oral health data.

Coordination among clinicians and agencies could maximize impact of interventions. Both clinicians and others in the oral health landscape see the need for centralized coordination to address the areas above. Centralized coordination could focus on advocacy, policy, and shared messaging as key tools to address these issues. Yet, despite the value of coordination being commonly raised, respondents also pointed out that the siloed nature of programs and services often made this a difficult goal to achieve. Many state-level partners cited the lack of an active statewide coalition as a factor in challenges with coordination across oral health systems.

Integrating oral health as a key component of overall health could address other barriers. Partners noted that many of the concerns identified stem from a lack of integration between oral health services and other health and community services.

Though current programs to integrate oral health in existing health systems exist, they are not universally adopted and do not reach all Coloradans. Coordinated efforts could focus on ways to embed oral health in existing systems that benefit individuals, such as standard medical insurance, primary care services, and community-based service delivery at schools, etc. Additionally, education and communication around oral health could shift public and workforce perceptions, helping people to understand the importance of oral health and its connection to overall health, increasing oral health literacy, and encouraging individuals to prioritize oral health.

Colorado needs to focus on integration of more than just clinical systems to address oral health inequities. A few partners who indicated they are working on systems change at a state or national level believe that the United States is too focused on solely clinical strategies to prevent and manage oral diseases. These partners relayed that, unlike strategies to prevent chronic diseases such as diabetes, there are limited to no community-based oral health outreach and education programs. Some partners raised concerns that the lack of collaboration across state agencies is exacerbating the focus on costlier clinical services, thus exacerbating oral health inequities. Some respondents suggested collaborations with food security, education, housing, and other state programs could help integrate oral health data and strategies into more upstream public health approaches.

Sufficient funding is critical for supporting oral health equity. The need for adequate funding was a common concern raised by respondents across the data sources. However, the statement “Our budget consistently has multiple line items for equity-advancing activities” was one of the lowest-rated items in the survey of organizations providing oral health services. This suggests that although there is near universal acknowledgement of the need for funding to achieve equity-related goals, funding is not available within organizations to prioritize these goals. This could be due to an inability to allocate funds or a lack of external funding sources available to meet the needs of equity-advancing activities.

Colorado needs to focus on systems change to address historical, current, and future oral health inequities. Community members and oral health partners understand that upstream factors, especially generations of systemic racism, have contributed to current oral health inequities. Statewide and national partners relayed that the overwhelming unmet oral health needs in underserved communities need to be addressed while still focusing on strategies, policies, and partners to move toward more systemic improvements to decrease disparities.

Diverse voices should be emphasized. Finally, although the findings thus far represent a wide variety of perspectives, continued focus on engaging diverse voices is necessary to create a strategic plan that represents the breadth and depth of the oral health landscape in Colorado. To inform the implementation and evolution of the strategies prioritized in Colorado, further outreach and ongoing engagement with communities that face inequitable barriers to oral health is vital. Community voices that

should continue to be engaged and/or should be elevated during the development and implementation of the COHSP include: Spanish speakers, BIPOC [Black, Indigenous, and people of color] individuals, older adults, persons with disabilities, members of the LGBTQ+ community, refugees, people experiencing homelessness, those who speak languages other than English or Spanish, people from organizations providing consumer protection services, low-wage-earning communities, and oral health clinicians working in home/institutional settings (long-term care, detention). Organizations with strategies represented in the COHSP need to intentionally and regularly involve diverse community voices to not only provide community perspective but also to support equity-focused organizational changes, such as building in community advisory and oversight boards.

Implications for Strategic Planning

Building on the above key takeaways, JVA identified the following implications for the development of the COHSP.

Not all individuals and communities will face the same challenges in accessing the appropriate services that support oral health through the lifespan. Major factors to consider are language, culture, geography, income, type of employment, and lack of investment by public and private partners in core programs and services that improve health. The COHSP should be developed in partnership with communities experiencing the highest burden of oral health inequities to address the upstream determinants of oral health and to advance strategies that serve everyone. This can be done by leveraging existing trusted relationships and organizations within communities.

Additionally, before implementing strategies, it will be necessary to consider the community perception and receptiveness of strategies. It is recommended to evaluate whether strategy and implementation design is responsive to the needs, values, and lives of impacted communities. For example, partners interviewed expressed interest in teledentistry as a means to expand coverage to poorly and never served communities, but focus group participants expressed skepticism regarding how well the technology would work for dental services. Education to increase the public's knowledge of and comfort with accessing teledentistry should also be considered.

Finally, there is an opportunity to strengthen the scale and suitability of the workforce supporting oral health across Colorado in public health, clinical, human services, educational, and other systems. Increased funding could enable more individuals from communities with the most oral health inequities to be employed. However, concurrent strategies are necessary to provide the existing workforce a clearer understanding of health equity, strategies for achieving it, and how to best pursue these strategies during day-to-day work activities. Efforts should also be made to increase the number of staff who speak the languages of the communities being served.

COLORADO ORAL HEALTH STRATEGIC PLAN

Introduction and Background

The Colorado Department of Public Health and Environment (CDPHE) is embarking on the development of a comprehensive Colorado Oral Health Strategic Plan (COHSP) designed to address the systemic inequities that lead to poor oral health outcomes statewide. The goal of this work is to create a plan in close collaboration with underserved, poorly served, and never served communities to design a COHSP that helps tackle the systemic inequities that lead to poor oral health outcomes statewide.

Good oral health supports the essential human functions of chewing, swallowing, speaking, and smiling and is a key component to overall health. In Colorado, many communities continue to experience health inequities resulting from a lack of historical and current investments by multiple sectors and from systemic inequities in access to health. Research has demonstrated that individual and community attributes, such as race, age, geography, and other social determinants of health, highly influence oral health outcomes.

Fortunately, over the last decade, Colorado's Oral Health Network (COHN) has made significant strides in decreasing oral health inequities. The COHN is composed of community-based organizations, philanthropies, training programs, clinical systems, state programs, and other partners.

Despite this progress, there has been no system of prevention, financing, and care that ensures optimal oral health for underserved and never served communities. The COHN has not had regular opportunities to collaborate, as a result of the loss of Oral Health Colorado, the statewide oral health coalition that ceased day-to-day operations several years ago. The Colorado Oral Health Strategic Plan is a necessary tool to guide state and community partners to eliminate oral health inequities in Colorado's underserved and never served communities.

History and Purpose

The Oral Health Unit (OHU) is part of the Health Access Branch within the Prevention Services Division (PSD) at the Colorado Department of Public Health and Environment (CDPHE). In 2018, the OHU was one of 20 state health departments awarded the State Actions to Improve Oral Health Outcomes cooperative agreement from the U.S. Centers for Disease Control and Prevention (CDC) Division of Oral Health (CDC 18-1810). Colorado's oral health coalition, Oral Health Colorado (OHCO), facilitated the development of the statewide plan and maintained it until OHCO lost funding. The OHU has spent considerable time and effort to sustain several important pieces of OHCO's

critical work, including overseeing and supporting the development and implementation of the 2022–2027 statewide oral health strategic plan, referenced here as the COHSP.

Co-developed with underserved, poorly served, and never served communities and other oral health partners, the COHSP will focus on the systemic inequities that lead to poor oral health outcomes and will envision an equitable oral health system statewide.

One method for ensuring that the needs of underserved communities remain at the forefront of a process is the creation of a Plan Design Team (PDT). The COHSP PDT is made up of COHN members from community and human services organizations. The PDT provides expert guidance to ensure the strategic plan development process and final plan prioritize equity-focused strategies and partnerships. Additionally, the PDT provides oversight to help guide culturally appropriate messaging and engagement of communities.

INFORMING PERSPECTIVES

To inform the strategic planning process, CDPHE's OHU sought feedback on the state of oral health in Colorado. CDPHE contracted with Joining Vision and Action (JVA) to facilitate a community and partner engagement process to gain a more comprehensive understanding of what is currently working in the state, as well as to gather feedback on potential areas of improvement and collaboration.

This report will be shared with key partners prior to strategic planning sessions to inform the generation of strategies that address the current state of oral health as experienced by the community, the oral health network, and other partners.

Data Collection Methods

Informed by a mixed-methods research approach, the following report highlights feedback gathered from multiple partner groups, including community members, community-based organizations, representatives of state programs, and organizational partners. Data was collected through focus groups with community members, interviews with representatives of state agencies and partner organizations, and a survey administered to members of the COHN. The data presented in this report will provide a snapshot of the state of oral health in Colorado to inform the strategic planning process.

RESEARCH FINDINGS

Focus Groups

Key takeaways

Connectedness and Communication are Community Strengths
In talking about strengths of their communities in relation to health and healthcare, participants mentioned education and communication, and many felt their communities take care of and look out for each other. Trusted information sources mentioned most frequently were schools, faith leaders, health specialists, community resource centers, and family and neighbors.

Systemic Barriers Prevent Community Members from Prioritizing Oral Health
Barriers to accessing and prioritizing oral health identified by focus group members speak to upstream determinants of health such as economic inequities, lack of transportation infrastructure, inequitable accessibility of resources and services, and education. Community members identify economic barriers such as the high cost of dental service, lack of insurance or Medicaid (though it was noted that costs are high even for those who have coverage, and jobs), and systemic workplace inequities such as difficulty taking time off to accommodate the current system of oral health care delivery (e.g., dental services offered only during working hours). Communities may face a lack of transportation options and availability of oral health clinicians in their geographic region, which speaks to inequities in resource infrastructure. Finally, the current oral health care system may not be culturally relevant to all Colorado communities. Focus group participants mention not being able to find a dentist who speaks their language or has familiarity and understanding of their culture, even if the office has staff who do. Participants also indicated feeling that more community education and awareness about oral health care and resources, and more diversity and cultural awareness among clinicians, would be beneficial.

Community Voice Must be Elevated
Although participants in the focus groups represented a diverse subset of the population, the following steps are recommended to gain a fuller understanding of how the findings outlined above impact communities with historically the highest burden of oral health inequities.

- **Solicit input—via focus group, interview or other method—from the following populations:**
  - **Older adults.** No focus group participant was over the age of 44.
  - **Persons with disabilities and members of the LGBTQ+ community.** Few participants identified as belonging to these

populations, and research indicates these groups face additional barriers to accessing healthcare services.

  - **Refugees and people experiencing homelessness.** Few participants identified as members of these populations. Partnering with community-based organizations may be an effective way to reach these populations in larger numbers.

- **Conduct focus groups in the top five to 10 languages spoken in Colorado.** Initial focus groups were only conducted in English and Spanish.
- **Hire local and trusted interpretation services.** This will increase the likelihood of participation.
- **Partner with and compensate community-based organizations to host focus groups.** Many populations are best reached and best served by organizations they already have ties to. This may also be the best approach for reaching communities for whom safety and security are of particular concern, such as survivors of intimate partner violence or people without documentation.
- **Develop simplified ways for community members to provide feedback**. This may include reaching out to individuals at events such as congregate meal sites for older adults, or soliciting comments via video.
- **Dive more deeply into questions of whether community members trust dental care clinicians and why.** Again, these questions will be best explored through partnering with organizations that community members already have positive, trusting relationships with.

Focus group background

JVA facilitated six focus groups with community members from across the state. Four groups were facilitated in English, and two in Spanish. One of the focus groups facilitated in English consisted of members of a youth advocacy council who ranged in age from 14–18 years old. Of the 56 focus group participants, 49 completed a follow-up survey. Of these respondents, 67% identified as male, 54% as Black/African American, and 31% as Latino/Latina/Latinx. (See Appendix C for additional details on the focus groups and participant demographics.)

Community strengths, assets, and outreach

Participants describe communities in which people connect, support each other, and draw strength from communication and education. Connection to the community at large comes from participation in activities such as sports, fitness, and volunteering. School staff, faith leaders, health specialists, food banks, other resource centers, family members with medical backgrounds, and neighbors provide trusted information to individual community members. Communication also happens online via WhatsApp and

Facebook groups, and telehealth platforms. Participants most frequently identify mothers, wives, and family dentists as those who are talking to them about keeping their mouths healthy, with messages about flossing regularly and not eating candy or smoking.

Use of dental services

Community members in these focus groups expressed their belief that their dental care is very important. However, they also noted that they must prioritize necessities such as feeding their families and paying other bills over paying for dental care.

Community members who do not have a regular dentist cited lack of insurance and the high cost of dental services as the main barriers to accessing care. Those who live in rural communities said they struggle with access to services, with some saying there is only one dentist office in the town where they live and others saying they would have to travel more than an hour to see a dentist.

Adult participants said they are more likely to prioritize preventive dental care for children, which is consistent with youth focus group participants mentioning visiting a general dentist or orthodontist. Participants who had a regular dentist were more likely to go if they were actively treating a dental problem such as pain or bad breath. When asked where they go when they or their family members experience a dental emergency, participants identified the following: their regular family dentist, their family doctor, or the hospital. Several participants also mentioned that they seek information online through Google, WhatsApp, or Facebook groups, or reach out to family and friends for advice before going to a medical or dental office.

Access to dental services

Cost was the most common barrier to accessing dental services, regardless of insurance status, which aligns with national barriers to care. For those who do have Medicaid or insurance to cover dental services, some said there are a lot of limitations on what is covered. Some participants mentioned some knowledge of sliding-fee-scale or low-cost clinics, but none were aware of credit models, such as CareCredit, as an option to pay for dental services. Spanish-speaking participants also said language barriers impact their ability to understand what insurance will cover. One focus group participant raised the issue of safety and privacy for immigrants who lack documentation status, relaying that accessing services may not be safe for many Coloradans.

> *"If insurance was more affordable, we would get it. But having limited economic resources means we can't afford them. Language barriers are an issue, too, not being able to understand what the insurance would cover. Disconnect between services and immigrant communities. People don't want others to discuss their legal status, especially because ICE raids recently. People think local orgs gave their info to ICE."*
>
> – Focus group participant

Transportation, especially in rural areas, was also named as a barrier to accessing services, along with a lack of appointments outside of working hours and a lack of emergency dental clinics.

When asked if they feel comfortable and respected accessing dental services and if they feel their cultural background is recognized and accepted, most participants said yes, they do feel respected, but some also indicated that better cultural awareness is important and suggested training for dental professionals.

> *"I think if they had knowledge about certain cultural backgrounds/ practices, like religious headwear/headgear; like the ins and outs of when someone is sitting down, what they should touch or not touch; I think that would be helpful, better awareness about that."*
>
> – Focus group participant

Spanish-speaking participants noted that there are always staff who speak their language at the dental offices they go to, but the dentists themselves may not, and they would prefer seeing a dentist that speaks their language. A Black participant indicated that it is hard to find Black dental clinicians.

One focus group participant said she always seeks services in Spanish but they are not always available. She described a recent visit to a clinician with her husband, who does not speak English. She explained: "I speak good English. I felt the provider was uncomfortable. She referred my husband elsewhere but kept me. We didn't understand why she sent him away. It was disheartening because it felt like racism against my husband for not speaking English. It's an uncomfortable situation for an expensive, paid service. It would be ideal to have someone who understands the culture and language."

Participants were also asked if they trust what they are told regarding a dental clinician's plan of care and the associated costs. Most but not all participants said they trust what they are told. Spanish-speaking participants in particular noted that treatment is often more expensive than they expect and they often seek a second opinion or third-party advice.

> *"Seems to me, I go to the dental office for one thing and they find so many more things to charge me for. I never feel comfortable with them taking me to a side office and start 'convincing' me to go on with a super expensive plan."*
>
> – Focus group participant

Community dental programs

Most focus group participants indicated that when they need dental care, they go to a dentist's office for services. They were generally not aware of other community-based programs (which may or may not exist in their communities), aside from what is offered for children in schools. When asked about places in the community where they think dental services should be offered, responses included churches, hospitals, colleges, the mall/commercial centers, and at work. However, a couple of participants thought such locations might lack necessary space, equipment, or funding to provide dental services. Some of the youth participants who are athletes mentioned that colleges have come to their high schools to offer physicals and physical therapy visits and that perhaps this

could be done with dental services, too. Notably, youth also mentioned that there was a lot of emphasis on dental care in elementary school but that once they got to high school, that stopped. One participant mentioned a desire for navigators, perhaps at schools, to provide information on available services and help families sign up for them. Schools were noted as one of the most common sources of information about dental care and services, which presents a potential gap for adults without children.

Community water fluoridation

Participants were asked if they have ever heard about fluoride being added to their tap water and if they know how it helps their teeth. Some were aware of this practice but didn't know much about it, and several participants said they do not trust tap water in general. Reasons for this mistrust of tap water include that they "don't trust the source," aren't sure if the water is treated, or have concerns about the impact of aging pipes. One participant reported having "heard that tap water makes you docile," but did not specify whether this was related to fluoride. Overall, participants were interested in learning more about fluoride in tap water and how it helps their teeth and said they don't mind fluoride being added to the water if there are no side effects.

> *"As fluoride helps prevent cavities in the teeth, so when added to the water, I think it's nice and more effective in helping to maintain the teeth."*
>
> – Focus group participant

Perceptions on teledental services

A little over half of participants in English-speaking focus groups were open to the idea of teledental visits or consultations. Some people said they could see using such a service to seek advice or to follow up after a dental visit, and one participant specifically highlighted its potential in emergencies. Several others who were open to teledental care did not specify in what scenario they foresaw using it. Meanwhile, one youth participant who is in college out of state mentioned having a device that attaches to a phone to allow the orthodontist to check on the student's braces without the student having to come into an office, which is convenient. Other participants thought teledental service could be helpful for people with mobility concerns but suggested there would be limitations for those who are less comfortable managing technology and noted that emergencies and pain can't be managed through an app.

When it came to the Spanish-speaking focus groups, however, about 60% of participants said they would not consider teledental services because they would not trust a virtual diagnosis, it would be more difficult to show the dentist where the pain is, they lack an adequate computer or adequate internet service, or they think teledental services would be uncomfortable or "weird." One Spanish-speaker noted that although she has used other telehealth services, she would not do so for dental care. Other participants in the focus groups in Spanish said they would at least consider teledental services for "initial visits," "knowledge," or "counseling."

> *"No, that wouldn't make sense to me. I've done virtual visits for my daughter, but it doesn't feel like we actually get checked out. I prefer to take her and have her seen in person. I could tell them the pain I have, but how would they know virtually?"*
>
> – Focus group participant (Spanish facilitation)

State Program Interviews

Key takeaways

Collaboration and partnerships are critical. Respondents tended to identify partnership and collaboration as a core value of their agencies, as well as a strategy currently being used to work toward health equity. This theme also appeared in the ideas that respondents listed for increasing health equity, such as partnering with the community for planning and strategy development, as well as collaboration and engagement with all partners. This appears to be an important area in which OHU could play a role; respondents indicated that OHU could facilitate connecting programs, sharing best practices and data, and ensuring that agencies understand each other's work and roles.

Access is a top priority. Increasing access to services that prevent and manage oral diseases emerged across responses to several different questions and was a common theme when participants were asked to share the intended outcomes of their work. Access was also listed as a challenge faced in working toward achieving health equity, with specific barriers to access including transportation in rural areas. Respondents indicated that OHU could expand access to oral health services through general system change and by providing specific services (at schools, for example). Finally, access to care in all areas of Colorado was listed as an ideal outcome of the COHSP.

Increased awareness of oral public health and oral health is needed. Responses to several questions suggest that respondents perceived a need to expand awareness of programs providing oral health services and overall oral health education among their priority communities. A lack of awareness was listed as a challenge faced in working toward health equity, both in terms of individual Medicaid recipients being unaware that they are eligible for benefits and there being a need for more community awareness of oral health and resources available. There was a particular gap noted for individuals who are not eligible for certain programs—interviewees indicated that programs tend to reach

out to eligible populations, but those who do not qualify for those programs miss out on information. Increasing awareness was also listed as an idea for increasing health equity, and interviewees indicated that OHU is well positioned to distribute information and coordinate campaigns and communications with the public.

Workforce development is foundational for equity efforts. Interviewees frequently mentioned activities and strategies focused on better preparing members of the oral health workforce to work toward health equity and the general oral health of the community. For example, interviewees suggested encouraging diversity in faculty and student populations and training staff on equity considerations as strategies for promoting health equity. The need for a workforce that is reflective of the community was also listed as a challenge for achieving equity, and the need for increasing the number of bilingual staff that spoke the first language of patients was frequently cited for both clinical and nonclinical programs.

Agencies recognize that community voice should drive their priorities, yet that is not reflected in practice. Interviewees listed prioritizing community engagement and inclusion as a strategy for increasing health equity. However, when asked to describe how their agencies determine their priorities, they chose program participants and consumers least frequently, with local advisory groups coming in third after federal funding/guidelines and legislation. This may suggest that agencies are not able to set their priorities based on input from the communities they serve as much as they would like. This could relate to interviewees' observation that state funders such as the OHU can be challenging to work with as a result of rigid processes and a top-down approach.

State program interview background

To inform the strategic planning process, CDPHE sought to understand the current state of oral health resources and identify areas of success and opportunities to advance oral health equity in Colorado. Thus, JVA worked with CDPHE's OHU to facilitate interviews with representatives of state programs that have a direct impact on oral health. Interviews were conducted via phone or Zoom, using a standardized, semi-structured set of questions to guide the conversations.

Participants

Participants in these interviews represented the agencies listed below in alphabetical order. See Table 7 in Appendix D for descriptions of the work each organization does:

- Colorado Department of Education (CDE)
- Colorado Department of Health Care Policy & Financing (HCPF)
- Colorado Department of Human Services (CDHS) Office of Early Childhood (OEC)
- CDHS Head Start Collaborative Office (HSCO)
- CDHS State Unit on Aging (SUA)

- CDHS Long-term Care Ombudsman (LCO)
- CDPHE School Based Health Centers (SBHC)
- CDPHE Maternal Child Health (MCH)
- CDPHE Health Promotion Chronic Disease Prevention Branch (HPCDPB)
- Department of Regulatory Agencies (DORA)
- University of Colorado School of Dental Medicine (UCD)

Participants were asked how their agencies determine their **priorities**, and the following responses were provided (listed in order of frequency mentioned):

- Federal funding/guidelines
- Legislation
- Regional/local advisory groups
- Community needs assessments
- Accreditation guidelines
- Training and competency standards
- Program participants
- Consumers

They were also asked to share the **intended outcomes** of their work, and the primary themes that emerged are as follows (in alphabetical order):

- Improve systems and service delivery
- Increase access to services and support
- Protect the legal rights of underserved populations
- Reduce barriers and racial inequities
- Respond to local needs
- Understand intersections of various types of health and healthcare systems
- Use resources in efficient and effective ways

When participants were asked about the **core values** of the agencies they represent, the following themes were identified (in alphabetical order):

- Accountability and transparency
- Advocacy, sustainability, and prevention
- Community engagement and inclusion

- Equitable delivery of and access to resources and services
- Fiscal responsibility and consumer protection
- Integrity, professionalism, and quality standards
- Partnership and collaboration
- People-first approaches that provide dignity, empowerment, self-determination, and autonomy

Understanding of equity and strategies used

Participants were asked to share what equity means to them and their agencies and what strategies they are using to promote health equity in their work. The following statement summarizes the responses by the majority of state program staff interviewed for this report on the meaning of equity:

> *Health equity means everyone gets the services and resources they need in order to have opportunities to get and stay healthy, regardless of identity, geography, or insurance status. Policies and practices designed to meet the needs of the most vulnerable, historically underserved populations will benefit everyone.*

Strategies that state program representatives are using to work toward health equity revolved largely around integrated healthcare models, workforce development focused on recruitment of diverse candidates, person-centered/equity-focused strategies, and demographic data collection and use. Multiple interviewees mentioned the need to tailor programs and services to those who have historically experienced the most barriers, making funding more accessible and equitable, and leveraging partnerships to access and engage underserved communities. Workforce shortages and limitations were the most common challenges mentioned to achieving health equity, followed by lack of community awareness around resources, benefits, and connections between oral health and overall health. Also mentioned were access barriers, including transportation and technology, and funding limitations and arduous processes associated with accessing available funding.

State programs that have a core focus on systems change highlighted the need to understand, leverage, and seek to appropriately organize the delivery of different governmental services to improve community health. Individuals seeking to align statewide systems to support “no wrong door to oral health” approaches discussed leveraging taxpayer dollars to provide the right services, at the right time, in the right way for communities with inequities.

Ideas for improvement related to health equity

Participants were asked to share their thoughts on ways to improve systems and service delivery to work toward improving health equity. The results are grouped by theme in the tables below. Notably, in every state program interview, community engagement and inclusion of community voices was mentioned.

> *"The magic happens at the local level; communities figure it out. They problem solve on their own because they're not waiting for you at the state ..."*
>
> – State program representative

Table 1. State interviewees' ideas for increasing health equity: Community and partner engagement

Community and Partner Engagement
Collaboration and engagement with all partners
Community advisory boards to provide strategic direction and oversight of state programs
Intentional and authentic partnership with and empowerment of community to assist in planning and strategy development
Investment in education and information sharing to increase community awareness of the importance of oral health and available resources

Table 2. State interviewees' ideas for increasing health equity: Systems level

System Level
Direct services, enabling services, and systems and policies that facilitate equity from the top of the pyramid
Health and racial equity questions for vendors and a technical assistance plan, standards, and requirements to support that
Ongoing assessment of programs to drive changes/improvements
Pilot projects or strategies focused on populations facing inequities
Planning and development of more flexible systems that meet community health needs while decreasing barriers to services
Strategies for flexible funding and equitable distribution of funding (driven by population data, statewide needs assessment, and partner feedback)

Table 3. State interviewees' ideas for increasing health equity: Information and technology

Information and Technology
Evaluation plan that measures outcomes in terms of equity
Improved data collection and use, support for data infrastructure
Interoperable systems, cloud storage for patient data access
Training and technical assistance from oral health clinicians to medical clinicians to encourage them to do oral health screenings and know how to bill for them
Use of resources from CDPHE's Office of Health Equity and training resources from Oral Health Unit

Table 4. State interviewees' ideas for increasing health equity: Workforce development

Workforce Development
Establishment of a network of diverse public health, education, human services and clinical workforces, including those who speak languages other than English and Spanish
Home-visiting investment task force and awareness-raising about home visits
Learning and growth for professionals to understand how we got to inequity
Pay equity and work-life balance for oral health professionals
Webinars and education opportunities for nurses, focused on resources and prevention and how to use existing toolkits

Table 5. State interviewees' ideas for increasing health equity: Service delivery

Service Delivery
Translation and interpretation policies focused on language access and justice
Telehealth and virtual services
Medical and dental health integration, integration of all primary healthcare services
Translation/interpretation services at local level
Overservice to Black, Indigenous, and people of color (BIPOC) and people experiencing poverty
Integration of social, public health, education, and clinical services
Expansion of Medicaid clinicians to ensure we can serve all our members

Reflections on working with CDPHE's OHU

Participants who have experience working with or have knowledge of the OHU's work were asked to share some reflections on working with the department.

Overlap and opportunities for collaboration

State interviewees described specific areas of overlap with CDPHE's OHU including voucher programs, advocacy and educational support for oral health, and shared messaging strategies. Also mentioned were rule- and policymaking and overseeing licensure of oral health professionals.

When asked what future opportunities they see for collaboration with OHU, participants mentioned they would like to see additional funding and resources to support oral health screenings and cleanings at schools, sharing of training materials and provision of education to help nurses, distribution of oral-health-related information and tools for parents, and collaboration focused on policy and system change to increase access to oral health services for all Coloradans. It was also suggested that OHU could facilitate partners coming together to connect programs, share best practices and data, and better understand each other's work and roles. Development of a statewide oral health campaign and alignment of communication and education, in partnership with local communities, was another area that participants indicated OHU would be well positioned to take on.

Ideas for communication and relationship building

When asked what OHU and other state agencies can do to effectively communicate and build relationships, participants discussed a variety of methods already in place. The OHU newsletter was mentioned as a resource that partners can sign up to receive and share with their network, and participants shared that webinars were very helpful during the COVID-19 pandemic and should continue. It was suggested that OHU could have staff from other programs make presentations at OHU team meetings to help develop connections and share what various programs are working on. Diverse partner representation at meetings and sharing processes and decisions with the public were also mentioned. Overall, most participant comments revolved around themes of open communication and creating space to share ideas and gain understanding of what partners can and cannot do.

Barriers to working with OHU

Participants were also asked to discuss barriers they have faced in working with OHU. Responses were largely consistent with common sentiments about working with large government agencies. They described rigid processes involving a lot of paperwork, nitpicky details, and lengthy waiting times, primarily in relation to receiving funding. Interviewees suggested these challenges disproportionately hurt small communities and organizations with limited capacity. Inadequate capacity of organizations' staff and leadership to respond to requests from OHU was mentioned multiple times, and participants shared that they think the department should bring partners together to make decisions jointly about how work should get done, as opposed to setting standards for those doing the work to follow.

Participants also mentioned that they are not always sure if work they are asked to do for OHU is actually used and that there seem to be hidden agendas at times. Another notable comment was that communication happens more in panic situations and that a lot of strategic planning is taking place right now in public health, so there is a critical opportunity to align these plans in a thoughtful and proactive way. It is important to take note of these barriers discussed, while acknowledging that participants talked much more about the strengths surrounding their work with OHU and indicated a strong desire to continue collaborating to improve the state of oral health in Colorado.

Vision for the future of oral health in Colorado

Participants were also asked to share their ideal vision for the future of oral health, and health in general, in the state. Interviewees talked about providing the best healthcare and health equity to all residents, investment in prevention and education, coordinating care across an individual's life and assessing how lived experiences affect health outcome, and coordinating meaningful collaboration among partners doing related work.

Specific to oral health, participants expressed the desire to have a dentist in every town so no one needs to travel for care, more pediatric dentists, and the establishment of an oral health unit in a new department focused on health equity. It was suggested that OHU can support these things through grants and trainings, education and toolkits, and

by providing community engagement touch points and asking questions that can elicit wider responses (e.g., what does “healthy” mean for this community?). Another suggestion was a shared platform through which partners could provide and access community engagement information to ensure data is being compared. This would serve as a tool to help partners collaborate to achieve their vision for oral health equity.

Ideal outcomes of strategic plan
Finally, participants were asked to share what they would like to see reflected in the COHSP, and the following themes emerged:

- Access to care in all areas of Colorado
- Strategies to connect parents to clinicians
- Services for undocumented students and families
- Staff dedicated to connecting with other programs
- A crosswalk framework that is actionable and has an accountability plan
- Investment in education and clinician expansion
- Broad partner feedback on the COHSP
- A living document with room to change as life and partners change
- Big-picture goals, but realistic and achievable objectives so it can be use

Key Informant Interviews

Key takeaways

Among the representatives from state and national funding partners, community-based organizations, policy and research organizations, clinicians, and membership organizations representing clinicians who were interviewed, similar themes emerged around goals, approaches to equity, and areas they would like to see addressed.

Access for all is the No. 1 goal. While organizations might apply different levers (such as increasing affordability and coverage, promoting awareness, or community partnerships) to move toward this goal, equitable access to and use of oral health services is the overarching goal across organizations.

Innovative and flexible service models are a key strategy to promote equitable access. These could include anything from teledentistry or mobile care clinics to promotores de salud models or trauma-informed care. However, organizations piloting or offering these types of models often face an uphill battle in terms of ensuring alignment with existing practice act guidance, finding sustainable funding, and expanding their programs.

Involving the community is key to serving the community equitably. Community involvement can occur at a variety of levels, from partnering with multiple community members in the design and decision-making process for services, to ensuring the community sees itself represented in an organization's staff, board, and broader workforce.

Data can open the door to informed decision-making. Organization representatives recognize the power of data and are already leveraging it when they can to ensure they are effectively serving their community by using demographic analysis. However, data is often siloed, difficult to access, or collected and stored haphazardly across different organizations.

We can't do the work without a diverse, prepared workforce. The current workforce struggles with burnout, student loans, lack of diversity, and siloed training. Additional funding and efforts are needed to recruit and adequately prepare a workforce that represents its members' communities and knows how to employ modern strategies for oral health.

We need to come together. Ultimately, none of the above strategies can be effectively addressed without some *coordination around systems-level policy change that moves toward integrating oral health with other health systems*. This level of unified coordination could also promote knowledge sharing, streamlined data collection and use, and shared messaging to promote oral health as a priority in Colorado.

Background

JVA worked with CDPHE to identify and interview key partners whose work relates to or overlaps with that of the OHU. Interviewees represented state and national funding partners, community-based organizations, policy and research organizations, clinicians, and membership organizations representing clinicians. Specific organizations are listed below in alphabetical order, and a table describing their work can be found in Table 8 in Appendix E. Interviews were conducted via phone or Zoom, using a standardized, semi-structured set of questions to guide the conversations.

- AFL Enterprises, LLC
- CareQuest
- Caring for Colorado Health Foundation
- CDHS Community Partnerships
- CDPHE Prevention Services Division
- Colorado Consumer Health Initiative
- Colorado Community Health Network
- Colorado Dental Association
- Colorado Dental Hygienists' Association

- Colorado Health Institute
- Colorado Trust
- Delta Dental of Colorado
- Denver Health
- Kids in Need of Dentistry
- Servicios de la Raza

Across all of these organizations, access to oral health care for all was a recurring goal, though representatives named a variety of levers used to increase this access depending on whether the strategies were short-term or long-term, as summarized in Table 6, below. Note that the longer-term goals around improving access to oral health services more explicitly addressed equity and diversity, as well as improving oral health and overall health outcomes.

Table 6. Short- and long-term goals of program interviews

Lever to increase access	Number using in short term	Number using in long term
Growing the workforce (increasing diversity, cross-training)	4	3
Increasing awareness	3	0
Integration with other health systems	3	2
Affordability/Insurance coverage	2	1
Improving data collection/Measurement	2	2
Community partnership/collaboration	1	3

As seen in the table above, a focus on workforce was consistent regardless of time frame, but overall, longer-term strategies moved away from awareness toward more community partnership and collaboration.

Organizational equity practices and strategies

In addition, organization representatives conveyed that they were also engaging in practices to improve equity as they worked toward their short- and long-term goals. The most common practice was adopting a community-focused model (such as trauma-informed care, anti-poverty work, or family partnership models). This was followed closely by increasing diverse representation among their board, staff, or broader workforce and by providing training on equity. Several organization representatives also highlighted the practices of tracking demographics of those served to ensure equity, as well as including community members in decision-making or feedback opportunities. A few of the interviewees mentioned addressing policy or broader systems, or making equity-focused work a funding priority.

While these organization representatives were able to identify a variety of strengths they brought to their equity work (content knowledge, their reputation and relationships, responsiveness to patients and equity concerns, diversity, and systems focus), they identified two main barriers: entrenched power structures and lack of resources (workforce, time, data, and financial support). When asked how they saw their strategies around equity evolving, most participants focused on how they could expand their focus and action areas through collaborative strategies that both leveraged technology and increased diversity of the workforce, ultimately resulting in policy change.

Partnerships and gaps

Collaboration across different types of organizations and systems remained a prominent theme, with participants identifying several different types of work and/or service provisions outside of their organizations that assist them in reaching their goals. These include the philanthropic community, screening services, and state and national programs. Other, broader categories of support included opportunities for interprofessional communication, access to relevant data, trainings, and direct access to the community.

As organization representatives discussed methods for leveraging partnerships to further their goals, several key gaps in their oral health work were also identified. The most prominent was the lack of unity, resulting in a lack of a coordinated plan, coordinated advocacy, and coordinated messaging. Another prominent gap identified was the lack of financial support, both for programs and for the workforce specifically. Lack of adequate data, or inability to access and use existing data, also came up frequently as a problematic gap in the current system. Less frequent, though still mentioned multiple times, were the issues of a lack of innovative service models such as teledentistry and mobile medical units; systemic barriers such as siloed health record systems and lack of insurance reimbursement for oral health because it is not integrated with other medical insurance; and workforce limitations.

Ultimately, all of the gaps identified came up again when organization representatives were asked how the strategic plan could reflect their goals. Overall, the requests focused on creating a unified effort that brings together diverse partners to create coordinated messaging and advocacy strategies. Such strategies could bring about policy change in the key areas of: 1) increasing flexibility and sustainability of oral health funding, including funding to increase, diversify, and train the workforce, 2) integrating oral health care with other healthcare systems, and 3) coordinating effective data collection and use.

Not all of the organizations invited to participate in a key informant interview were available at the time of the interviews. JVA and the OHU are continuing to engage other partners, with a focus on gaining insights from more community-based organizations and state programs.

Survey

Key takeaways

CDPHE leveraged its network to ensure that partners from a wide range of organizations providing oral health services could provide feedback via this survey. Moving forward, CDPHE should seek input from entities that so far have not been strongly represented in this process. This should include organizations providing consumer protection services and those providing oral health services at work/home and in more institutional settings (e.g., long-term care or detention).

In regard to strategies for promoting oral health equity, it may be worth investigating why organizational leaders and other respondents have diverging opinions and perceptions on some topics related to oral health equity. The following areas of divergence are especially noteworthy:

- The degree to which staff reflect the demographics of the communities they serve
- The importance of improving access to/awareness of services
- The importance of increasing advocacy for equitable oral health policies
- The importance of expanding the number/coverage of clinicians

Responses from all participants suggest possible strategies for increasing oral health equity in Colorado, including:

- Increasing accessible oral health services in community settings (and ensuring the community is aware of these services)
- Increasing the availability of funding and flexible funding parameters
- Improving access to demographic data

Regarding future engagement, respondents indicated they are eager to:

- See oral health interests supported in a coordinated, intentional way
- Have one centralized organization driving this work, but only if the chosen organization can do the following:
    - Fully represent all regions of Colorado, including rural communities
    - Be strong in advocacy, policy, and shared messaging
    - Find a balance between advancing oral health specifically (not losing it among other health interests), and integrating oral health into existing health and family/resource/education services

There is some momentum from individuals and organizations willing to be involved in this process, but coalition and consensus building will be needed to ensure the issues above are addressed.

Survey design and respondents

An in-depth survey was designed to give individuals working at partner organizations an opportunity to share insights on the state of oral health in Colorado. The survey covered the topics of oral health activities, oral health equity, and thoughts on future engagement. A total of 81 survey responses were collected. The largest percentage of respondents (40.74%) said their primary role was organizational leadership. That was followed by program administration/coordination (22.22%).

Survey respondents were also asked what type of organization employed them. They could choose as many responses as were relevant. The most common response was nonprofit organization, at 41.98% of respondents, followed by dental health care and public health department, each at 20.99% of respondents.

Asked what populations their organization prioritizes for oral health activities, most respondents said their organization prioritized children, with 60.49% of respondents indicating their organization served children ages 5 and under, and 49.93% indicating their organization served children ages 6–12. Participants could choose more than one answer. Respondents were also asked what geographic area their organization serves for oral-health-related activities. Survey takers could indicate serving more than one Health Statistics Region (HSR). More than half of survey respondents said their organization works statewide.

For more detailed information on survey design and respondents, see Appendix F.

It is important to consider the following findings within the context of the demographics of survey respondents. Although a diverse array of individuals responded to the survey in terms of role, type of organization, type of services, and geographic area served, as outlined above and detailed in Appendix F, some perspectives will be more represented in this data than others.

Oral health activities

Respondents were asked to select all of the oral-health-related activities their organization is currently conducting. The top two responses were promoting access to care, and data collection and evaluation (each chosen 35 times). These were followed by providing oral health prevention and management services (33), and policy and advocacy efforts to promote oral health (31). Nearly all options were chosen at least 11 times. The one exception was consumer protection, which was selected only twice. Participants could select more than one response.

Respondents that indicated their organization provided direct oral health services (i.e., general or specialty dental services, or oral health prevention and management

services) were asked a follow-up question on where they provided oral health services. The most commonly selected options were safety-net clinics, school-based health clinics, and community-based settings. At the other end of the spectrum, worksite, short- or long-term care facilities, in-home, and detention facilities were each selected only once. Participants could select more than one response.

See Appendix F for details on survey responses related to oral health activities.

Oral health equity

Strategies for promoting oral health equity
Respondents were asked to rate the importance of various strategies for promoting oral health equity in the context of their work, on a scale of very unimportant to very important. Overall, survey participants indicated that each strategy was important to promoting health equity in their work. The highest-rated strategy—improving access to/awareness of services—was rated a 4.4 out of 5. The lowest-rated strategy—collecting and analyzing demographic data—was rated a 4.

Organizational leaders tended to rate each item as higher in importance than did other respondents. In several cases, this implies that there are some items that organizational leaders believe are *very* important that other respondents believe are just important (e.g., improving access to/awareness of services, increasing advocacy for equitable oral health policies, and expanding the number/coverage of clinicians). In all other cases, respondents from both groups generally agreed that the item in question was important, but not *very* important.

Helpfulness of services/resources in elevating equity
Next, survey respondents were asked to rate how helpful various services or resources would be in elevating equity for their work, on a scale ranging from very unhelpful to very helpful. Mean scores generally suggested that each service or resource would be considered helpful to the overall group of respondents. The one exception to this was the most highly rated item, funding. This item's mean score of 4.5 indicates that slightly more respondents believe this would be very helpful.

Organizational leaders tended to rate each item as being more helpful than did other respondents, though this divergence was smaller than in the case of the previous question, and both groups generally agreed that each item would be helpful. There were some cases that broke this pattern, with respondents not in leadership positions rating tools, collaboration with other organizations that are equity focused, trainings on communicating equity and justice concepts and/or activities, and a community advisory board slightly higher than organizational leaders rated them.

Significance of barriers to oral health equity
Survey respondents were also asked to rate the significance of a list of barriers to achieving oral health equity for all Colorado communities, on a scale ranging from very

insignificant to very significant. Lack of accessible oral health services in community settings was rated the most significant barrier among the overall group of respondents, with a rating of 4.5, suggesting that respondents tended to see this barrier as very significant, while the remaining items were closer to significant.

Organizational leaders generally agreed with other survey respondents regarding the significance of these barriers.

Organizations' equity practices

The final question related to oral health equity asked respondents to rate their level of agreement with a series of statements about their organization's equity practices, ranging from strongly disagree to strongly agree. The overall group of respondents tended to agree with most of the statements, though none of the mean scores was greater than 4, suggesting that the group did not strongly agree with any of them. Two items had a mean score lower than 3.5 ("Our budget consistently has multiple line items for equity-advancing activities" and "It is routine practice to ensure community leaders and/or community-based organizations are able to provide oversight and regular input into organizational processes and decisions").

While organizational leaders and other respondents tended to have similar levels of agreement, this question contains a statement that showed the largest divergence between the two groups. There was nearly a full one-point difference in levels of agreement with the statement: "Our staff reflect the demographics of the communities we serve." Leadership tended to agree with the statement, while other respondents tended more toward the middle of the response range.

See Appendix F for details related to oral health equity survey responses.

Future engagement

Respondents were asked to rank three types of organizations in order of how they would prioritize them for funding. Across the board, survey takers were generally in agreement that funding for staff in an existing health coalition or other health group, to include oral health in organizational efforts, should be the top priority. Ranked second was funding for a stand-alone oral health coalition, similar to Oral Health Colorado; and third was funding for multiple organizations for specific issues.

Respondents were also given the chance to add their own option and rank it alongside the three above. Only six respondents filled in this field and ranked it higher than at least one of the three options listed above. These responses included funding to support a policy advocacy group (2 responses), a public health department in a school setting, tele-oral health services, and support for BIPOC organizations to help connect with their community needs.

Although a small number of respondents ranked their own option higher than at least one of the three prepopulated options, there were a number of responses to this

question that provide qualitative insight into respondents' feelings on funding future statewide oral health endeavors. The most repeated idea was that there should be ONE organization that this work is organized around, and that even if multiple organizations are funded, there should be one coordinating or backbone organization. Several participants wrote in ideas about what this organization should prioritize, including advocacy and policy, integrating oral health into general health and other settings such as schools, and coordinating messaging around oral health in Colorado to speak with "one voice." There were also individual responses calling attention to concerns about sustainability of funding and rural engagement, as well as a suggestion to get Oral Health Colorado back up and running as it was before.

Respondents were also asked an open-ended question to elicit their suggestions for an organization that may be able to fill the role previously held by Oral Health Colorado (i.e., being accountable for and advocating for equitable oral health of all Coloradans). For this question, respondents could list up to five organizations. There were 48 responses overall to this question. While the majority of responses were listed just once, some organizations appeared multiple times.

The below organizations were listed four times:

- Colorado Community Health Network (CCHN)
- Colorado Consumer Health Initiative (CCHI)

Seven organizations appeared twice:

- Caring for Colorado
- CLLARO [Colorado Latino Leadership, Advocacy, & Research Organization]
- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Colorado Department of Public Health & Environment
- Colorado Health Institute
- Trailhead Institute

All other suggestions appeared only once. Some general themes emerged across all responses. The majority of organizations named (29 responses, or 60.42%) are statewide organizations. There were, however, approximately 20% of responses that identified either a local organization or a decentralized approach (e.g., county health alliances, regional leads across the state).

Half of the organizations suggested as a replacement for Oral Health Colorado focus on general health concerns (52%), not oral health specifically (only 8%), and about a

quarter have a focus extending even more broadly, beyond health (policy, family resource centers, etc.). This aligns with the trends seen in the previous open-ended question, where responses indicate an eagerness to see advocacy for oral health interests across settings and inclusive of statewide interests.

The final question on the survey asked respondents if they, or someone from their organization, would participate in a coalition to address oral health equity issues in Colorado. Over half of respondents said yes (57.89%), while about a quarter answered "maybe." The remainder answered "no," as seen in Figure 14 below.

CONCLUSION

A comprehensive and equity-focused oral health strategic plan for Colorado must consider the needs of the community and oral health partners. With this in mind, CDPHE's OHU worked with JVA to identify barriers created by current systems and opportunities to meet the needs of partner programs and community members, with an emphasis on reducing inequity through upstream approaches to system change. A variety of themes rose to the surface through this engagement process, including challenges related to accessing oral health services; workforce limitations such as the need for more diversity and cultural awareness; coordination of programs, services, and data systems; and flexible funding that prioritizes community-driven approaches. These challenges are interconnected, so solving them will require collaboration and coordinated efforts to continue engaging the partners and community members who will be impacted by identified strategies in the development and implementation of strategies. For example, access is a key and multidimensional issue.

Solutions need to consider not only ways to increase the number, type, locations, integration, and accessibility of current services, but also intentional efforts to expand and support the workforce by increasing the number and type of clinicians, their representation of the communities served, and their cultural and linguistic skills. There also needs to be recognition of how public oral health work impacts the individuals making up the workforce and the barriers associated with accessing the necessary education and training to expand their skills. Upstream determinants of health should be considered in access and workforce development strategies, as should the needs of the impacted communities, which will vary across Colorado (i.e., a one-size-fits-all approach won't work).

As OHU moves forward with the development of the COHSP, it should continue to leverage community voice through an open and inclusive planning process and by providing opportunities for partners and community members to offer input on strategies identified. The COHSP should include realistic objectives to achieve big-picture goals, while also remaining flexible and responsive to a changing environment. Community strengths and connections should be considered throughout the design and implementation process by building authentic relationships with the communities most impacted by systemic inequities. This can be achieved by working in partnership with

organizations serving these populations and providing such organizations with the funding and technical assistance they need to engage those they serve.

Additional focus groups facilitated in collaboration with community-based agencies can continue to identify the needs of historically marginalized communities and evaluate potential strategies for reducing systemic barriers. Coordinated efforts among partners are necessary to move forward on systems and policy change work, so there is a clear need for funding to support dedicated staff to implement the identified strategies in the next phase of the COHSP. Additionally, partners were loud and clear about the need to revive a coalition to support the coordination of efforts, funding, communication, outreach, and unified messaging strategies to work toward oral health equity in Colorado.

There is a great deal of energy and enthusiasm from professionals engaged in oral health work and from members of the community to develop and implement actionable strategies for improving oral health equity in Colorado. An effective public health approach will emphasize upstream interventions that address social determinants of health and reduce the systemic barriers that contribute to oral health inequities.

APPENDIX A: ENGLISH FOCUS GROUP GUIDE

Background

1. Do you have a dentist you go to regularly for you or your family?
    a. Why or why not?
2. When you think about all the things you are juggling in your lives—your job, health, social life, family, etc.—how important is a healthy mouth in the grand scheme of things?
    a. What are the types of things you are dealing with that take priority or are more urgent over taking care of your mouth?
    b. And what makes taking care of your mouth important/a priority?
    c. If you have problems with your mouth, how does that impact you?
3. If you or members of your family experience a dental emergency, who do you go to for help?
    a. How did you get connected to that person/program?

Community Outreach

Now I want to talk a bit about your community and health.

4. First, tell me a bit about what makes your community strong? Share some examples of what your community or people in your community do to help strengthen it?
5. What are some examples of things your community does to help it be healthy?
6. When a challenge or problem comes up that affects a lot of people in your community, how does your community react and problem-solve?
7. Tell us about some people in your community who you trust when it comes to getting information and making decisions about you and your family's healthcare, dental and otherwise (e.g., teachers, school staff, faith leaders, neighbors, friends, business owners).
    a. PROMPT: What about when you have any health emergency?
    b. PROMPT: What about when you have a dental emergency?
8. Focusing on dental health, who in your life talks to you and your family about how to prevent cavities, problems or diseases in your mouth, etc.?
    a. What have you heard that really "stuck" with you?
    b. What have you heard that made a difference in the way you take care of your mouth?

Access to Services

9. Is it hard to get dental services? If so, what makes it hard?
    a. PROBE BARRIERS: transportation, insurance coverage, etc.

IF NOT ALREADY DISCUSSED:

i. How easy or hard is it to pay for dental services? How does it fit in your budget?
ii. Are you aware of programs available to your community that help make dental health affordable?
iii. If so, would you please share what they are?
iv. Have you used these programs, and, if so, what has been your experience?
v. Have you heard of or utilized CareCredit financing?
vi. If so, what have you used it for?
vii. Do you find it helpful?
viii. Would you still have accessed those services if you couldn't pay with CareCredit?
ix. What challenges have you faced in accessing/using CareCredit?

10. When you go to a dentist or dental office, do you feel comfortable and respected? Please share why or why not.
    a. When you see a dental provider do you feel that you can generally trust what they tell you about a plan of care and the associated costs?
11. Raise your hand/type in the chat/unmute and let us know if you have trouble accessing healthcare providers (dental or other) who speak your language.
12. Raise your hand/type in the chat/unmute if the staff/providers you go to for dental care look like you/share your cultural background.
13. Do you feel that who you are as a person is recognized, respected and understood by the providers you go to? Why or why not? (if needed explain that you are asking about background/culture/identity/age)
    a. How important is this to you, and why?
    b. What would recognizing, respecting and understanding your culture/background look like when you see a provider?

Community Programs

14. Dental care may be offered in lots of different places—at community health centers, at schools, WIC, Head Start, the pediatrician's office, etc. Raise your hand if you've already gotten dental care in one of these types of places.
    a. Would these types of offerings make a difference in your ability to get services? Why or why not?
        i. Where are the most important places these services could be offered?
        ii. What are the downsides of getting dental services in these types of places?

15. A friend tells you that a local dentist is offering virtual/teledental visits. Is this something you would consider using for yourself or your family? Why or why not?
    a. IF NEEDED: What would be helpful about seeing a dentist in a virtual visit (video visit, etc.)?
    b. IF NEEDED: What would be a barrier to (or reason for not) getting dental care virtually?
16. Have you ever heard about fluoride in your tap water?
    a. How do you feel about fluoride being added to tap water?
    b. Do you understand how it helps your teeth?
    IF NEEDED:
    a. How did/do you get informed about this topic?
    b. PROBE: When you think about you and your family drinking tap water, do you think it is good or bad overall? And why?
        i. Of everything we've talked about today with fluoride in drinking water, what is most important to you?

Closing

17. What questions about your community's health haven't we asked?
18. IF NEEDED/TIME: Are there any experiences with taking care of your or your family's mouths that we didn't get to that stand out to you? If so, what are they?

THANK YOU FOR YOUR THOUGHTS TODAY!

APPENDIX B: SPANISH FOCUS GROUP GUIDE

Fondo

2. ¿Tiene un dentista al que va regularmente para usted o su familia?

    A. ¿Por qué o por qué no?

3. Cuando piensa en todas las cosas con las que está haciendo malabares en su vida (trabajo, salud, vida social, familia, etc.), ¿qué importancia tiene una boca sana en el gran esquema de las cosas?

    A. ¿Cuáles son los tipos de cosas con las que está lidiando que tienen prioridad o son más urgentes que cuidar su boca?

    B. ¿Y qué hace que cuidar tu boca sea importante / una prioridad?

    C. Si tiene problemas con la boca, ¿cómo le afecta eso?

4. Si usted o algún miembro de su familia experimentan una emergencia dental, ¿a quién acudir en busca de ayuda?

    A. ¿Cómo se conectó con esa persona / programa?

Alcance comunitario

Ahora quiero hablar un poco sobre su comunidad y su salud.

5. Primero, cuénteme un poco sobre lo que fortalece a su comunidad. Comparta algunos ejemplos de lo que su comunidad o las personas de su comunidad hacen para ayudar a fortalecerla.

6. ¿Cuáles son algunos ejemplos de las cosas que hace su comunidad para ayudarla a estar saludable?

7. Cuando surge un desafío o problema que afecta a muchas personas en su comunidad, ¿cómo reacciona su comunidad y cómo resuelve el problema?

8. Cuéntenos sobre algunas personas de su comunidad en las que confía cuando se trata de obtener información y tomar decisiones sobre usted y su familia, la atención médica, dental y de otro tipo (p. Ej., Maestros, personal escolar, líderes religiosos, vecinos, amigos, dueños de negocios).

    A. PREGUNTA: ¿Qué sucede cuando tiene alguna emergencia de salud?

    B. PREGUNTA: ¿Qué sucede cuando tiene una emergencia dental?

9. Centrándonos en la salud dental, ¿quién en tu vida te habla a ti y a tu familia sobre cómo prevenir caries, problemas o enfermedades en tu boca, etc.?

A. ¿Qué ha escuchado que realmente se le “pegó”?

B. ¿Qué ha escuchado que marcó la diferencia en la forma en que cuida su boca?

Acceso a los servicios

10. ¿Es difícil obtener servicios dentales? Si es así, ¿qué lo hace difícil?

A. EJEMPLOS DE BARRERAS: transporte, cobertura de seguro, etc.

SI NO YA SE HA DISCUTIDO:

I. ¿Qué tan fácil o difícil es pagar los servicios dentales? ¿Cómo encaja en su presupuesto?

ii. ¿Conoce los programas disponibles en su comunidad que ayudan a que la salud dental sea asequible?

iii. Si es así, ¿podría compartir cuáles son?

iv. ¿Ha utilizado estos programas y, de ser así, ¿cuál ha sido su experiencia?

v. ¿Ha oído hablar de la financiación de CareCredit o la ha utilizado?

vi. Si es así, ¿para qué lo ha usado?

vii. ¿Lo encuentra útil?

viii. ¿Seguiría accediendo a esos servicios si no pudiera pagar con CareCredit?

ix. ¿Qué desafíos ha enfrentado al acceder / utilizar CareCredit?

11. Cuando va al dentista o al consultorio dental, ¿se siente cómodo y respetado? Por favor comparta por qué o por qué no.

A. Cuando consulta a un proveedor de servicios dentales, ¿siente que, en general, puede confiar en lo que le dicen sobre un plan de atención y los costos asociados?

12. Levante la mano / escriba en el chat / deje de silenciar y avísenos si tiene problemas para acceder a proveedores de atención médica (dentales u otros) que hablen su idioma.

13. Levante la mano / escriba en el chat / deje de silenciar si el personal / los proveedores a los que acude para recibir atención dental se parecen a usted / comparten su origen cultural.

14. ¿Siente que quien es usted como persona es reconocido, respetado y comprendido por los proveedores a los que acude? ¿Por qué o por qué no? (si es necesario, explique que está preguntando sobre antecedentes / cultura / identidad / edad)

A. ¿Qué importancia tiene esto para usted y por qué?

B. ¿Cómo sería reconocer, respetar y comprender su cultura / antecedentes cuando vea a un proveedor?

Programas comunitarios

15. La atención dental se puede ofrecer en muchos lugares diferentes: en los centros de salud comunitarios, en las escuelas, WIC, Head Start, el consultorio del pediatra, etc. Levante la mano si ya recibió atención dental en uno de estos tipos de lugares.

A. ¿Este tipo de ofertas marcarían una diferencia en su capacidad para obtener servicios? ¿Por qué o por qué no?

I. ¿Cuáles son los lugares más importantes en los que se podrían ofrecer estos servicios?

ii. ¿Cuáles son las desventajas de obtener servicios dentales en este tipo de lugares?

16. Un amigo le dice que un dentista local está ofreciendo visitas virtuales / tele dentales. ¿Es esto algo que consideraría usar para usted o su familia? ¿Por qué o por qué no?

A. SI ES NECESARIO: ¿Qué sería útil de ver a un dentista en una visita virtual (visita por video, etc.)?

B. SI ES NECESARIO: ¿Cuál sería una barrera para (o una razón para no) recibir atención dental de manera virtual?

17. ¿Alguna vez ha oído hablar del fluoruro en el agua del grifo?

A. ¿Qué opina de que se le agregue fluoruro al agua del grifo?

B. ¿Entiendes cómo ayuda a tus dientes?

SI ES NECESARIO:

A. ¿Cómo se informó / se enteró sobre este tema?

B. INDAGUE: Cuando piensa en usted y su familia bebiendo agua del grifo, ¿cree que es bueno o malo en general? ¿Y por qué?

i. De todo lo que hemos hablado hoy sobre el flúor en el agua potable, ¿qué es lo más importante para usted?

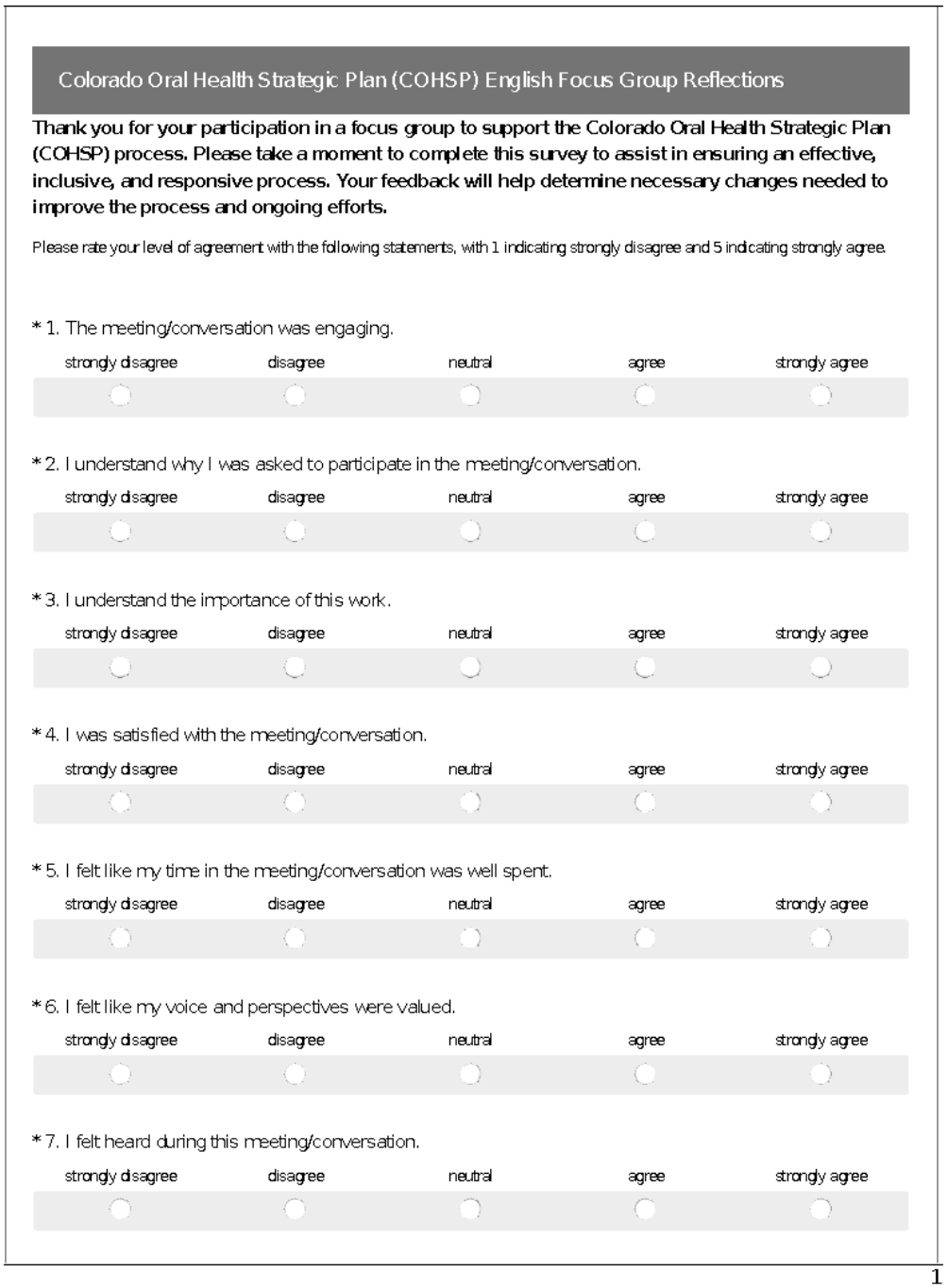
Cierre

18. ¿Qué preguntas sobre la salud de su comunidad no le hemos hecho?
19. SI ES NECESARIO / TIEMPO: ¿Hay alguna experiencia con el cuidado de su boca o la de su familia que no llegamos a destacar? Si es así, ¿Que son?

POR FAVOR DEJE SU EMAIL EN EL CHAT PARA ENVIARLE UNA ENCUESTA Y SU TARJETA DE REGALO.

¡GRACIAS POR SUS PENSAMIENTOS HOY!

APPENDIX C: FOCUS GROUP FOLLOW UP SURVEY AND FINDINGS



Colorado Oral Health Strategic Plan (COHSP) English Focus Group Reflections

Thank you for your participation in a focus group to support the Colorado Oral Health Strategic Plan (COHSP) process. Please take a moment to complete this survey to assist in ensuring an effective, inclusive, and responsive process. Your feedback will help determine necessary changes needed to improve the process and ongoing efforts.

Please rate your level of agreement with the following statements, with 1 indicating strongly disagree and 5 indicating strongly agree.

* 1. The meeting/conversation was engaging.

strongly disagree | disagree | neutral | agree | strongly agree

* 2. I understand why I was asked to participate in the meeting/conversation.

strongly disagree | disagree | neutral | agree | strongly agree

* 3. I understand the importance of this work.

strongly disagree | disagree | neutral | agree | strongly agree

* 4. I was satisfied with the meeting/conversation.

strongly disagree | disagree | neutral | agree | strongly agree

* 5. I felt like my time in the meeting/conversation was well spent.

strongly disagree | disagree | neutral | agree | strongly agree

* 6. I felt like my voice and perspectives were valued.

strongly disagree | disagree | neutral | agree | strongly agree

* 7. I felt heard during this meeting/conversation.

strongly disagree | disagree | neutral | agree | strongly agree

1

* 8. I felt like I could be honest during the meeting/conversation.

strongly disagree	disagree	neutral	agree	strongly agree
○	○	○	○	○

* 9. I felt respected during the meeting/conversation.

strongly disagree	disagree	neutral	agree	strongly agree
○	○	○	○	○

* 10. How did you learn about the opportunity to participate in this focus group? (Select all that apply)

- [ ] Someone emailed it to me
- [ ] It was shared in an email newsletter I receive
- [ ] I saw it on social media
- [ ] I saw a flyer
- [ ] Other (please specify)

11. Do you have any other comments, feedback, or thoughts that you would like to share about your experience in this process? Thank you for helping inform this work!

2

Colorado Oral Health Strategic Plan (COHSP) English Focus Group Reflections

Demographic information (optional)

12. With which option do you most identify? (Select all that apply)

- [ ] Male
- [ ] Female
- [ ] Nonbinary
- [ ] Not listed (please specify)
- [ ] Transgender
- [ ] Prefer not to answer

13. What are your pronouns? (Select all that apply)

- [ ] She/her/hers
- [ ] He/him/his
- [ ] They/them/their
- [ ] Prefer not to answer
- [ ] Not listed (please specify)

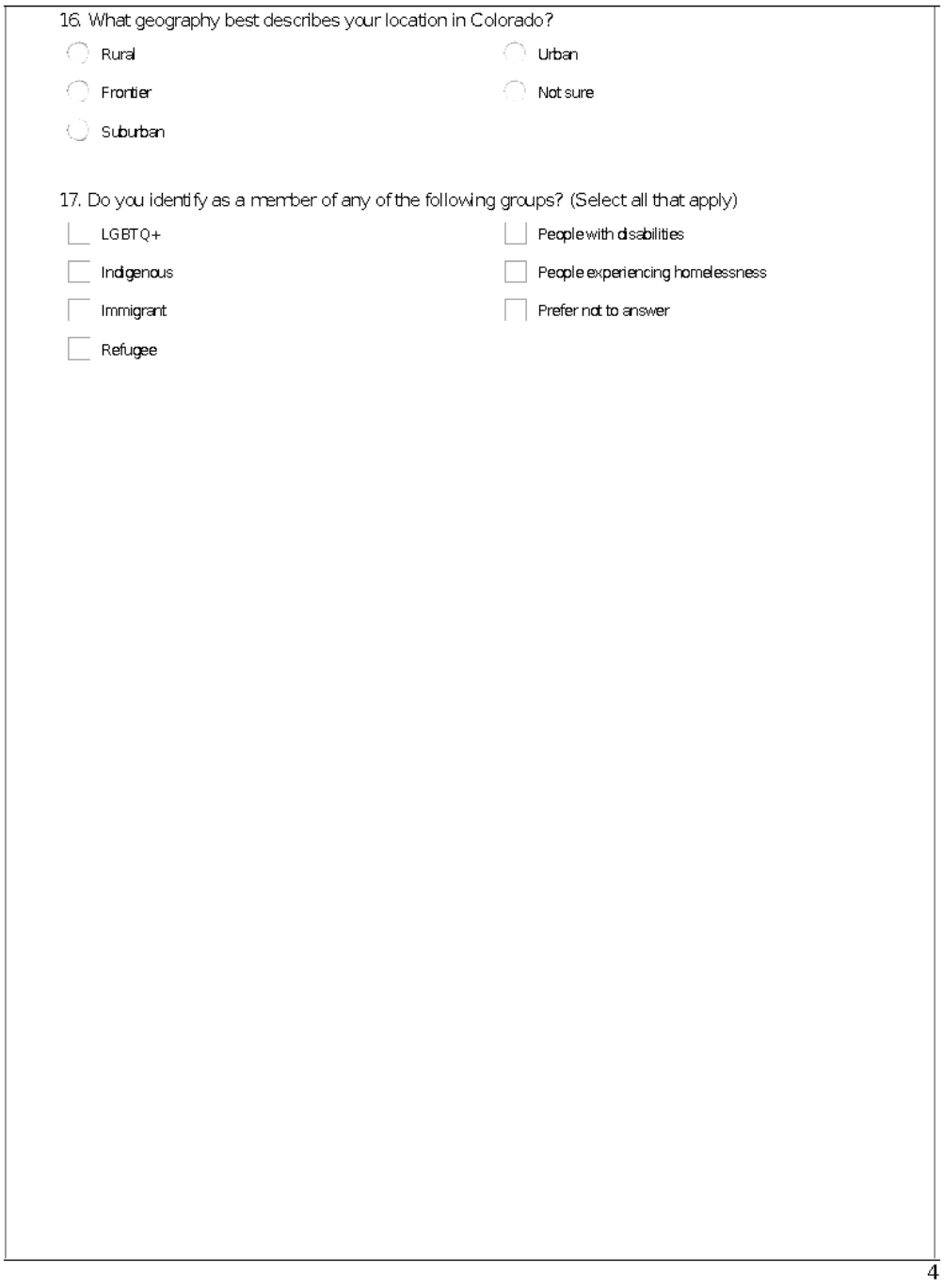
14. What race/ethnicity best describes you? (Select all that apply)

- [ ] Asian, Pacific Islander or Native Hawaiian
- [ ] Black or African American
- [ ] Latino/Latina/Latinx or Hispanic
- [ ] Middle Eastern or North African
- [ ] Not listed (please specify)
- [ ] Native American or Alaska Native
- [ ] White
- [ ] Prefer not to answer

15. What is your age range?

- ( ) Under 18
- ( ) 18-24
- ( ) 25-34
- ( ) 35-44
- ( ) 45-54
- ( ) 55-64
- ( ) 65+

3


16. What geography best describes your location in Colorado?

- ○ Rural
- ○ Urban
- ○ Frontier
- ○ Not sure
- ○ Suburban

17. Do you identify as a member of any of the following groups? (Select all that apply)

- ☐ LGBTQ+
- ☐ People with disabilities
- ☐ Indigenous
- ☐ People experiencing homelessness
- ☐ Immigrant
- ☐ Prefer not to answer
- ☐ Refugee

4

Participants

Participants were recruited with assistance from PDT members and partner organizations and were provided with gift cards to reimburse participants for their time and input. They were also asked to complete a brief survey after the focus group to

share feedback about the process and provide demographic information. All demographic questions in the survey were optional and offered "Prefer not to answer" as a response. Most questions, with the exception of age range and geographic location, allowed participants to select more than one answer, so totals may exceed 100%.

The majority, or 67%, of focus group participants identified as male, and 31% identified as female. When asked what pronouns they use, 65% of participants selected "he/him/his," 33% selected "she/her/hers," and 4% selected "they/them/theirs." More than half (54%) of participants identified their race/ethnicity as Black or African American, followed by 31% who identified as Latino/Latina/Latinx or Hispanic, and 15% who identified as white. Additional answer options provided were Asian, Pacific Islander or Native Hawaiian, Middle Eastern or North African, and Native American or Alaska Native, each of which were selected by 2% of participants. The most common age range selected was 25–34 years old, with 67% of participants falling in this age range. The age range of 35–44 was selected by 15% of participants, 18–24 was selected by 10%; and 8% of participants were under 18. When asked about geographic location in Colorado, two participants skipped the question. Of those who responded, 49% selected "rural," followed by 23% who selected "urban," 15% who selected "suburban," and 2% who selected "frontier." Additionally, 11% selected "not sure."

Participants were also asked if they identify as members of various underrepresented groups, but seven people skipped this question. Of the 42 participants who did answer, 48% selected "Indigenous," 19% selected "immigrant," 10% selected "LGBTQ+," 5% selected "people with disabilities," and 2% each selected "refugee" and "people experiencing homelessness." Ten people (24%) selected "prefer not to answer." Lastly, participants were asked how they learned about the opportunity to participate in a focus group, and the majority (55%) indicated they saw the information on social media. The next-most-common response was "Someone emailed it to me," with 18% selecting this answer, followed by 16% who selected "I saw a flyer," and 6% who selected "It was shared in an email newsletter I receive." The "Other" option was selected by 14%, with answers including that the focus group was conducted during a youth leadership council meeting and that they heard about it through a family member.

APPENDIX D: STATE PROGRAM INTERVIEWS

JVA worked with CDPHE's OHU to facilitate interviews with representatives of state programs that have a direct impact on oral health. Interviews were conducted via phone or Zoom, using a standardized, semi-structured set of questions to guide the conversations. Participants in these interviews represented the agencies on the table below, listed along with the type of work each organization does:

Table 7. State programs represented by interviewees

State Program	Areas of Focus
Colorado Department of Education (CDE)	Educating school nurses, ensuring access to data, and serving as a point of contact for supporting students
Colorado Department of Health Care Policy & Financing (HCPF)	Serving as a liaison between members (Medicaid recipients) and providers (accepting Medicaid); ensuring members are served in an equitable fashion and have access to care; managing provider reimbursement
Colorado Department of Human Services (CDHS) Office of Early Childhood (OEC)	Supporting school readiness and managing home visiting systems; connecting programs to bring more services and supports to children and families
CDHS, Head Start Collaborative Office (HSCO)	Ensuring children and families are ready for kindergarten by building public awareness for families and providers to understand the value of oral, physical, and mental health; ensuring safe and stimulating learning environments to support children's cognitive, social, and emotional needs
CDHS Long-term Care Ombudsman (LCO)	Providing advocacy for residents of skilled nursing homes and licensed assisted living residences; services include recruitment, training, and management of certified ombudsmen who conduct site visits at long-term care facilities
CDHS State Unit on Aging (SUA)	Providing services to help older adults maintain independence; services include transportation, nutrition and meal support, legal assistance, directed services, and evidence-based health and wellness programs for older adults
CDPHE Health Promotion Chronic Disease Prevention Branch (HPCDPB)	Providing support for chronic disease initiatives, prevention and management, health systems, and promotion of population health
CDPHE School Based Health Centers (SBHC)	Providing funding to launch or sustain operation of a school-based health center; SBHC takes an integrated approach to providing behavioral health services, primary care, and oral healthcare for students and community members
CDPHE Maternal Child Health (MCH)	Providing support for systems and services that impact the health of maternal and child populations

Department of Regulatory Agencies (DORA)	Ensuring qualified and proper practice of dentists and dental hygienists
University of Colorado School of Dental Medicine (UCD)	Providing education and resources related to population health and social determinants of health, and promoting best practices in community engagement, person-centered care, and research

STATE PROGRAM INTERVIEW SCRIPT

Background

1. To begin, please tell me briefly about your work and role at [STATE PROGRAM] and why that is important to Coloradans?

Organizational/Program Insights

2. Can you please describe to me the programs and areas of focus that [STATE PROGRAM] is currently working on or prioritizing?
    a. What are the outcomes you are trying to achieve through that work?
    b. IF TIME ALLOWS/LOWER PRIORITY: What have been some of the successes with that work?
    c. IF TIME ALLOWS/LOWER PRIORITY: What have been some lessons learned and/or pivots related to that work?
3. How would you describe your program's/organization's core values?
4. How does [STATE PROGRAM] come to decide what areas/efforts to prioritize?

Understanding of Equity

Now I'd like to spend some time talking about how health equity shows up in your work.

5. To begin, what does health equity mean to you and your organization?
6. Thinking in the short term or in the present, what does working towards equity look like for [STATE PROGRAM]? In other words, how does equity show up in your day to day practice? Prompt: think individually, team/interpersonal, organizational.
7. Given how you described health equity above, what are the big, long-term strategies you have or wish you had to achieve that goal?

8. What supports, services or resources do you think would be critical for being able to elevate the equity lens in your work and among those you work with? Why those over others?
9. What ideas do you have to advance health equity in Colorado?

Alignment with Oral Health

Now switching gears, I'd like to get a little more specific in talking about areas of alignment (or not) between [STATE PROGRAM] and oral health.

-- Note: If familiar with OHU/oral health, ask questions 10-15, then skip to question 18. If unfamiliar, skip to questions 16-17.--

10. IF FAMILIAR: In what ways, if any does your work influence or relate to oral health?
11. IF FAMILIAR: Within your oral health work, what are your main priorities? What are you most proud of?
12. IF FAMILIAR: How frequently do you work in oral health and/or with CDPHE's Oral Health Unit?)
13. IF FAMILIAR: Thinking back to the values of [PROGRAM/ORGANIZATION] that you mentioned earlier (*LIST*), how do those show up in your oral health work?
    a. IF FAMILIAR: Flipping the question, how does your oral health work advance your values?
14. IF FAMILIAR: What do you see to be the greatest challenges to achieving equitable oral health in Colorado?
    a. What ideas do you have to address those challenges?
15. IF FAMILIAR: In what ways do you see, or know of, intersections between the work you are doing at [STATE PROGRAM] and that occurring within CDPHE's Oral Health Unit?
    a. Do you see areas of overlap? If so, can you please explain where?
    b. What about areas of strategic alignment? If so, can you please explain where?
        i. If we were to develop a strategic plan that reflected all state programs that impact oral health, then how can your program's work be reflected in the plan? Do you need support from leadership, other things?

[NOTE TO CDPHE: Explain OHU and your work as appropriate]

16. IF UNFAMILIAR: Given your work and your focus, what do you see to be the greatest challenges to achieving equitable oral health in Colorado?
    a. What ideas do you have to address those challenges? What would be important to consider?
17. IF UNFAMILIAR: When you think about what I just shared, do you see overlapping priorities and values between your work? Where/how so?
    b. What about areas of strategic alignment? Can you please explain where?
        i. If we were to develop a strategic plan that reflected all state programs that impact oral health, then how can your program's work be reflected in the plan? Do you need support from leadership, other things?

ALL - *Opportunities for Alignment*

I'd love to now spend a little time talking about current and future potential collaborations.

18. What would your ideal future collaboration with CDPHE's OHU look like?
    a. Potential prompt at the moderator's discretion - why is that important to collaboration?
19. What does meaningful communication across (and within) state agencies and programs look like to you? What is critical for success?
    a. [Moderator follow up on process as well as relationships/emotional aspects of communication]

--- Only ask questions 19-20 for those that have worked with OHU in the past --- Share: These answers will be deidentified and confidential

20. [IF WORKED WITH CDPHE] When thinking about working/collaborating with CDPHE's OHU, have you experienced challenges or limitations in the past (i.e., historical barriers)? In what ways?
    a. Do you have ideas about what the causes of those challenges or limitations might have been?
    b. Do you have ideas for how to best address (or avoid) those challenges or limitations in the future?
21. [IF WORKED WITH CDPHE] What suggestions do you have to improve the working relationship and/or streamline processes between [STATE PROGRAM] and CDPHE"s OHU?
    a. What might be future limitations on how you work together?

Big Picture

Before we close, I'd like to get your perspectives on the bigger picture of what we are all trying to achieve related to the health and wellbeing of Coloradans.

22. Do you see a shared vision (i.e., ideal future) related to health/oral health in Colorado? What is that vision? In other words, what are you trying to achieve?
    a. How could CDPHE's OHU support the work you and [STATE PROGRAM] are trying to accomplish in pursuit of that vision?
23. If you could wave the magic wand to improve health/oral health in Colorado, what would you do?
    a. If you could wave the magic wand to ensure that all players in this space are collaborating and moving toward that shared vision, what would you do?

Closing

Just a few more questions before wrapping up…

24. As CDPHE works to develop Colorado's Oral Health Strategic Plan over the next 9 months, in what ways could that strategic plan reflect your work and/or goals?
    a. What are specific areas of duplication that you could see between your work and CDPHE's oral health unit?
    b. What advice do you have to ensure alignment and effective strategies between [STATE PROGRAM] and CDPHE's Oral Health Strategic Plan?
25. In what ways would you like to be involved or kept up to date on CDPHE's planning work?
26. As we continue down this path to develop a strategic plan grounded in equity, is there anything else you'd like to share or think we should be aware of?
27. Finally, who else should we be talking to?

Thank you very much for your time!

APPENDIX E: KEY INFORMANT INTERVIEWS

JVA worked with CDPHE to identify and interview key partners whose work relates to or overlaps with that of the OHU. Interviewees represented state and national funding partners, community-based organizations, policy and research organizations, clinicians, and membership organizations representing clinicians. Interviews were conducted via phone or Zoom, using a standardized, semi-structured set of questions to guide the conversations. Participants in these interviews represented the agencies on the table below, listed along with the type of work each organization does:

Table 8. Organizations represented by interviewees

Organization	Areas of Focus
AFL Enterprises, LLC, Oral health consultant	Consulting firm working with nonprofit dental clinics to help them test strategies to deliver care in a more equitable way, including the development of teledentistry
CareQuest	National funder supporting oral health equity initiatives that center involvement of communities of color, community driven policy and systems change, coalition building, advocacy for dental therapy, value-based care, and primary care integration
Caring for Colorado Health Foundation	Foundation funding nonprofit programs working to improve or create equity and health, wellbeing, and opportunity for children, youth and families. Interest areas include early childhood, adolescence and services and supports for families and funding is available for community and system level work, prevention, and workforce models aimed at and improving access to care and strengthening the safety net
CDHS Community Partnerships	State program overseeing local human services, area agencies on aging, early childhood licensing, food; office of economic security; child welfare & domestic; everything outside of 24-hour care
CDPHE Prevention Services Division	State public health department working with school-based health centers, continuous quality improvement, and access to care
Colorado Consumer Health Initiative	Nonprofit membership organization focused on equitable access to care and coverage, policy and systems change, and coalition building
Colorado Community Health Network	Primary Care Association serving 20 federally qualified community health centers, with a focus on developing a statewide strategy to support those health centers, integrating dental care into medical settings, oral health workforce development, and network building
Colorado Dental Association	Membership organization working on legislative advocacy and access to care, with a focus on Medicaid and workforce development
Colorado Dental Hygienists' Association	Membership organization supporting dental hygienists throughout the career, including their education process. advocacy and legislative work
Colorado Health Institute	Nonprofit research and consulting organization focused on data analysis and evidence-based decision making

Colorado Trust	Foundation funding health equity efforts that focus on working with communities and community organizers to identify issues that are challenges to health equity in their community
Delta Dental	Foundation funding nonprofit organizations and programs state focused on oral health equity and increasing the access and utilization of oral health care
Denver Health	Medical care facility working to integrate dental services, increase access to care, and change policy to influence healthcare service delivery
Kids in Need of Dentistry	Nonprofit organization focusing on equity and access to dental care for children and youth
Servicios de la Raza	Community-based nonprofit organizations providing mental health, victim services, education, preventative care, and dental screenings, with a focus on serving immigrant populations

KEY INFORMANT INTERVIEW SCRIPT

Background

1. Thinking about the current state of oral health in Colorado, what does your organization's current work entail that addresses the oral health needs of Coloradans? What about health needs more broadly?

Organizational Equity Practices and Strategies

2. What strategies or practices does your organization use to address equity as you work to achieve those broader goals?
    a. How do you see these strategies evolving over the next few years?

Partnerships and Gaps

3. What work and/or service provision is happening outside of your organization that assists you in being successful in reaching these goals?
4. How do you currently leverage partnerships to reach your goals?
5. Are there any gaps in your oral health work that need to be addressed?
    a. If these gaps were to be reflected in a statewide strategic plan, who do you envision being able to work on them, and what might that partnership look like?
        i. Specifically, what should CDPHE address as it relates to successes and challenges you see?
6. As CDPHE works to develop Colorado's Oral Health Strategic Plan over the next few months, in what ways could that strategic plan reflect your work and/or goals?

7. In what ways would you like to be involved or kept up to date on CDPHE's planning work?
8. As we continue down this path to develop a strategic plan grounded in equity, is there anything else you'd like to share or think we should be aware of?
9. Who else should we be talking to?
10. Finally, as part of this project, we are collecting feedback from the stakeholders we speak with to help us evaluate how well we are doing at creating an equitable process. In the coming days, you will receive a brief survey via email, and we would greatly appreciate you taking three to five minutes to complete that.

APPENDIX F: STATEWIDE PARTNER SURVEY

The survey was available as a public link shared in the OHU newsletter and was also sent via a targeted email list of 265 individuals, provided by CDPHE staff.

The majority of the survey questions asked respondents to rate items on a five-point Likert scale. For analysis of these questions, each response was assigned a numeric value ranging from 1 to 5. Mean scores were then calculated to make it possible to present a high-level summary of how particular groups responded to each question (whether that be the overall group of respondents, organizational leadership, or respondents not in leadership positions).

One question asked respondents to rank three items based on how they would prioritize funding for each one. For analysis of this question, the numeric ranking of each item was averaged to summarize how respondents generally ranked the various items, with lower scores indicating a higher prioritization.

Respondents

The typical respondents to this survey tended to be those who represent at least one of the following perspectives: leaders or program coordinators in their organizations, working at a nonprofit/community or healthcare organization, prioritizing service to children under 12, and serving the north-central region or working statewide. Potentially underrepresented perspectives include those with front-line roles (clinical, community health worker, teacher), those working in education (early care through postsecondary), those whose organizations prioritize educators or other vulnerable populations (experiencing homelessness, lower-income families/individuals), and serving the southern regions of Colorado.

Of the 81 survey responses collected, 54 came via the targeted email list and 27 via the web link. Of these 81 responses, the most common response to the question about respondents' primary role was organizational leadership (40.74%), followed by program administration/coordination (22.22%). See the full breakdown of roles in Table 9 below. Note that for analysis of responses, these roles can be categorized more broadly as "organizational leadership" (row in gray below) and "staff, volunteer, or consultant" (rows in white below). This broader categorization allows analysis to look for possible differences in perspectives depending on a participant's general position within their organization.

Table 9. Survey respondent roles

Primary Role	Percent Response
Organizational leadership (e.g., executive director, CEO, dental director, director of equity, diversity, inclusion)	40.74% n = 33
Program administration/coordination (e.g., program coordinator)	22.22% n = 18
Clinical staff (e.g., dental hygienist in a community-based setting, health navigator employed by a healthcare clinic, clinical team member of dental, medical, behavioral health)	11.11% n = 9
Organizational staff or volunteer (e.g., community health worker, promotor/ promotora de salud, outreach or education coordinator, church or school staff or volunteer)	11.11% n = 9
Academic staff (e.g., professor, teacher, school staff)	2.47% n = 2
Student (e.g., high school, post-secondary)	0.00% n = 0
Other (please specify): · State government · State of Colorado Division of Youth Services · Clinical staff and program manager · Organizational staff (policy and advocacy) · Consultant (2) · Lobbyist · Consumer advocate · Nonprofit intermediary · Public health	12.35% n = 10
TOTAL	81

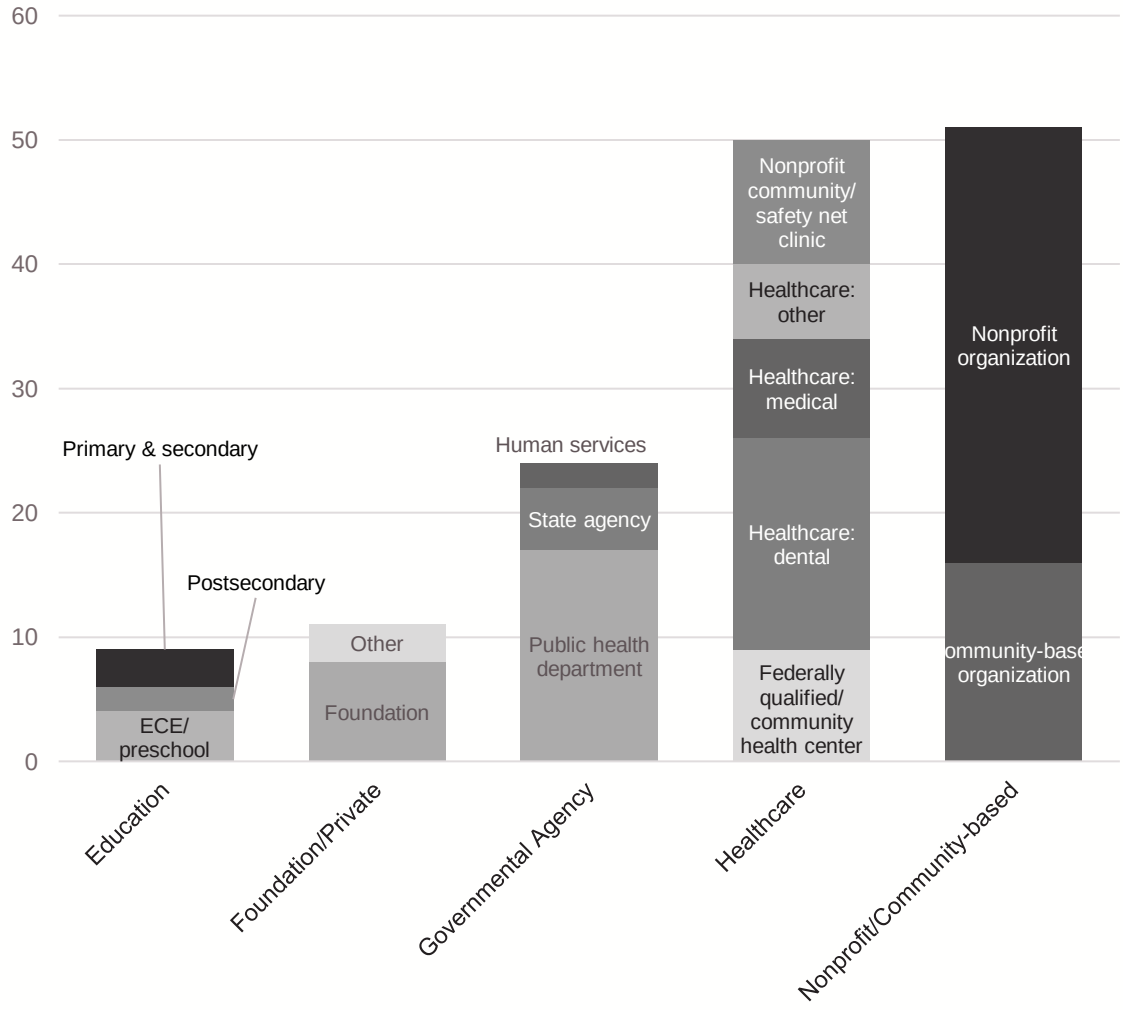
Table 10. Where survey respondents work

Organization Type	Percent Response
Nonprofit organization	41.98% n = 34
Healthcare: dental	20.99% n = 17
Public health department	20.99% n = 17
Community-based organization	18.52% n = 15
Nonprofit community/safety net clinic	12.35% n = 10
Federally qualified/community health center	11.11%

	n = 9
Foundation	9.88% n = 8
Healthcare: medical	9.88% n = 8
Healthcare: other	7.41% n = 6
State agency	6.17% n = 5
Early care & education (ECE)/preschool	4.94% n = 4
Education: primary & secondary	2.47% n = 2
Education: postsecondary	2.47% n = 2
Human services (e.g., area agency on aging, child welfare agency)	2.47% n = 2
Other (please specify) · Self · Lobbying firm that represents groups listed above · CF3 master trainer, clinical trainer for dental benefits company · Public school system · Association · Nonprofit membership organization	7.41% n = 6
Total Respondents: 81	

Considering these organization types in broader categories shows us a similar picture, with the vast majority of respondents working in nonprofit/community-based organizations or some form of healthcare, as seen in Figure 1 below.

Figure 1. Frequency of respondents selecting each possible response to "How would you classify the type(s) of organization where you are employed? (please select all that apply):" (n = 81)



The least prioritized populations out of the groups listed were educators, with only 16% of respondents prioritizing early childhood educators, and 4.94% of respondents prioritizing K–12 teachers. See the full breakdown of prioritized populations in Table 10 below.

Table 11. Populations prioritized by survey respondents' organizations

Prioritized Population	Percent Response
Children age 5 and under	60.49% n = 49
Children age 6 to 12	49.38% n = 40
General public	37.04% n = 30

Healthcare clinicians (e.g., nurses, dentists)	34.57% n = 28
Older adults	33.33% n = 27
Teenagers	32.10% n = 26
Parents	25.93% n = 21
People with disabilities	27.16% n = 22
Working-age adults (e.g., pregnant people)	24.69% n = 20
Healthcare clinicians in training (e.g., dental hygiene students)	23.46% n = 19
Early childhood educators	16.05% n = 13
K–12 teachers	4.94% n = 4
Other (please specify) · People experiencing homelessness or otherwise vulnerable populations (5) · Geography-specific (3) · All of the above (2) · National training and technical assistance for Health Resources and Services Administration (HRSA) grantees	14.81% n = 12
Total Respondents: 81	

Respondents were also asked what geographic area their organization serves for oral-health-related activities. Survey takers could indicate serving more than one Health Statistics Region (HSR). Because there are over 20 such regions, Table 11 below groups them by the general region of Colorado.

The most common singular survey response was statewide, at 50.62% of respondents. The only single HSRs selected by more than 10% of respondents were HSR 20: Denver County (17.28%), HSR 15: Arapahoe County (16.05%), HSR 14: Adams County (13.58%), and HSR 21: Jefferson County (11.11%). All of these HSRs are in Colorado's north-central region, which also was the region with the most survey respondents (69.14% of respondents). The regions with the fewest respondents were the West (3.70%), San Luis Valley, and the Southeast (both 4.93%) regions.

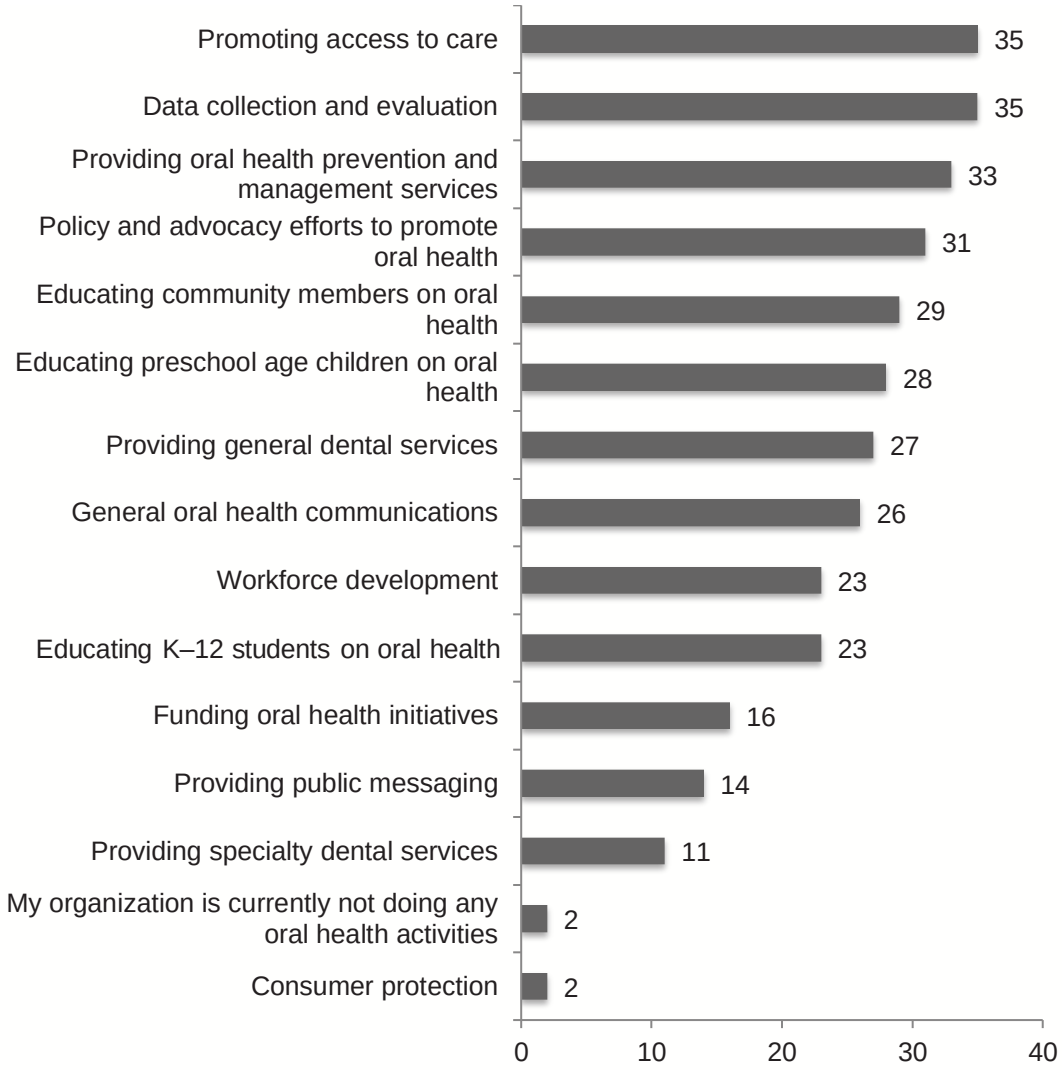
Table 12. Survey respondents by geographic region

Geographic Area (Region and HSR)	Sum of respondents
Statewide	**41**
Statewide (all of the below Health Statistic Regions [HSR])	41
North Central	**56**
HSR 14: Adams County	11
HSR 15: Arapahoe County	13
HSR 16: Boulder and Broomfield counties	3
HSR 17: Clear Creek, Gilpin, Park and Teller counties	1
HSR 20: Denver County	14
HSR 21: Jefferson County	9
HSR 3: Douglas County	5
Northeast	**17**
HSR 1: Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties	6
HSR 18: Weld County	5
HSR 2: Larimer County	4
HSR 5: Cheyenne, Elbert, Kit Carson and Lincoln counties	2
South/South Central	**12**
HSR 13: Chaffee, Custer, Fremont and Lake counties	6
HSR 4: El Paso County	3
HSR 7: Pueblo County	3
Northwest	**11**
HSR 11: Jackson, Moffat, Rio Blanco and Routt counties	4
HSR 12: Eagle, Garfield, Grand, Pitkin and Summit counties	5
HSR 19: Mesa County	2
National	**9**
National	9
Southwest	**6**
HSR 9: Archuleta, Dolores, La Plata, Montezuma and San Juan counties	6
Southeast	**4**
HSR 6: Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero and Prowers counties	4
San Luis Valley	**4**
HSR 8: Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache counties	4
West	**3**
HSR 10: Delta, Gunnison, Hinsdale, Montrose, Ouray and San Miguel counties	3
International	**1**
International	1

Oral health activities

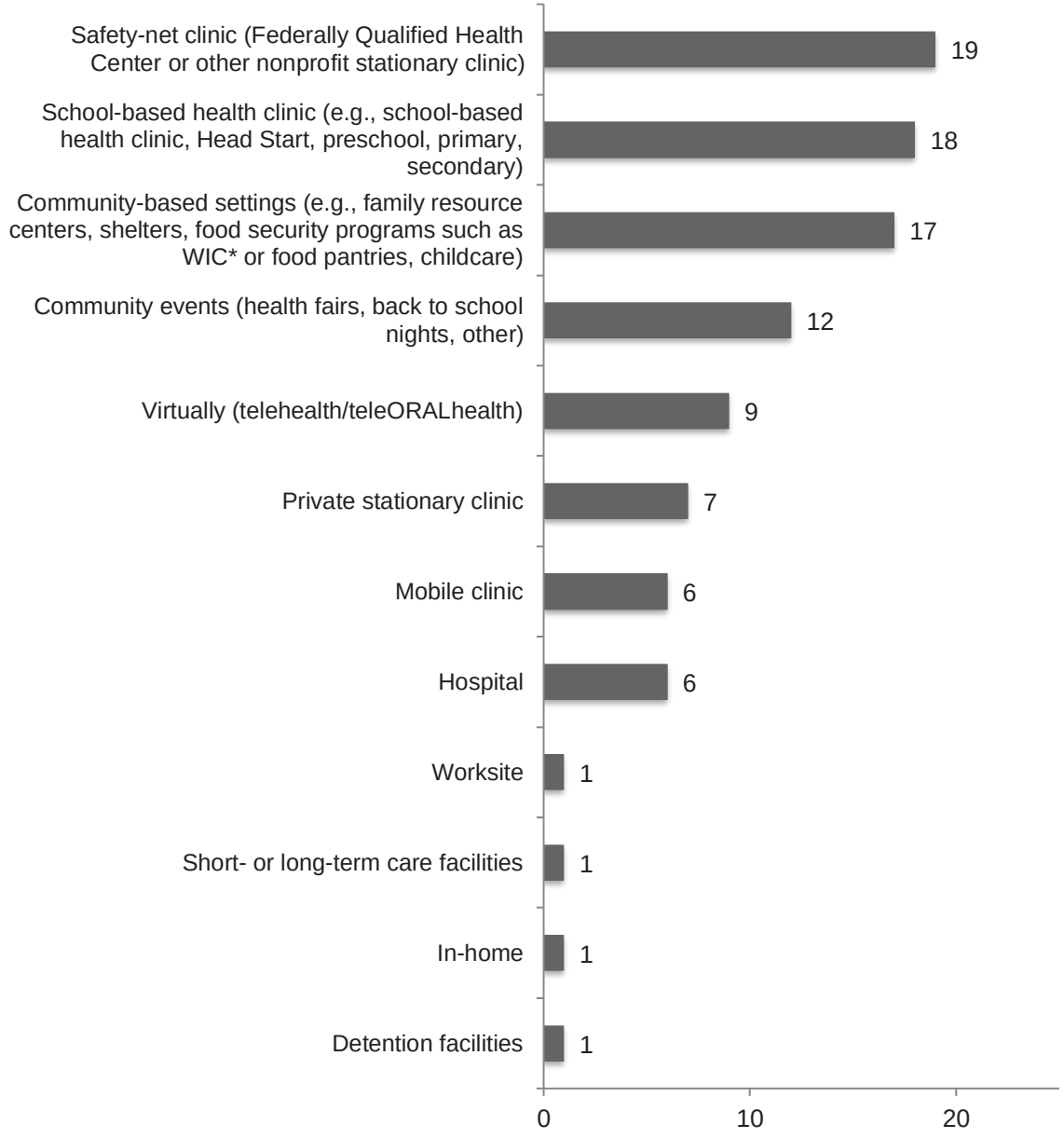
Respondents were asked to select all of the oral-health-related activities their organization is conducting. Nearly all options were chosen at least 11 times. The one exception to this was consumer protection, which was only selected twice. Participants could select more than one response. Figure 2 summarizes how many responses selected each option. Participants could select more than one response.

Figure 2. Frequency of respondents selecting each possible response to "Please indicate the oral-health-related activities that your organization is currently conducting" (n = 76)



Respondents that indicated their organization provided direct oral health services (i.e., general or specialty dental services, or oral health prevention and management services) were asked a follow-up question on where they provided oral health services. The most commonly selected options were safety-net clinics, school-based health clinics, and community-based settings. At the other end of the spectrum, worksite, short- or long-term care facilities, in-home, and detention facilities were each selected only once. Participants could select more than one response.

Figure 3. Frequency of respondents selecting each possible response to "Where do you provide oral health services?" (n = 38)

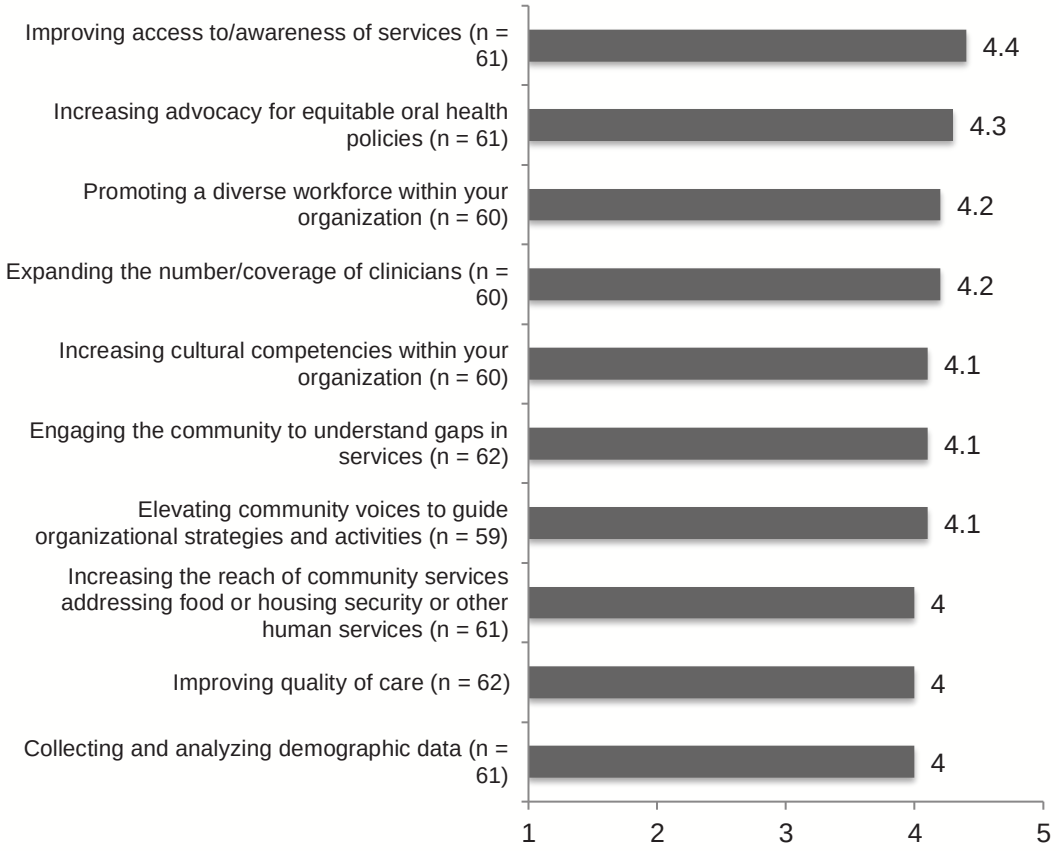


*WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Oral health equity

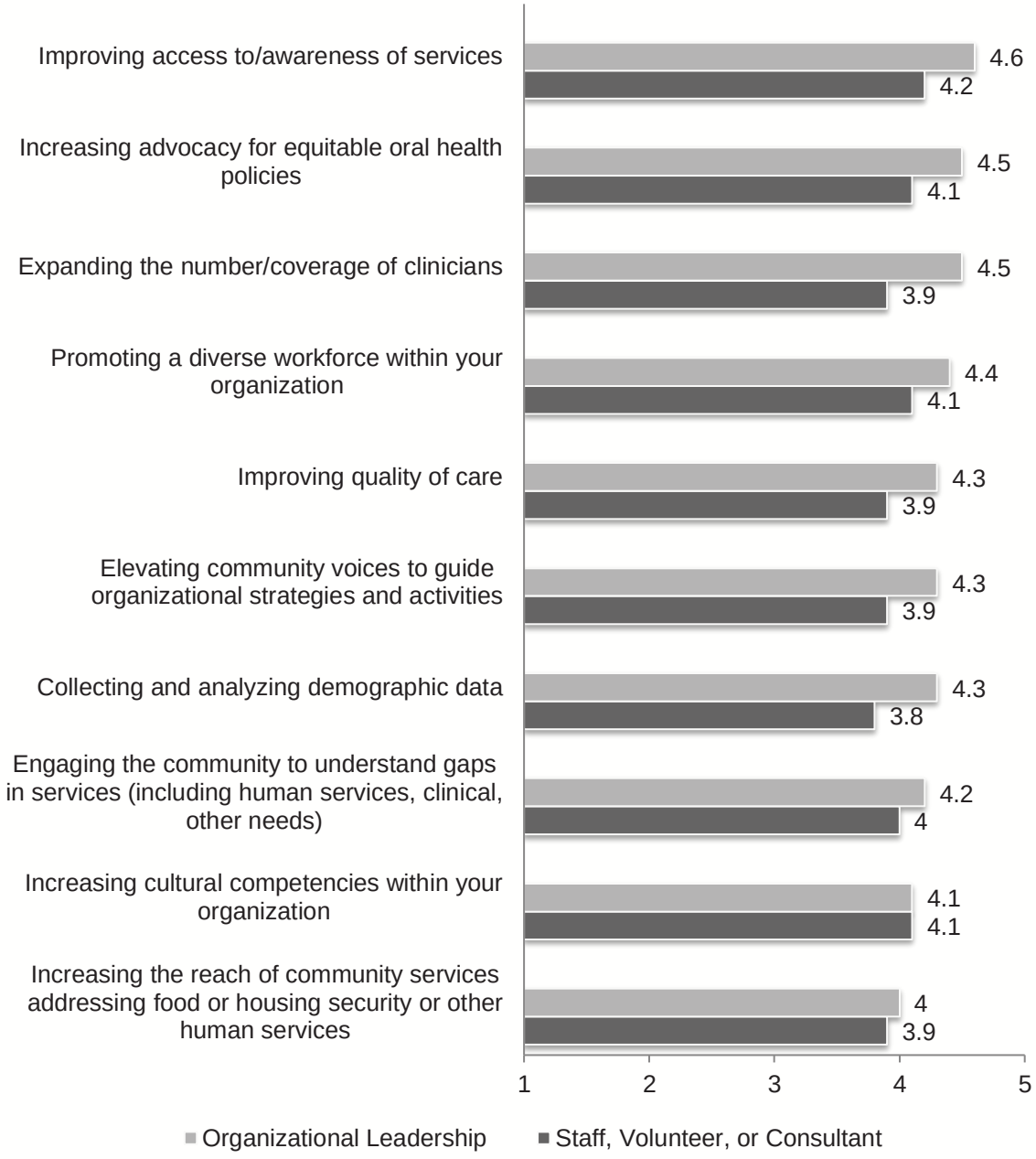
Respondents were asked to rate the importance of a series of strategies for promoting oral health equity in the context of their work, using a five-point Likert scale (with responses ranging from very unimportant to very important). Figure 4 shows the mean score that each item received. The level of importance attached to each item did not vary widely, with the most highly rated item (improving access to/awareness of services) receiving a score of 4.4 and the lowest-rated item (collecting and analyzing demographic data) receiving a 4. This suggests that respondents generally felt that each item was important to promoting health equity to their work.

Figure 4. Mean ratings of importance for items under the question "How important are the following strategies for promoting oral health equity to your work?"



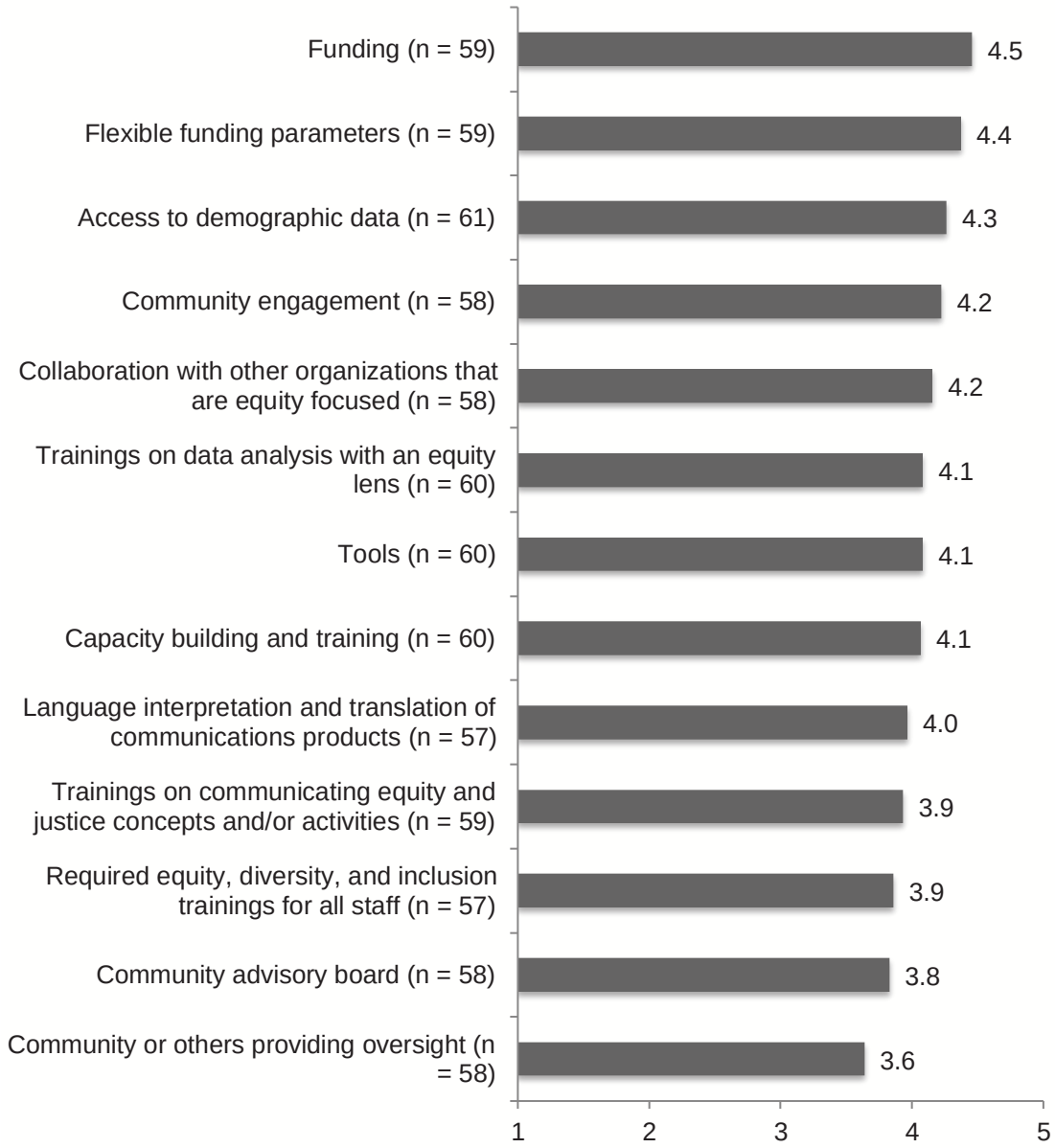
Organizational leaders tended to rate the importance of each item higher than other respondents, as summarized in Figure 5. In several cases, this divergence implies that there are some items that organizational leaders believe are *very* important that other respondents believe are just important (e.g., improving access to/awareness of services, increasing advocacy for equitable oral health policies, and expanding the number/ coverage of clinicians). In all other cases, respondents from both groups generally agreed that the item in question was important, but not *very* important.

Figure 5. Mean ratings of importance for items under the question "How important are the following strategies for promoting oral health equity to your work?," disaggregated by position type



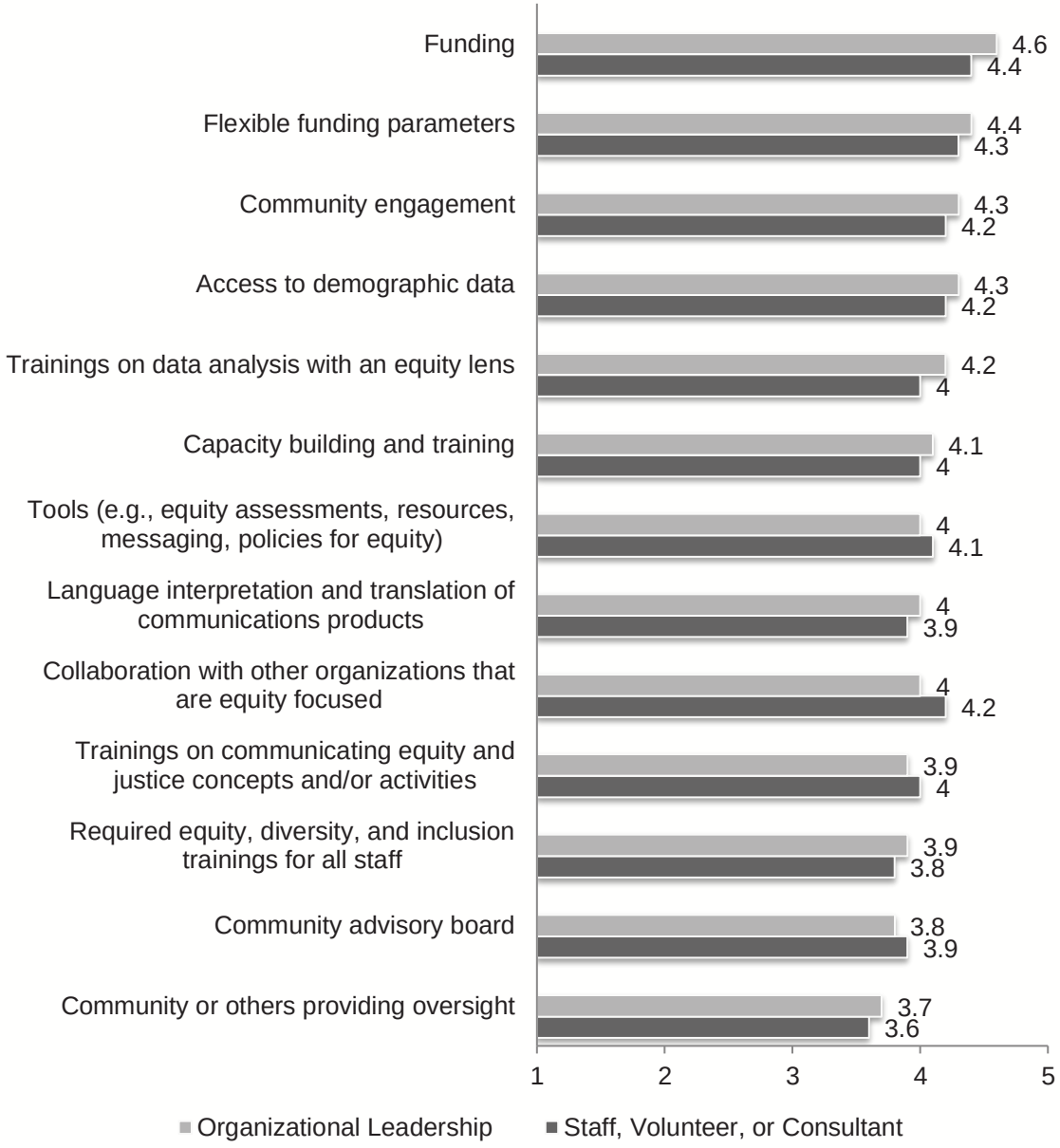
The second question addressing oral health equity asked respondents to rate how helpful various services or resources would be in elevating equity for their work, using a five-point Likert scale ranging from very unhelpful to very helpful. Responses to this question diverged more widely than those to the previous question, but mean scores still generally suggested that each item would be considered helpful to the overall group of respondents. The one exception to this was the most highly rated item, funding. This item's mean score of 4.5 indicates that slightly more respondents believe this would be very helpful.

Figure 6. Mean ratings of helpfulness for items under the question "How helpful would the following services or resources be for elevating the equity lens in your work and among those you work with?"



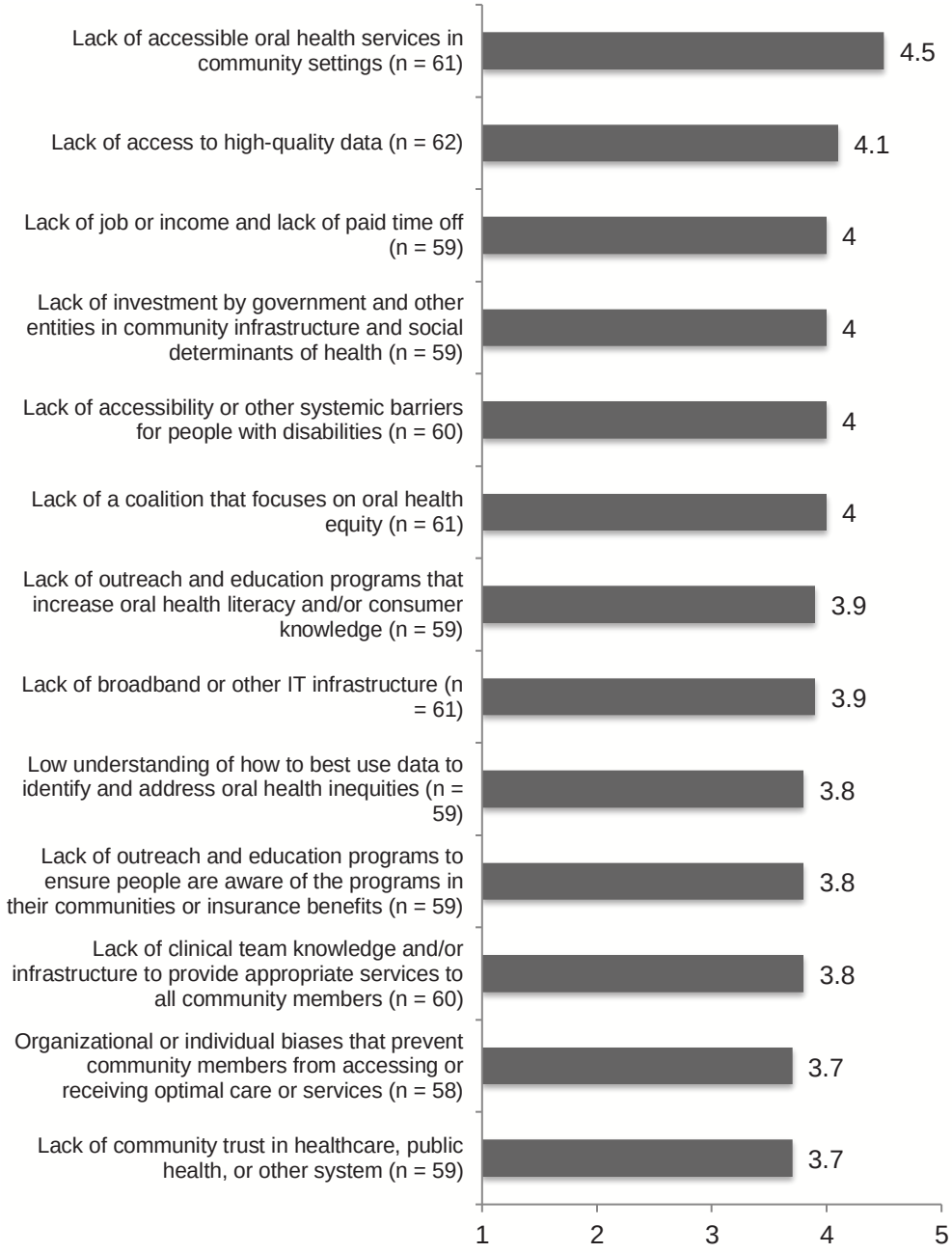
Organizational leaders tended to rate each item as being more helpful than did other respondents, though this divergence was smaller than in the case of the previous question, and both groups generally agreed that each item would be helpful. There were some cases that broke this pattern, with respondents not in leadership positions rating tools, collaboration with other organizations that are equity focused, trainings on communicating equity and justice concepts and/or activities, and a community advisory board slightly higher than organizational leaders rated them.

Figure 7. Mean ratings of helpfulness for items under the question "How helpful would the following services or resources be for elevating the equity lens in your work and among those you work with?," disaggregated by position type



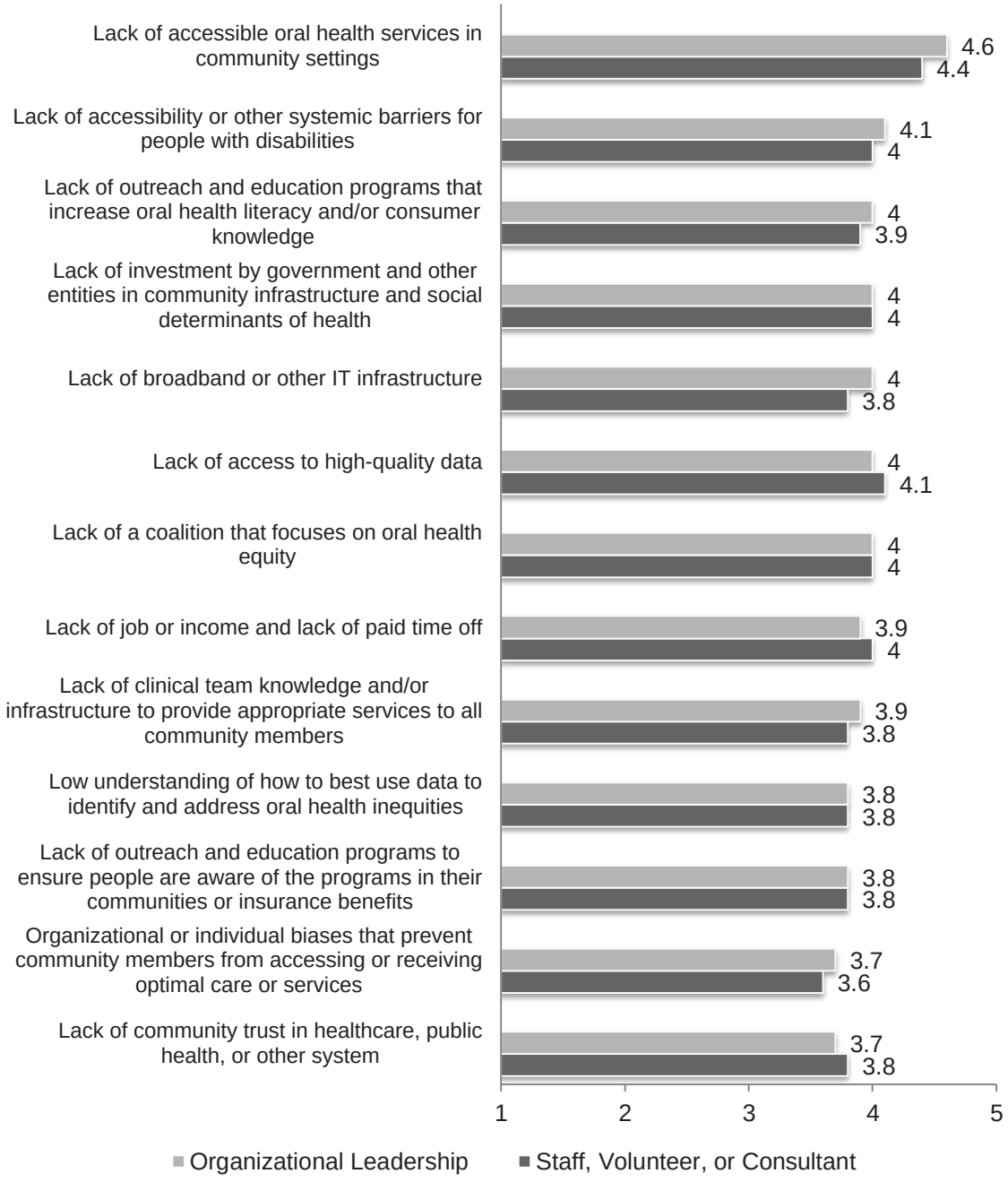
The third question related to oral health equity asked respondents to rate the significance of a list of barriers to achieving oral health equity for all Colorado communities on a five-point Likert scale ranging from very insignificant to very significant. Lack of accessible oral health services in community settings was rated the most significant barrier among the overall group of respondents, with a rating of 4.5, suggesting that respondents tended to rate this barrier as very significant, while the remaining items were closer to significant.

Figure 8. Mean ratings of significance for items under the question "How significant do you believe the following barriers are to achieving oral health equity for all Colorado communities?"



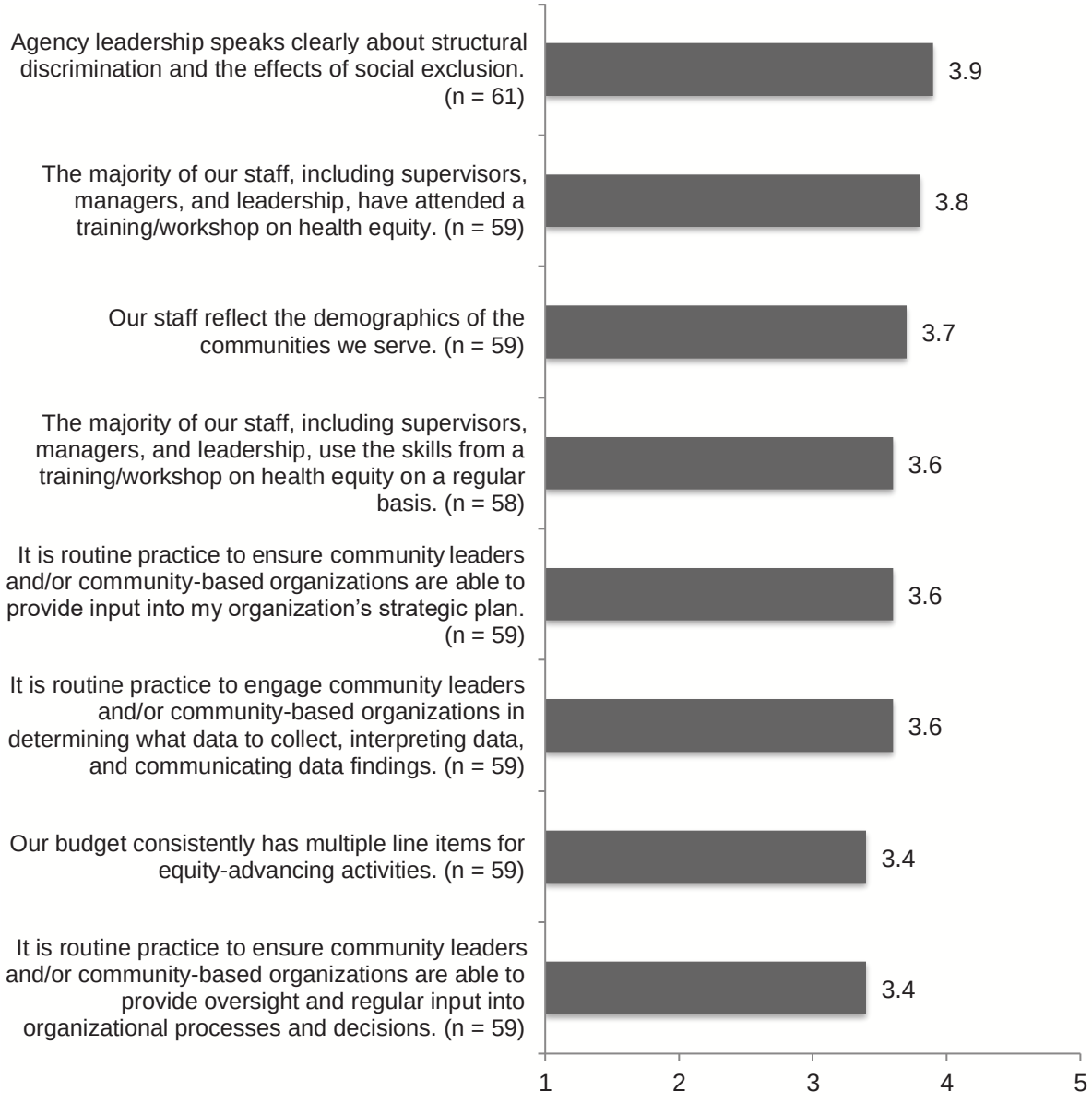
Organizational leaders generally agreed with other survey respondents regarding the significance of these barriers. The mean scores of each item varied by 0.1 points or less for the majority of items, with only lack of accessible oral health services in community setting and lack of broadband or other IT infrastructure diverging by 0.2 points.

Figure 9. Mean ratings of significance for items under the question "How significant do you believe the following barriers are to achieving oral health equity for all Colorado communities?," disaggregated by position type



The final question related to oral health equity asked respondents to rate their level of agreement with a series of statements about their organization's equity practices on a five-point Likert scale ranging from strongly disagree to strongly agree. The overall group of respondents tended to agree with most of the statements, though none of the mean scores was greater than 4, suggesting that the group did not strongly agree with any of them. Two items had a mean score lower than 3.5 (Our budget consistently has multiple line items for equity-advancing activities and It is routine practice to ensure community leaders and/or community-based organizations are able to provide oversight and regular input into organizational processes and decisions), suggesting that respondents had more neutral feelings toward these statements.

Figure 10. Mean ratings of agreement for items under the question "Please indicate how much you agree or disagree with the following statements about your organization's equity practices"



While organizational leaders and other respondents tended to have similar levels of agreement, this question contains a statement that showed the largest divergence between the two groups. There was nearly a full one-point difference in levels of agreement with the statement: Our staff reflect the demographics of the communities we serve, with leadership tending to agree with the statement while other respondents tended more toward neutral.

Figure 11. Mean ratings of agreement for items under the question "Please indicate how much you agree or disagree with the following statements about your organization's equity practices," disaggregated by position type

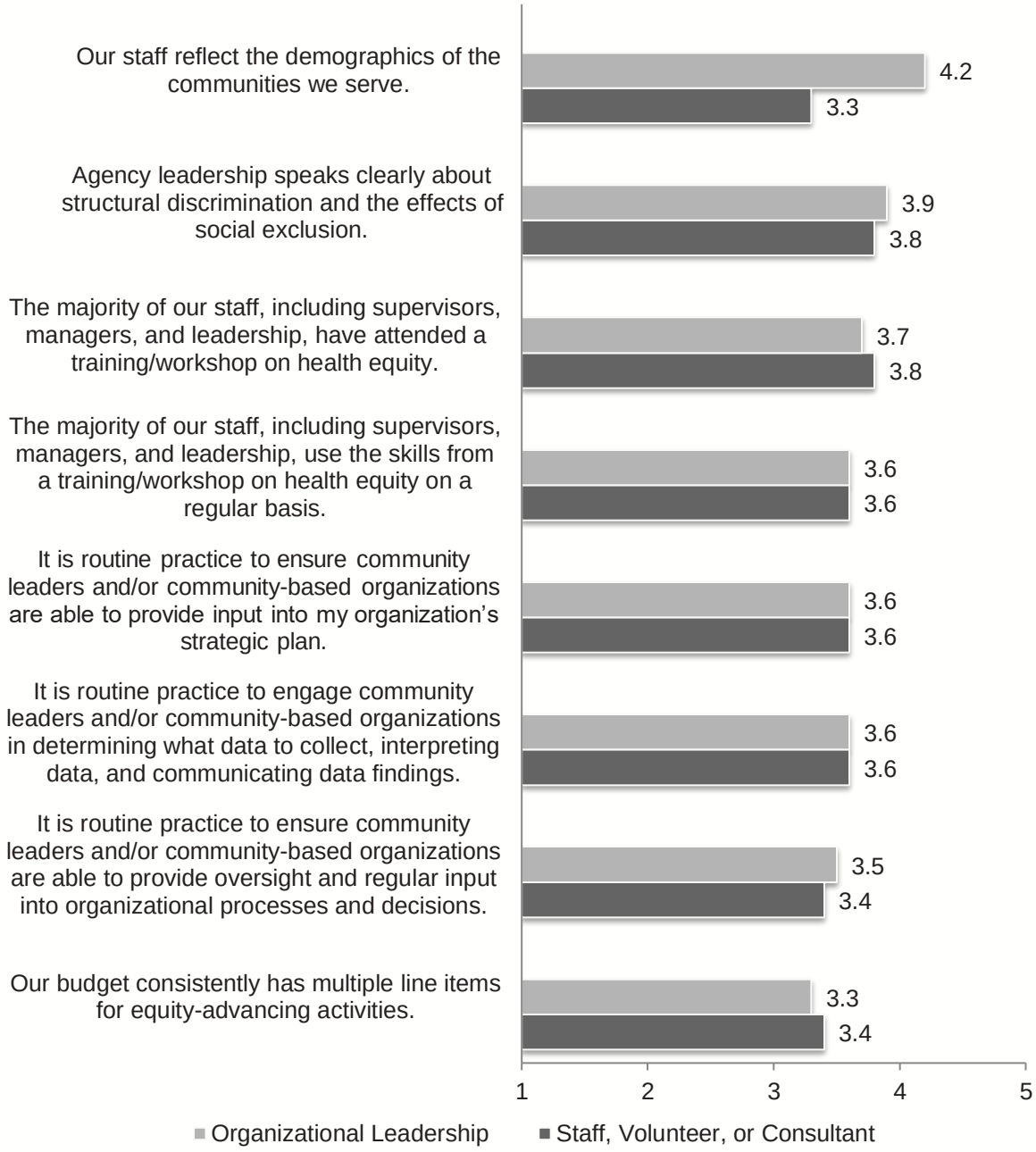
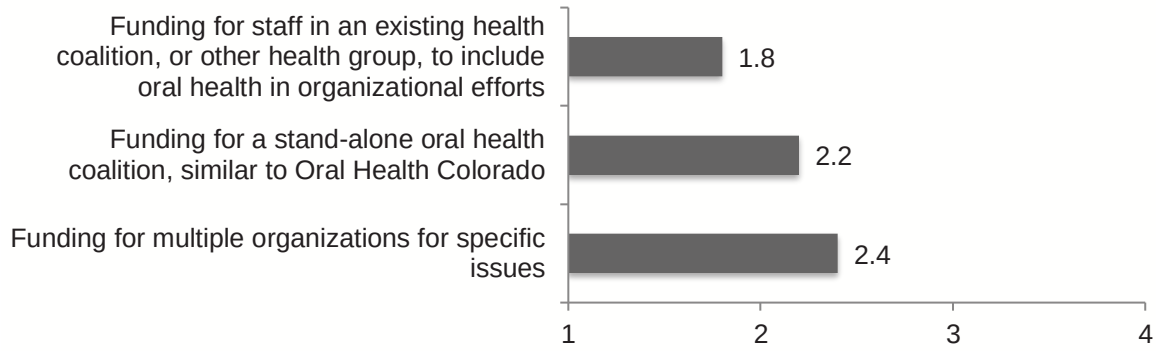
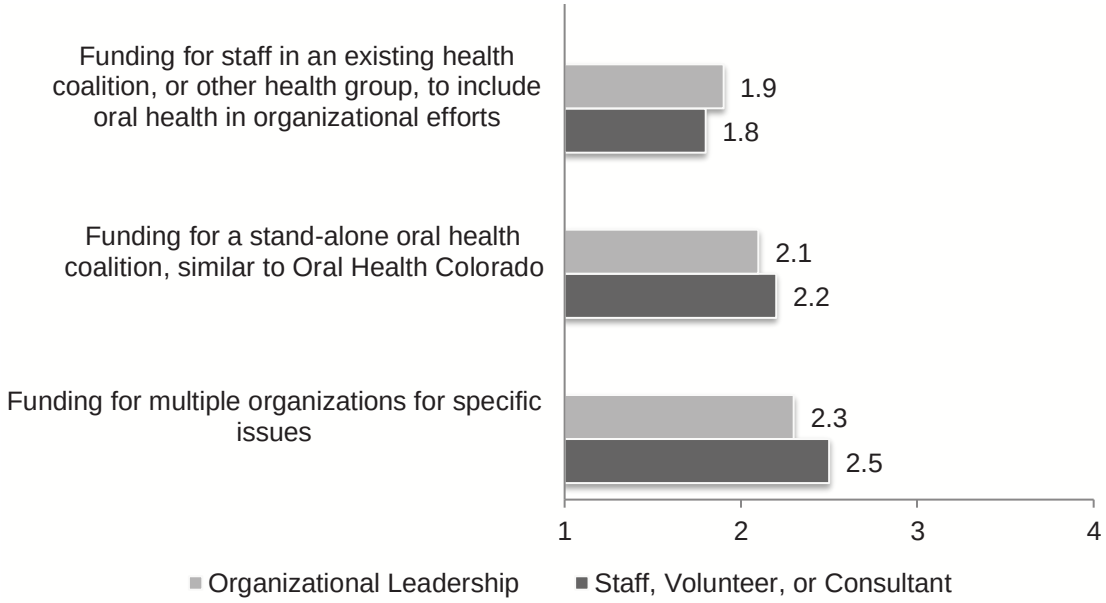


Figure 12. Mean ratings of importance for items under the question "What types of organizations do you think should be prioritized to receive funding to fill the gap created when Oral Health Colorado ceased day-to-day operations?" (n = 52)*



*Note that lower scores indicate higher prioritization.

Figure 13. Mean ratings of agreement for items under the question "What types of organizations do you think should be prioritized to receive funding to fill the gap created when Oral Health Colorado ceased day-to-day operations?," disaggregated by position type*



*Note that lower scores indicate higher prioritization.

Figure 14. Frequency of respondents selecting each possible response to "Would you, or someone from your organization, participate in a coalition to address oral health equity issues in Colorado?" (n = 57)