Funders Oral Health Policy Group

FOHPG is Facilitated by AFL Enterprises

For more information, contact us at: FOHPG@afl-enterprises.com
Putting Your Money Where Your Mouth Is: The Case for Funding Oral Health Programming

Cosponsored by Grantmakers In Health and Funders Oral Health Policy Group

Sheraton Memphis Downtown Hotel
April 18, 2019
Introductions

Briefly share your:
- Name
- Role
- Hope or intention for today’s discussion
Agenda Review
The Oral Health System Today: Opportunities, Gaps, and Barriers

Grantmakers in Health + Funder Oral Health Policy Group
We believe that **no family should be held back from their dreams because of dental disease**. In 1997, CDHP was conceived to advance innovative policy solutions to address the inequities of dental disease.

- Integrate oral health where families **live, learn, and work**
- End inequities in oral health due to **race, income & geography**
- Ensure oral health care is driven by **better health & quality of life**
Oral health is part of a more complicated equation for family success – making it hard to picture the final product.
Oral Health Disparities

Young Hispanic and Black children have 2x the rate of untreated cavities than white children.

Latino & Black children are less likely than white children to have visited a dentist in last 6 mo.

Black adults are 2x more likely than Hispanic adults to lose all of their teeth.
One-Size-Fits-All System

*Who wins?*

- Who needs more support, but didn’t get it?
- Did some people get too much?
- What was the impact on their health and well-being?
Bi-directional impact of oral health is complex. It impacts us throughout life, in areas including:

- Childhood success
- Economic security
- Stability for mind and body
Advancing oral health equity

- Building strategic partnerships
- Improving data to target resources
- Meeting people where they are
- Holding a broad view of oral health
Thank You

Meg Booth
Executive Director
mbooth@cdhp.org
@CDHP_ED
@Teeth_Matter
www.cdhp.org
Building a Movement for Oral Health Equity

Putting Your Money Where Your Mouth Is

By: Sarah de Guia, JD

April 18, 2019
**Vision:** All of California’s communities, institutions, and systems support the health and well-being of communities of color so that all residents can thrive and prosper.

**Mission:** CPEHN works to create a health equity agenda that builds power and political will for policy and systems change that result in improved health for all communities.

- **We advance equity-centered policies** that reflect community needs for better health.
- **We build people power** to influence policymakers through lived experience and community expertise for equity centered policies and systems.
- **We connect and convene partners, and regions** to build knowledge, relationships, and understanding across cultures.
- **We amplify voices and stories** to build leadership, sustainability, and advocacy strength.

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What is Health Equity?

Health equity is the absence of **avoidable or remediable differences** among groups of people, who are often defined by an economic, social, demographic or geographic similarity. The common characteristic among [these] groups...is the **lack of political, social and economic power**.

Everyone, regardless of race, income, gender, sexual orientation, age and ability should have the same opportunities to live a healthy life.

Many systems have been created to unjustly keep some out while allowing others to benefit and prosper.

We must work together across race, income, sector and system to advocate for the many who don’t have access to oral health care and prevention.

Until we all have an equal opportunity to live healthy lives, we will all live in an unjust society.
Social Conditions Impact our Health

In some counties, communities of color face stark differences in earnings. For example, in San Francisco County, African Americans face the widest income disparity earning 71 cents less for every one dollar of White households. Annually this equates to a $71,491 wage gap between African American and White households. Latinos fare worse in Sierra County (62 cents less) and American Indian/Alaska Native in Mono County (81 cents less).  

Median Household Income by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Median Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>$72,061</td>
</tr>
<tr>
<td>African American</td>
<td>$43,476</td>
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<tr>
<td>Latino</td>
<td>$47,206</td>
</tr>
<tr>
<td>Asian</td>
<td>$69,010</td>
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<tr>
<td>Native American</td>
<td>$45,319</td>
</tr>
<tr>
<td>Other</td>
<td>$51,869</td>
</tr>
</tbody>
</table>

Diagnosed With Diabetes

- Latino
- White
- African American
- Native American
- Asian
- Pacific Islander
- Multiracial
Studies show that communities of color and low-income communities are more likely to live in areas with toxic waste including higher concentrations of contaminated water.

“Sugar consumption is a big issue in our community...because of its cheap price, parents let their children without limit consume these products.” Centro Binacional para el Desarrollo Indígena Oaxaqueño

“The problem is their families would have to abstain from buying groceries for the week in order to pay for the services needed,” Inland Empire Youth Immigrant Coalition
Oral Health (In)Equities

Oral Health & Employment

• Employed adults **miss 164 million hours** of work due to oral health problems
• Adults with missing teeth are more likely to report **trouble finding employment**

Oral Health & Chronic Conditions

• Communities of color often have **higher rates of chronic conditions** such as heart disease and diabetes. Black women have **higher rates of maternal mortality**
• Oral health can further exacerbate these conditions

Oral Health & Education

• Children of color are more **likely to be impacted by tooth decay**
• Students who reported tooth pain were **4x more likely to have a lower GPA**
Our Oral Health Partners

• Korean Resource Center (LA)
• Black Women for Wellness (LA)
• Roots Community Health Center (Bay)
• API Forward Movement
• Asian Health Services (Bay)
• Centro Binacional para el Desarrollo Indigena (Central Valley)
• Nile Sisters Development Initiative (San Diego)
• Inland Empire Immigrant Youth Coalition (IE)
• Latino Health Access (OC)
Findings from Oral Health Assessment

Lack of affordable dental care
- Incomplete coverage/no access to coverage
- Unaffordable out of pocket costs
- Lack of understanding of benefits

Cultural and Linguistic Gaps
- Lack of quality providers that offer culturally and linguistically appropriate care
- Latinos & Asians often have difficulty understanding providers and experience negativity

Fragmented Health Systems
- Difficulty accessing providers in a timely fashion
- No connection between primary care providers

Underlying Social & Environmental Inequities
- Lack access to healthy foods
- Experience unequal income opportunities

California Pan-Ethnic Health Network
Everyone loves WINS!

**Influx of resources:** Medicaid waiver & Proposition 56 (tobacco tax)

**Adult dental:** Restoration of adult dental benefits in Medi-Cal

**Internal advocacy:** The Department of Health Care services recently shared information on language access with Medi-Cal Dental providers

**County oral health assessments:** Most local health jurisdictions are funded for oral health planning
What’s happening?

Policy Priorities
- Language Access
- Surgery Sweetened Beverages
- Virtual Dental Homes
- Restoration of Adult Dental
- Health4All

Strengthening Connections
- Leveraging strengths in equity focused oral health network
- Aligning with National OPEN Network
- Elevating consumer/community voices
What can funders do?

**Offer more core support funding**
- Supports the underlying mission of the organization
- Helps organizations try and fail and try again
- Builds trust and removes operational barriers

**Fund advocacy to help address systems change needs**
- There are many forms – education to administrative advocacy
- Remember what most groups lack is political, social and economic power

**Fund the connections to oral health**
- Oral health touches all aspect of health, economics, education and disparities
- Increase grants or programmatic funding to integrate oral health into overall health
Thank you!

For more information, please contact me:
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Sdeguia@cpehn.org
510-832-1160 x 304
Oral Health In Communities and Neighborhoods (OH I CAN)
Addressing the Burden of Poor Oral Health in Georgia

Charles E. Moore, MD
Director, Urban Health Initiative
Otolaryngology Chief of Service, Grady HS
President/Founder, HEALing Community Center
Professor, Emory University
RWJF Clinical Scholar
“One Cannot Be Healthy Without Oral Health”
Oral health in America: A Report from the Surgeon General

- Dental Diversion Program
- School Based Health Program
- Dental Residency Program
- Training of Non-traditional Providers
- Innovative Use of Technology
Community Nutrition Programs

• Cooking Demos
• Nutrition Program
• Addressing food deserts in low resourced communities led to the beginning of this effort.
• Referrals from ER to Otolaryngology
• Non-traumatic dental issues
• Very limited access to routine dental care for low resourced individuals and families in Georgia.
Initiate and Expand of oral health program

- Dental Diversion Program
- School Based Health Program
- Dental Residency Program
- Training of Non-traditional Providers
- App / Oral Health Repository
- Oral Health Business Plan
OH I CAN Website / Repository

https://ohican.org/

OH I CAN
ORAL HEALTHCARE IN COMMUNITIES AND NEIGHBORHOODS PROGRAM

Home

Program Description

As part of the Urban Health Initiative (UHI) at Emory University in Atlanta, GA, the OH I Can program addresses the vast oral health disparities that exist for low income and minority families, the dental/healthcare neighborhood program seeks to create a community wide comprehensive oral health network in a low income and minority neighborhood to increase access to oral health education and oral health services.
What will it do?

Estimated total costs will increase/decrease based on supply costs, overhead costs, labor costs, and costs associated with the clinic setup (e.g., # chairs, square footage, etc.).

Case mix and payor mix can vary based on desired inputs.

- User can choose to provide basic to comprehensive dental services.

Different revenue model summaries will be provided based on the desired service model.

- e.g., Federally Qualified Health Center, multi-payor, versus donation only

Clinic layout estimated 1K-2K square feet (3-4 dental suites, waiting room, dentist office, sterilization area, and lab).

Benefit/Value:

Ultimately, this model will allow the user to toggle in volumes to determine loss portion/capital outlay needed based on revenue assumptions for a dental clinic.
Thank You!

cemoore@emory.edu
Discussion: The Oral Health System Today

Which strategies are working?

What possibilities exist for more impactful work?
PUTTING YOUR MONEY WHERE YOUR MOUTH IS:
THE CASE FOR FUNDING ORAL HEALTH PROGRAMMING
APRIL 18, 2019

THE ORAL HEALTH SYSTEM TODAY: OPPORTUNITIES, GAPS & BARRIERS

FUNDERS ORAL HEALTH POLICY GROUP (FOHPG) PRESENTATION OF
AREAS OF ORAL HEALTH INVESTMENT:

WHAT OUR MEMBERS ARE FUNDING

JEFFREY S. KIM, PROGRAM DIRECTOR
THE CALIFORNIA WELLNESS FOUNDATION
WHAT DO WE WANT TO ACHIEVE?

* What public policy efforts are we investing in?

* How we can use a social justice lens to make change together?
What we are funding

My organization currently funds work in the following oral health policy activities:

16 responses

- Workforce policy: 11 (68.8%)
- Payment policy: 6 (37.5%)
- Federal regulations: 3 (18.8%)
- State regulations: 11 (68.8%)
- Dental education policy: 3 (18.8%)
- Medicare, Medicaid, ACA: 1 (6.3%)
- While we don't often directly fund policy: 1 (6.3%)
- General operating for oral health advocacy: 1 (6.3%)

SOURCE: Funders Oral Health Policy Group 2018 Member Survey
EXAMPLES OF SPECIFIC ACTIVITIES

- Advocacy/engaging stakeholders in forming key strategies to address Medicaid reform in your state
- Funding state Medicaid policy and programs
- Medicare dental benefit investment along with policy strategy
- Advocacy for top of licensure opportunities for allied dental workforce to ensure access to preventive services
- New workforce models/virtual dental home
- Dental therapy - specifically enabling legislation, advanced dental therapist initiatives
MORE EXAMPLES OF SPECIFIC ACTIVITIES

- Workforce study, followed by efforts to form state policies on tele-dentistry, loan repayment programs, etc.
- Research and advocacy regarding expansion of school-based sealant programs
- Initiatives to integrate dental and medical education

YOUR IDEAS HERE
E.G., ADVOCACY FIELD BUILDING & EQUITY

California Pan-Ethnic Health Network
Advancing health justice and equity for 25 years

Justice in Aging
Fighting senior poverty through law

Visión y Compromiso
You have the opportunity to help make change
JOIN OUR LEARNING COMMUNITY: FOHPG

FOR MORE INFORMATION, CONTACT US AT:
FOHPG@AFL-ENTERPRISES.COM, OR CALL US AT
(720) 248-8265
What are the opportunities for strategic impact or to create systems change in partnership with other funders?

- What are some common changes we need in order to build more equitable systems of care?
- What initiatives are gaining traction to reduce disparities in care that could be leveraged?
- How do we support systems change & the interconnectedness of the systems?
- What are the levers we can pull to get real systems change?
Disparities and Determinants
Deep Dive Activity

* These patient stories have been curated by AFL-Enterprises from our work in communities over the past 10 years. We are sharing patient experiences to highlight successes, challenges, and opportunities for continued collaboration to attain oral health equity.
Case Scenario #1: The Cost of Fragmented Care

A child who did not receive timely dental care ended up in the hospital with a brain infection.

The treatment was costly. Antibiotics alone cost $10,000. A $200 dental appointment would have saved the health system $250,000.
Case Scenario #2: Access And Integrated Care

During a child's pediatric well-child visit at the community health center, the PCP noted the onset of dental disease and engaged oral health clinic staff in child's care.

- Motivational interviewing helped the child’s busy working mom and grandma, a primary caregiver for the child, understand the causes and address the onset of dental disease.

- Community health center provided nutritional counseling for family, along with resource support for affordable access to healthy foods.

- Family reduced sugar in diet, brushed daily with fluoridated toothpaste, improved overall oral health.
Case Scenario #3: Oral Health Care Education

A 4 year old refugee child presented for medical care. The medical team noted the child needed dental care, with 19 of 23 teeth requiring treatment due to decay.

The dental clinic provided treatment over 4 visits. Mom stated "My child cried every night for two years because she was in pain. Since you took care of her, she doesn't cry at night any more!"

- Without a medical partner identifying the dental disease, the child would still be in pain to the detriment of her overall well-being, and her ability to focus and learn in school.
- The parents are now getting dental care, too, and learning about preventive oral health care, and services available to them in a new country.
Case scenario #4: Patient-Centered Care

An 83 year old client at a PACE center told her case manager that her gums were bothering her. The case manager facilitated an appointment at a dental clinic. The dentist removed the dentures, and the client returned home.

Three weeks later, staff at the PACE center noticed that the client had become depressed. She had stopped attending social events such as a lunch, bingo, and dances.

The PACE center staff worked together with the dental clinic staff to discuss strategies to support the client, with the client perspective, experience, and priorities better represented in care and treatment planning.
Discussion Questions

Which social determinants of health are influencing each case scenario?

How are the identified social determinants addressed in each case? How might they be addressed more effectively?

Which other social determinants may have influenced this experience?
Discussion and Reflection: How Does Oral Health Connect to Your Work?

The **need**: What are the unmet needs to be addressed?

The **approach**: What approach do you suggest to meeting the need? Are there novel ideas you can offer?

What are the **policy implications** for this work?

The **benefits/challenges**: How do you articulate the benefits and challenges to success?

The **inputs**: Who are the influencers? Who else needs to be involved, provide buy-in or inform the approach for greater impact?
Putting Your Money Where Your Mouth Is: The Case for Funding Oral Health Programming

Local Perspectives: Tennessee Oral Health Snapshot

Veran A Fairrow, DDS, MPH; April 18, 2019
Tennessee’s first State Oral Health Plan 2017
Step 1:
Framing the issue of Dental Disease
Dental Disease in 2019

- Still in 2019: Tooth decay is one of the most common chronic conditions throughout the United States. [CDC.gov/oralhealth](https://www.cdc.gov/oralhealth)

- The average adult between the ages of 20 and 64 has three or more decayed or missing teeth. [ADA.org](https://www.ada.org)

- Because of the risk factors for tooth decay, many individuals and communities still experience high levels of tooth decay. [ADA.org](https://www.ada.org)
Dental Disease, better known as tooth decay:

- “Is the most common chronic disease of children 6 to 11 years and adolescents aged 12 to 19 years.”
- “Is 4 times more common than asthma among adolescents 14 to 17 years.”
- “9 out of 10 over the age of 20 have some degree of tooth decay.”
- “By age 34, more than 80% of people have had at least one cavity.”
- “Over $6 billion of productivity is lost each year because people miss work to get dental care.”

Dental caries (decay) is an infectious and transmissible disease; dental caries may be the most prevalent of infectious diseases that affect humans.
Framing the Issue of Dental Disease:

• Your Mouth “talks” to your Body and your Body “talks” to your Mouth.
  – Gum disease increases the risk of head & neck cancer
  – Tooth loss & gum disease increase the risk of Alzheimer's disease
  – Gum disease increases pancreatic & kidney cancer risk by 62%
  – 93% of people with gum disease are at risk for diabetes
  – Bacteria that live in your mouth can cause heart disease, high blood pressure & stroke
Figure 7 - Oral Health and Overall Wellness

The facts are...

- Gum disease increases the risk of head & neck cancer.
- Tooth loss & gum disease increase the risk of Alzheimer's disease.
- Cavities are caused by a germ that spreads while kissing & sharing food.
- Bacteria in your mouth travel to other parts of your body in your bloodstream.
- Diabetics & bleeding gums increases your risk of premature death by 450-700 percent.
- Pregnant women with gum disease have only a 1 in 7 chance of giving birth to a healthy child of normal size.
- Bacteria that live in your mouth can cause heart disease, high blood pressure & stroke.
- 83% of people with gum disease are at risk for diabetes.
- Research has found an association between gum disease and rheumatoid arthritis.
- The Surgeon General reports that at least 86% of American adults have gum disease.

Source: American Academy of Oral Systemic Health,
Dental Disease

“You cannot educate a child who is not healthy, and you cannot keep a child healthy who is not educated.”

Joycelyn Elders, MD, Former US Surgeon General

• Pool Oral Health Impacts:
  – Overall Health
  – Well-Being
  – Learning
  – School Attendance
  – Social Relationships
Step 2: Current Efforts

Prevention through:
- School-Based Programs
- Dental Clinics
- Community Water Fluoridation
Step 3: Primary Focus Areas

1. Monitoring Dental Disease in Tennessee
2. Oral Health Education & Advocacy
3. Prevention
4. Oral Health Resources & Workforce
Step 4: Recommendations
Recommendations:

• Monitoring Dental Disease in Tennessee
  – Recommendation 1: Develop a Tennessee oral health data source grid specific for the state

• Oral Health Education and Advocacy
  – Recommendation 5: Highlight integrated care models, specifically the Meharry Inter-professional Collaboration Model
Let this be the past.
Not our future

"Dentistry is the only profession that accepts amputation as treatment."
Recommendation:

- **Prevention**
  - Recommendation 5: Advocate the “lift the lip” and the fluoride varnish campaigns for medical providers

- **Oral Health Resources and Workforce**
  - Recommendation 3: Request TDH, Health Related Boards collect practicing status for dentists and hygienists during licensure and license renewal
United States per capita healthcare spending is more than twice the average of other developed countries.

**HEALTHCARE COSTS PER CAPITA (DOLLARS)**

- **Italy**: $3,542
- **U.K.**: $4,264
- **Australia**: $4,543
- **Japan**: $4,717
- **Canada**: $4,826
- **France**: $4,902
- **Sweden**: $5,511
- **Germany**: $5,728
- **Switzerland**: $8,009
- **United States**: $10,209
- **OECD Average**: $4,069


**NOTE**: Data are for 2012 or latest available. Chart uses purchasing power parities to convert data into U.S. dollars.

© 2018 Peter G. Peterson Foundation.

75% of healthcare costs are spent on PREVENTABLE DISEASES.

[ESCAPEFIREMOVIE.COM](http://ESCAPEFIREMOVIE.COM)

**source: cdc.gov**
Contact Information:

• Veran Fairrow, DDS, MPH
  – Tennessee Department of Health Director of Oral Health Services
  – veran.fairrow@tn.gov

• Tennessee State Oral Health Plan
  – www.tn.gov/oralhealth
Thank you!

Questions?
Promoting Equity Through Workforce Innovations: Impact of Dental Therapy in Tribal & Indigenous Communities

April 18, 2019

Stacy A. Bohlen, CEO, NIHB
*Sault Ste. Marie Tribe of Chippewa Indians (Michigan)*
About the National Indian Health Board

• Founded by Tribes in 1972 to serve as the Tribal advocate for healthcare

• Based in Washington DC

• Board of Directors includes a Tribal leader from each IHS Service Area elected to be the Area’s representative
Tribes: The (Ab)Original Governments in North America

The Constitution

We the People

of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common Defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this CONSTITUTION for the United States of America.

Article I.
IHS provides health care services directly to Tribes.

Urban Indian Health programs serve 600,000 AI/ANs.

Tribal governments can choose to run their own health programs in whole or in part with funding from IHS.

This choice is a direct exercise of Tribal Sovereignty.
Indian Health Service Overview

- IHS is funded at only around 56 percent of total need

- Nationally, IHS spends about $3,300 on each patient’s medical treatment – FAR less than other medical spending programs.

2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

- Medicare spending per beneficiary 2016: $12,829, 2017: $9,207
- National health spending per capita 2016: $8,759, 2017: $7,789
- Veterans medical spending per patient 2016: $7,515, 2017: $3,332
- Medicaid spending per enrollee (inflated) 2017: $3,332

See page 2 notes on reverse for sources. *Payments by other sources for medical services provided to AI/ANs outside IHS is unknown.

2/29/18 National Indian Health Board
Health Equity – An Indigenous Perspective
Health Disparities: An Indigenous Perspective

• AI/ANs born today have a life expectancy 5.5 years less than the rest of the US
  • 73.0 years to 78.5 years, respectively
  • In some states, disparity can be >20 years!

<table>
<thead>
<tr>
<th>Mortality Disparity Rates</th>
<th>AI/AN Rate 2009-2011</th>
<th>U.S. All Races Rate - 2010</th>
<th>Ratio: AI/AN to U.S. All Races</th>
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</thead>
<tbody>
<tr>
<td>All Causes</td>
<td>999.1</td>
<td>747.0</td>
<td>1.3</td>
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<tr>
<td>Diseases of the heart (Heart Disease)</td>
<td>194.7</td>
<td>179.1</td>
<td>1.1</td>
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<tr>
<td>Malignant neoplasm (cancer)</td>
<td>178.4</td>
<td>172.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Accidents (unintentional injuries)*</td>
<td>53.7</td>
<td>38.0</td>
<td>2.0</td>
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<tr>
<td>Diabetes mellitus (diabetes)</td>
<td>69.0</td>
<td>20.8</td>
<td>3.2</td>
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<tr>
<td>Alcohol-induced</td>
<td>50.0</td>
<td>7.6</td>
<td>6.5</td>
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<tr>
<td>Chronic lower respiratory diseases</td>
<td>46.6</td>
<td>42.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Cerebrovascular diseases (stroke)</td>
<td>43.6</td>
<td>39.1</td>
<td>1.1</td>
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<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>42.9</td>
<td>9.4</td>
<td>4.6</td>
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<tr>
<td>Influenza and pneumonia</td>
<td>26.6</td>
<td>15.1</td>
<td>1.8</td>
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<tr>
<td>Drug-induced</td>
<td>23.4</td>
<td>15.3</td>
<td>1.5</td>
</tr>
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<td>Nephritis, nephrotic syndrome (kidney disease)</td>
<td>22.4</td>
<td>15.3</td>
<td>1.5</td>
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<tr>
<td>Intentional self-harm (suicide)</td>
<td>20.4</td>
<td>12.1</td>
<td>1.7</td>
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<td>Alzheimer's disease</td>
<td>18.3</td>
<td>25.1</td>
<td>0.7</td>
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<td>Septicemia</td>
<td>17.3</td>
<td>10.6</td>
<td>1.6</td>
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<td>Assault (homicide)</td>
<td>11.4</td>
<td>5.4</td>
<td>2.1</td>
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<tr>
<td>Essential hypertension diseases</td>
<td>9.0</td>
<td>8.0</td>
<td>1.1</td>
</tr>
</tbody>
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* Unintentional injuries include motor vehicle crashes.
International Indigenous Health Disparities Commonalities

- Indigenous communities often have the worst health outcomes
- Regardless of nation’s health funding/coverage structure
- Result of colonialism and historical trauma
The Value of a Smile
Oral Health Crisis in American Indian/Alaska Native (AI/AN) Communities

• AI/AN children are 5x more likely than average to have untreated cavities in *permanent* teeth

• 46% of AI/AN adults age 65+ had untreated dental caries
  - Compared to 19% of non-Native adults age 65+

• Lack of oral health care services in Tribal communities has impacted generations!
Oral Health Provider Shortage in Indian Health System
A Tribal Solution: Dental Therapists

• Midlevel, focused providers

• Dentists can do ~500 procedures
  • DTs can do ~50 procedures

• But those 50 are most commonly needed
  • Meets between 1/2 and 2/3 of patient need

• Dental Therapists practice in remote settings with provider shortages
  • In Alaska since 2004

• Dentist is available for consultation
How Did Dental Therapy Come to the US?

• Practiced in 54 countries

• Starting in 2004, Alaska Tribes trained students in New Zealand
  • Tribes in Alaska run their own health care services through the Alaska Native Tribal Health Consortium

• Students came back and worked with ANTHC in their home communities

• Dr. Mary Williard and Valerie Davidson were leading forces
In Communities with Dental Therapists

- More kids get preventative care.
- Kids need fewer front teeth extractions.
- Fewer kids need general anesthesia.

<table>
<thead>
<tr>
<th></th>
<th>No DT Communities</th>
<th>High DT Communities</th>
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<tbody>
<tr>
<td>Child Preventative Care</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>15.5%</td>
<td>24.8%</td>
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<tr>
<td>Child Extraction Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.3%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Child General Anesthesia Rate</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>7.9%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>
Oral Health Delivery in Alaska Before DTs

• Many communities had no dental care at all!
• Others had only periodic visits from a dentist

• Valerie Nurr'araaluk Davidson
  • Former Lt. Governor of Alaska
  • Worked with ANTHC to bring DTs to Alaska

• Lincoln Bean’s son
  • Former NIHB Board Member
  • Son had a Dental emergency
  • Had to fly from Kake to Sitka during a storm
  • Had his condition been caught earlier, emergency services would not have been necessary
Alaska’s Dental Therapists

- 40 Dental Therapists serve over 45,000 Alaska Natives in 81 communities

- Provide culturally competent care with high patient satisfaction rates
  - 78% of DTs practice in their home village or region

- Based in larger towns that also have dentists (Bethel, Sitka, Nome)

- Travel to smaller Alaska Native communities on a regular schedule
  - Dentist follows up if necessary
Dental Therapy at Swinomish

• Swinomish hired Dental Therapist in 2016
  • The Tribe created its own licensing board with processes and standards
  • Developing this process took years of sustained Administrative support

• Since then:
  • 20% increase in patients seen
  • Dentists doing almost 50% more crown, bridge, and partials
  • Dental therapy has brought in revenue to support the expansion of the Tribe’s dental clinic
Other DT Tribes in the Pacific North West

- Port Gamble S’Klallam (WA) has a Dental Therapist since 2017
  - Washington State passed a dental therapy law

- In Oregon, Tribes are using Dental Therapists under a state pilot program
  - Dentists dedicate more time to treating complex needs.
  - One Tribe added two chairs to its clinic to see more patients.
Advocating in State Legislatures

- Many Tribes advocate to their state legislatures to license DTs

- Washington State, Arizona, Maine, Minnesota, Idaho, New Mexico, and Michigan allow DTs on Tribal land
  - Oregon has Tribal pilot projects
  - Active Tribal campaigns in Wisconsin, Montana, Nevada, & North Dakota

- NIHB helps coordinate Tribal advocacy campaigns with States
Growing Our Own

- Tribes need program closer than NZ
- Alaska training program is 3 academic years/2 calendar years
  - One year of classroom learning in Anchorage
  - One year of clinical learning in Bethel
- More than 90% of students are AI/AN
  - Dentistry is disproportionately white
- Dental Therapy is an accessible profession with steady work
Next Steps: Support for Alaska Dental Therapy Education Program

- Partnership with Ilisagvik College
  - (Far Northern Alaska)
  - Run by Dr. Mary Williard

- Educating a student costs ~$200,000

- Program needs support
  - Seeking accreditation
    - Expensive and time intensive Process
  - Expanded into facility more useful for classroom and clinical learning
Next Steps: Tribal Colleges & Universities

• Before Alaska’s program, Dental Therapists were trained in New Zealand

• Many Tribal colleges offer Associate’s degrees on a two calendar year track
  • Natural fit to replicate Alaska education program

• NIHB wants Tribal Colleges to be included in Dental Therapy education!
Next Steps: Implementation Costs

• Once legislation becomes law, battle is only half over

• Tribes still need to work with state
  • Rulemaking process
  • Medicaid Reimbursement
  • Setting up provider infrastructure

• Tribes in states with new Dental Therapy laws need support
  • Arizona
  • Michigan
  • Idaho
  • New Mexico
Resources for Getting Started at the Tribal Level

www.nihb.org/oralhealthinitiative
Changing the Narrative of Indian Health

Shutdown Leaves Food, Medicine and Pay in Doubt in Indian Country

Congress Is Starving the Indian Health Service and South Dakota Tribes Are Paying With Their Lives

Dr. Lowell Styler treated Services in Sault Ste. Mi back. Brittany Gristen for

Federal report reveals patient died needlessly in South Dakota IHS hospital

The Never-Ending Crisis at the Indian Health Service

As the chronically under-funded agency struggles, American Indians are getting sicker and dying sooner
Thank You!

Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board
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“Everyone thinks of changing the world, but no one thinks of changing himself.”

- Leo Tolstoy
Center

- Center is a state or attitude as well as a specific posture or way of acting. It is a state where we come into relationship with our bodily self in a way that is balanced and present.

- Center is your energetic base camp.

- We line up our structure in order to touch that balance within.

- Centering is not an end in itself but a self-connection we can carry into our dialogue with others, our work, and the deeper aspects of who we are.

Centering Practice:
Breath, posture, mood, commitment

• Length – Up & Down

• Width - Side to Side

• Depth- Front & Back
Pulling the Pieces Together

How can we apply the lens of equity and inclusion to system design?

What ideas presented today hold the most promise?

What would make this concept work?

What are potential outcomes?

What is the potential of this idea (quality/equity/impact)?
Commitments

What commitment can you make to further the work/dialogue when you return home?
Evaluations

You will receive the link shortly!
Save the Date!

Join us at the FOHPG Summer Meeting

Funders Oral Health Policy Group

July 31 – August 1, 2019
Austin, Texas

Guest foundations are invited to attend their first meeting compliments of FOHPG

For more information, contact us at: FOHPG@afl-enterprises.com

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