VIEWS FROM THE FIELD
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GRANT MAKERS IN HEALTH

Integrating Primary Care and Public Health: Opportunities for Oral Health

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As health philanthropy considers how to address the current individual and community burdens of increases in chronic diseases, I am optimistic when I reflect on the new and promising collaborations that are developing to better manage and prevent oral disease. There is growing urgency to address oral health at this time that is encouraging cooperation among dental care providers and primary care, public health, and health professionals.

Oral disease, though almost 100 percent preventable, represents the number one chronic disease among children. Yet, it continues to be less understood and undervalued for its importance in the assessment of an individual's health. To put this into perspective, at a recent National Health Policy Forum on Oral Health, Dr. Caswell Evans, associate dean of prevention and public health sciences, University of Illinois, and vice chairman, DentaQuest Foundation, stated, "There is likely no other body part that would go unnoticed if bleeding were to occur – for instance, if one's hand were to bleed while washing it. Bleeding and swelling gums show signs of disease and are overlooked by people *every day.* They are also a source of pain, tooth loss, shame, and social isolation for many."

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The oral health crisis can be a pathway for greater collaboration built on the basic concepts of primary care and public health. As with other disease elimination and control strategies, there is no single solution for oral disease prevention. We are, however, experiencing a level of awareness and action that positions oral health promotion and oral disease management as critical levers in our search for collaborative and productive action.

In the U.S. Surgeon General's *Report on Oral Health* (2000) and the subsequent Surgeon General's *Call to Action on Oral Health* (2003), Dr. Satcher pronounced oral health diseases a "silent epidemic," and Dr. Carmona issued the call for organizations, policymakers, and the professions to create collaborative models to reduce this disease. One action prescribed by the 2003 set of imperatives was to increase collaboration and partnerships to address oral health. In 2007, when the story of the death of a 12-year-old child from Maryland from an untreated dental infection was reported in *The Washington Post*, a new urgency was raised for all segments of the community to act to prevent the deaths of children or anyone from untreated oral disease.

Here is a summary of progress:

- Health philanthropy has increased its organizing around oral health. A group that began in 2005 as an informal gathering of six philanthropic institutions interested in becoming engaged in community oral health has now over 25 members.
- Grantmakers In Health has organized webinars and educational sessions to meet a demand of funders to better understand the dimensions of oral disease, a recurring health priority of the communities they serve.
- Collaborative funder engagement has led to the creation of a National Interprofessional Initiative on Oral Health, a growing collaboration of primary care health professions focused on making oral health a component of the education, licensing, and professional certification of primary care health professionals (primary care, obstetrics/gynecology, pediatrics, physician assistants, nursing, dentistry) supported by a common curriculum (*Smiles for Life*) and common resources.
- The *Smiles for Life* on-line oral health curriculum developed by the Society of Teachers of Family Medicine has achieved acceptance among professional organizations such as the American Academy of Family Practice, the American

Academy of Pediatrics, and soon, the American Academy of Physician Assistants and the American Nursing Association.

- A new U.S. National Oral Health Alliance is forming to promote common ground and involve multiple stakeholders concerned with the nation's oral health access problems.

These new national initiatives involve significant systems and cultural changes. They require the professions to utilize the bodies of knowledge and skills that are available in primary care, and they are finding pathways to work in partnership with the dental community to enhance the understanding of the benefits of working together in the context of greater community engagement.

Just as we experienced deep-rooted cultural differences between primary care and public health in earlier decades, we must attend to the historical dimensions of dental care. The dental profession is strongly rooted in the concept of personal dental services. As with primary care professionals, the demands and flow of care and the accompanying business models can be limiting factors for engaging beyond the everyday schedule of providing excellent care. As we are being challenged to get closer to the roots of our nation's health problems, we appreciate the interconnected combinations of conditions, biology, and the way people live their lives and work to influence each of these potential co-factors in the prevention of oral disease. The dental profession is growing in its appreciation of the benefits of community-based prevention strategies and broad multisectoral organizing for health, and sharing the primacy of its stakeholder role regarding conditions of the mouth.

The current state of affairs reminds me of the journey taken by medical professions to greater community collaboration. *Medicine and Public Health* (1997) involved multiple stakeholders in data collection and dialogue on how medicine and public health could move beyond programs to real change on behalf of better health for patients. The Institute of Medicine's *Improving Health in the Community* (1997) recommended community collaboration as a means of engaging clinicians and public health practitioners with their communities of interest. Dr. Hugh Fulmer at Carney Hospital in Dorchester, Massachusetts, pioneered *Community-Oriented Primary Care*, a new educational model for young clinicians seeking to understand the socioeconomic conditions that surrounded their patients. These earlier efforts experimented with "community" as the connection to people, using geography, race, ethnicity, gender, and, more recently, sexual orientation as opportunities for engagement.

This multisector approach proved successful with asthma management in health centers. We gained familiarity with peer health promotion, especially as community health workers, sometimes referred to as *promotoras*, peer educators, or natural helpers; partnered with primary care practitioners; delivered health messages; and encouraged behavior change with difficult-to-reach patients. Consider where the HIV/AIDS epidemic would be now if not for the willingness for partnerships among health professionals and people who represent communities most affected. The understanding of environment, stressors, and disease patterns helped hundreds of individuals, especially children, have better outcomes and better quality of life overall. There is an opportunity today to do the same with oral health.

Having worked in public health and prevention for over 30 years on numerous health topics, I am more and more convinced that we have overlooked an essential component of overall health by separating the mouth from the body. There is a need for policies that emphasize a commitment to wellness and disease prevention and a paradigm that appreciates environmental and social determinants of certain preventable illnesses. As funders, we can initiate and support opportunities to engage likely and unlikely partners in consensus building to encourage the importance of preventing oral disease.

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This is an opportunity for leadership in prevention. It is a call to redesign broken systems. The time is ripe for public/private partnerships and leaders who can facilitate change and forge alliances. I am greatly encouraged by the enthusiasm for the new U.S. National Oral Health Alliance and its commitment to forge common ground as it addresses access to oral health care and prevention. I believe that given the resources, including factual information and data, communities of people will make good choices about their health. I am encouraged by my colleagues in philanthropy who appreciate shared accountability for relieving social burdens by promoting collaboration among grantees, funders, and the broader community.

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