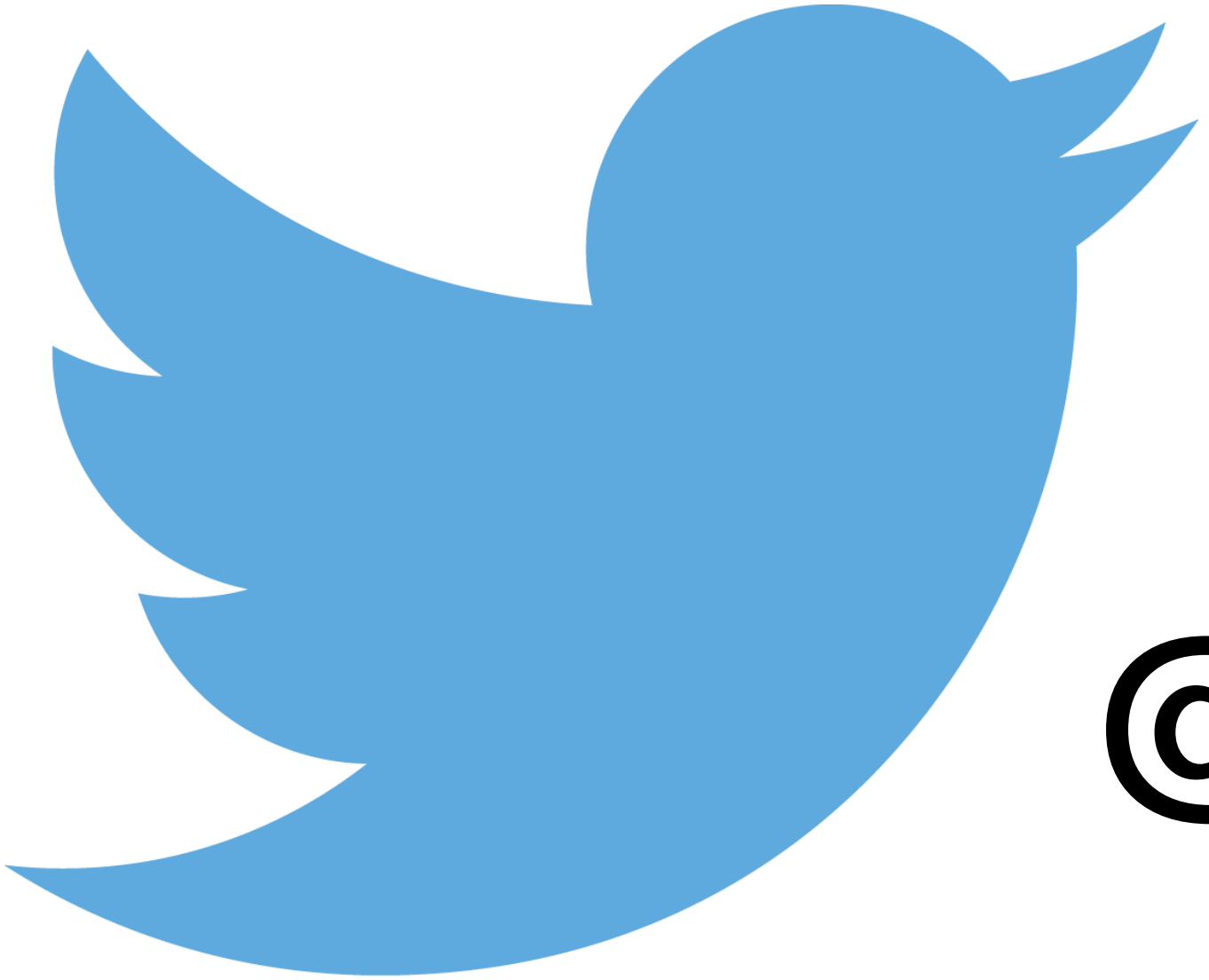
Funders Oral Health Policy Group



@GIHealth

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

Funders Oral Health Policy Group

The Oral Health System Today: Opportunities, Gaps, and Barriers

children's dental health project

Grantmakers in Health + Funder Oral Health Policy Group

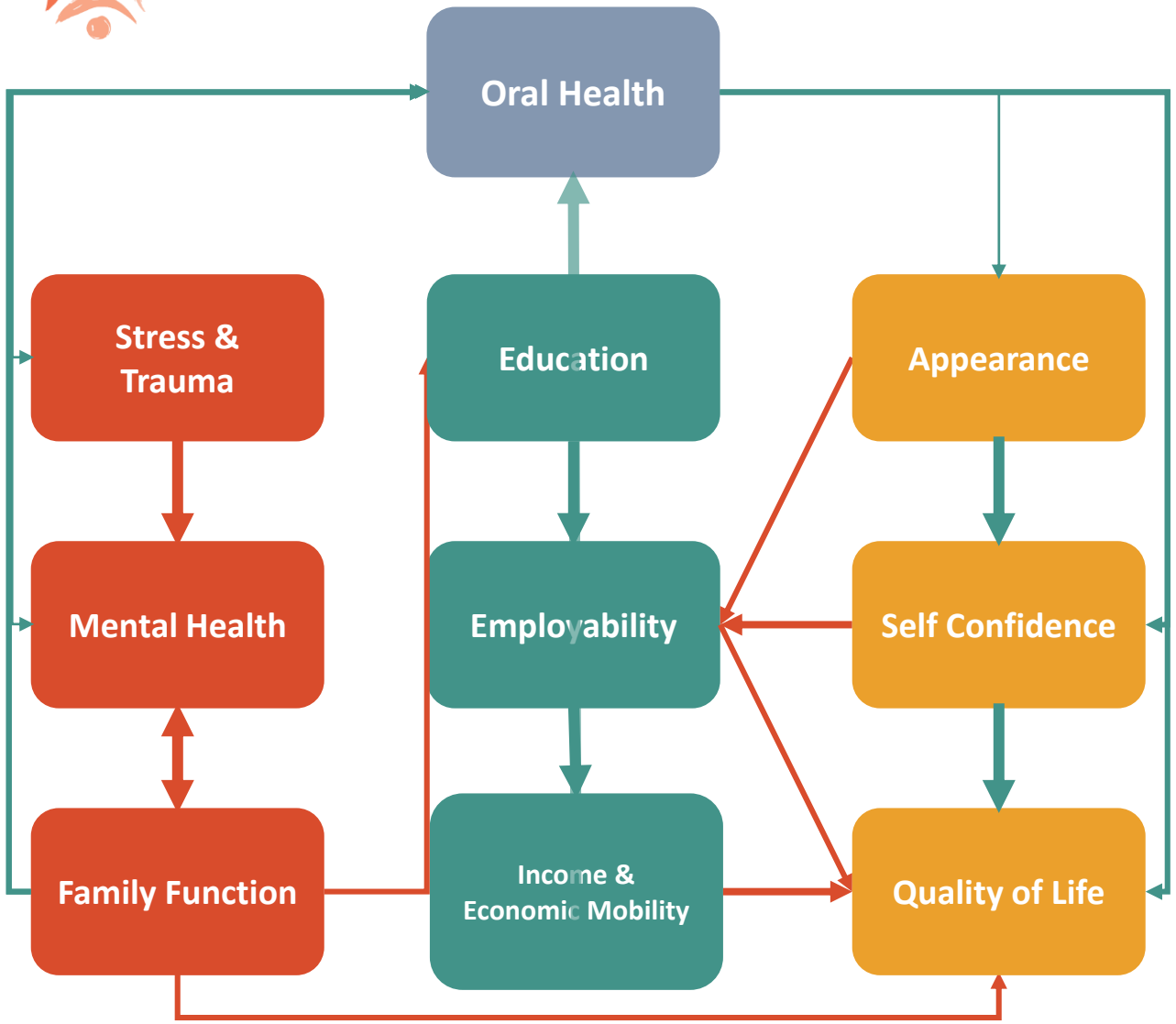
We believe that **no family should be held back from their dreams because of dental disease**. In 1997, CDHP was conceived to advance innovative policy solutions to address the inequities of dental disease.

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 System



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

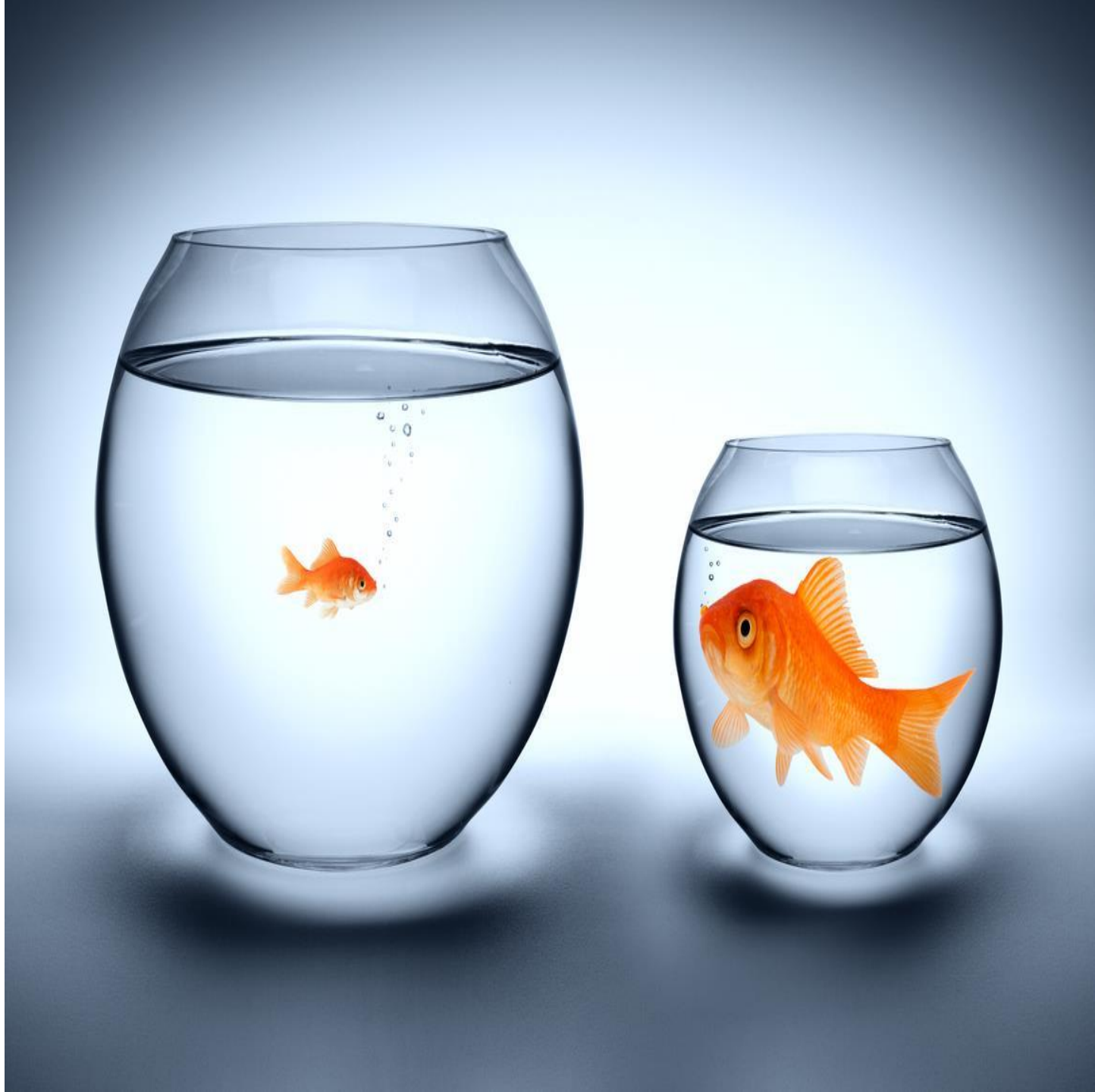
2x

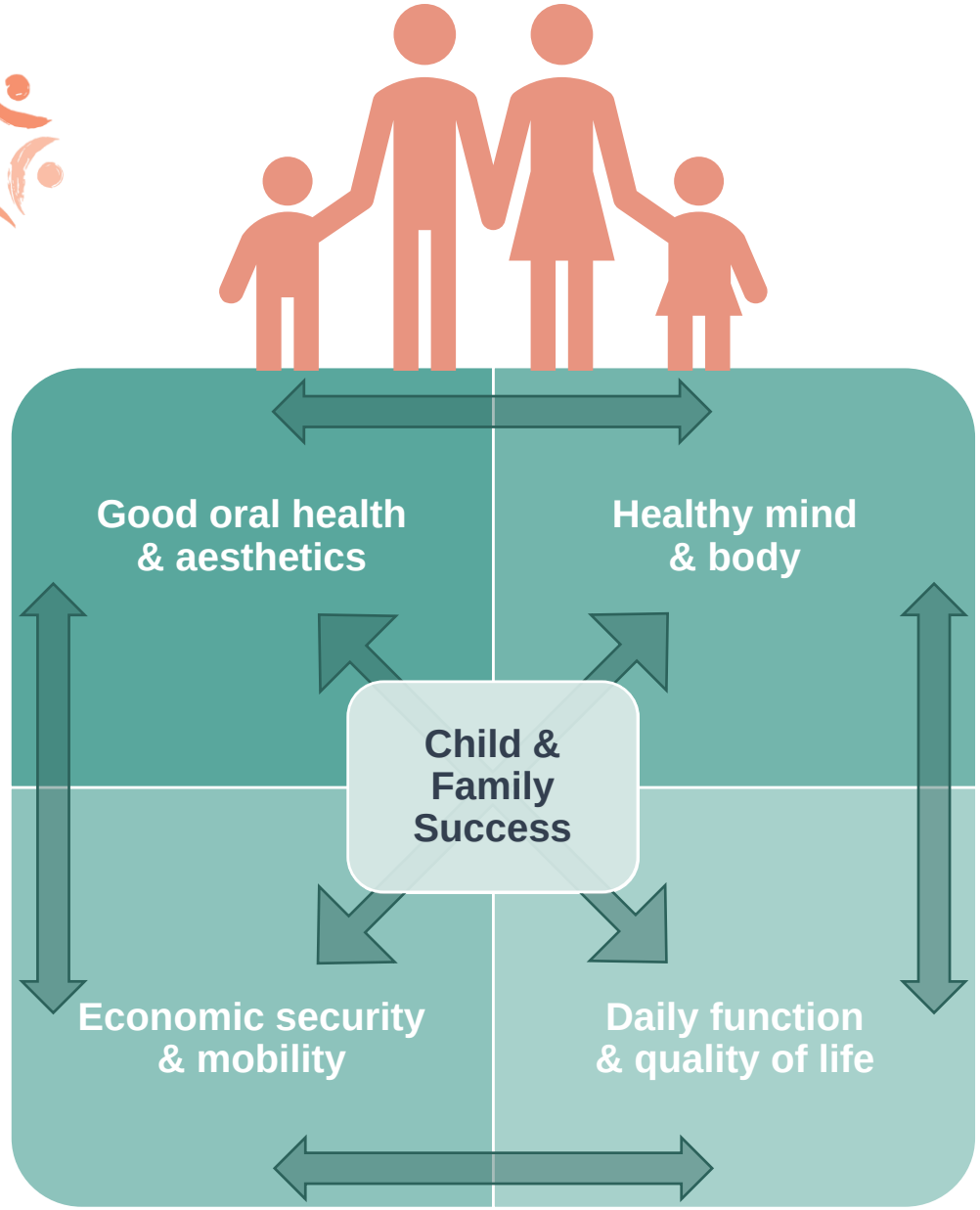
more likely than Hispanic adults to lose all of their teeth

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

Children's Dental Health Project, 2019. Fact Sheet. Meeting children's and families' comprehensive health needs: Building two-generation models that incorporate oral health. Available at: https://www.cdhp.org/resources/338-family-factors-shape-kids-ability-to-achieve-good-oral-health

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

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@Teeth_Matter

www.cdhp.org

children's dental health project

CPEHN

California Pan-Ethnic Health Network

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 build people power to influence policymakers through lived experience and community expertise for equity centered policies and systems

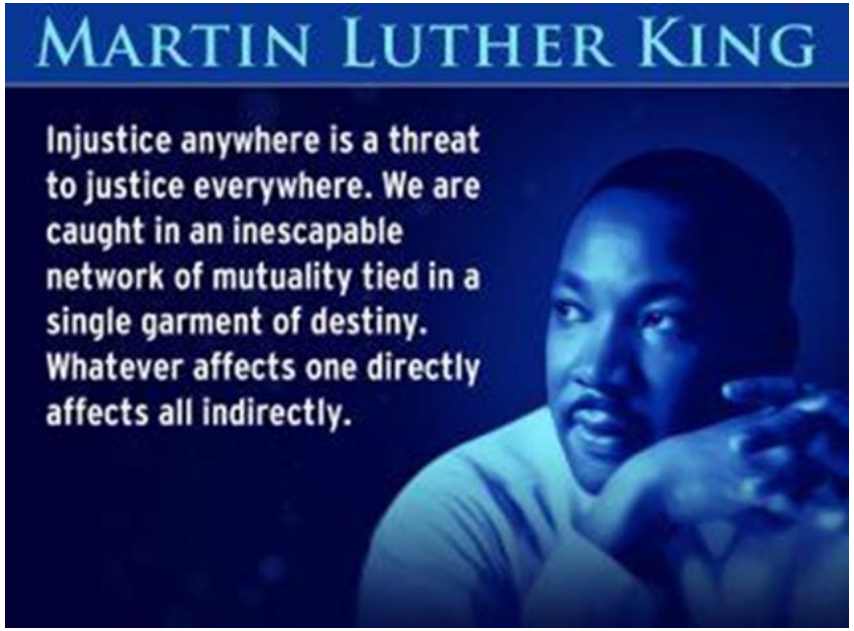
We advance equity-centered policies that reflect community needs for better health

We amplify voices and stories to build leadership, sustainability, and advocacy strength

We connect and convene partners, and regions to build knowledge, relationships, and understanding across cultures

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.

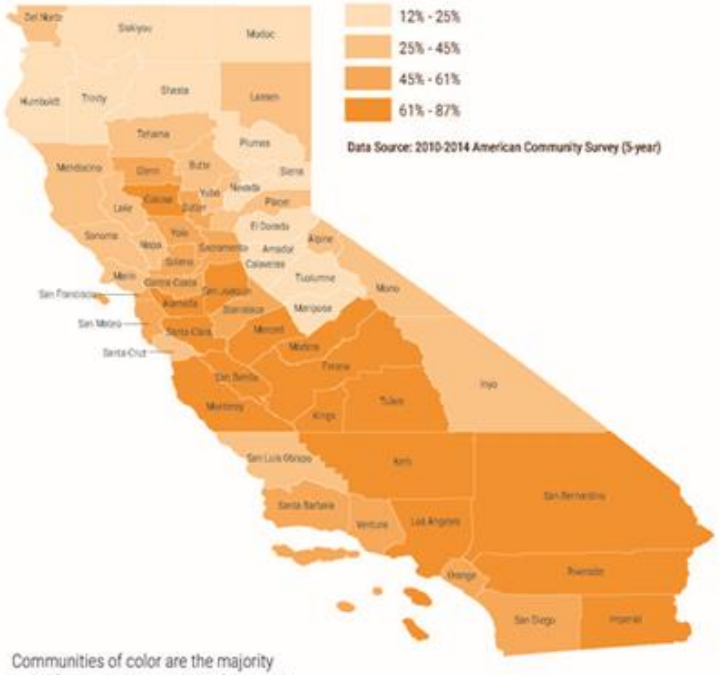
We must work together across race, income, sector and system to advocate for the many who don't have access to oral health care and prevention

Until we all have an equal opportunity to live healthy lives, we will all live in an unjust society

Social Conditions Impact our Health

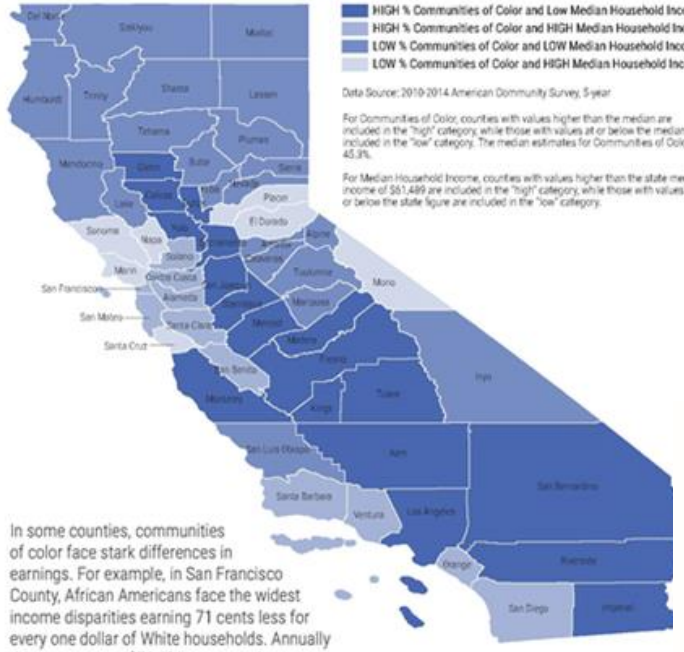
CPEHN
California Pan-Ethnic Health Network

MAP 1
Communities of Color in California



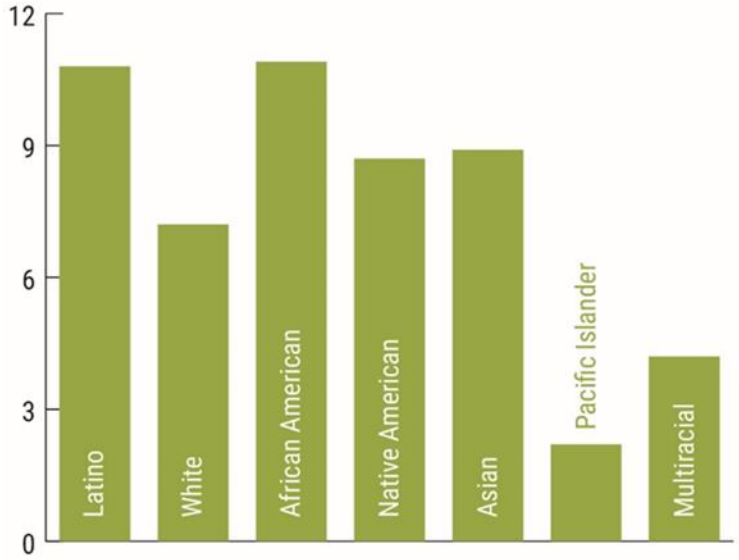
Communities of color are the majority in California, making up 61% of the total population. Imperial (87%), Los Angeles (73%), and Merced (69%) counties have the highest percent of communities of color.

MAP 2
Median Household Income and Communities of Color

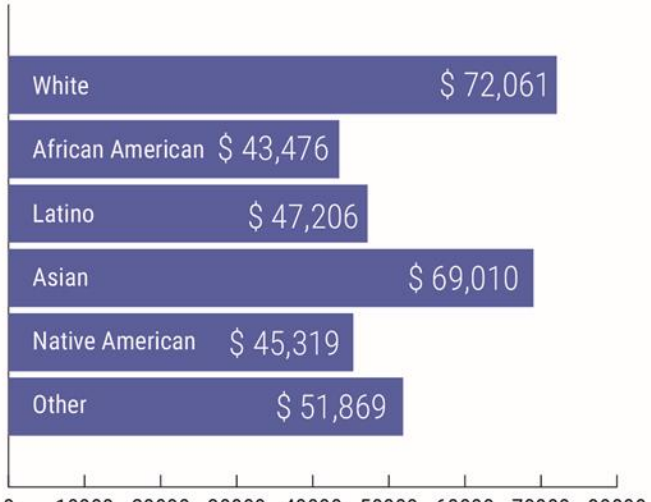


In some counties, communities of color face stark differences in earnings. For example, in San Francisco County, African Americans face the widest income disparities earning 71 cents less for every one dollar of White households. Annually this equates to a $71,491 wage gap between African American and White households. Latinos fare worse in Sierra County (62 cents less) and American Indian/Alaska Native in Mono County (81 cents less).[38]

Diagnosed With Diabetes



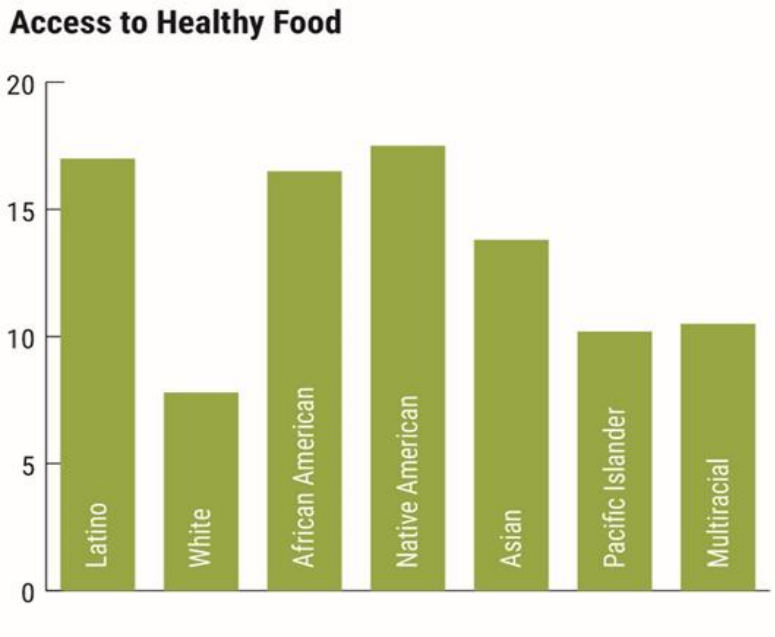
Median Household Income by Race/Ethnicity



Oral Health & the Environment

CPEHN
California Pan-Ethnic Health Network

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 Desarollo 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

CPEHN
California Pan-Ethnic Health Network

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

CPEHN
California Pan-Ethnic Health Network

- 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)

KRC

BLACK WOMEN FOR WELLNESS

ROOTS community health center

ASIAN PACIFIC ISLANDER FORWARD MOVEMENT

ASIAN HEALTH SERVICES

CENTRO BINACIONAL PARA EL DESARROLLO INDÍGENA OAXAQUEÑO
BINATIONAL CENTER FOR THE DEVELOPMENT OF OAXACAN INDIGENOUS COMMUNITIES

NileSisters DEVELOPMENT INITIATIVE

LATINO HEALTH ACCESS

INLAND EMPIRE IMMIGRANT YOUTH COALITION

Findings from Oral Health Assessment

CPEHN
California Pan-Ethnic Health Network

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

Everyone loves WINS!

CPEHN
California Pan-Ethnic Health Network

- **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?

CPEHN
California Pan-Ethnic Health Network

California OPEN Oral Health Progress and Equity Network

Policy Priorities

- Language Access
- Surgary 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

OPEN Oral Health Progress and Equity Network

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:

Sarah de Guia

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 Business Plan

The Office of Business Practice Improvement, Emory University's Internal Consulting Group

<u>What will it do?</u>

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).

<u>Benefit/Value:</u>

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

Robert Wood Johnson Foundation – Clinical Scholars
R. Howard Dobbs, Jr. Foundation

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

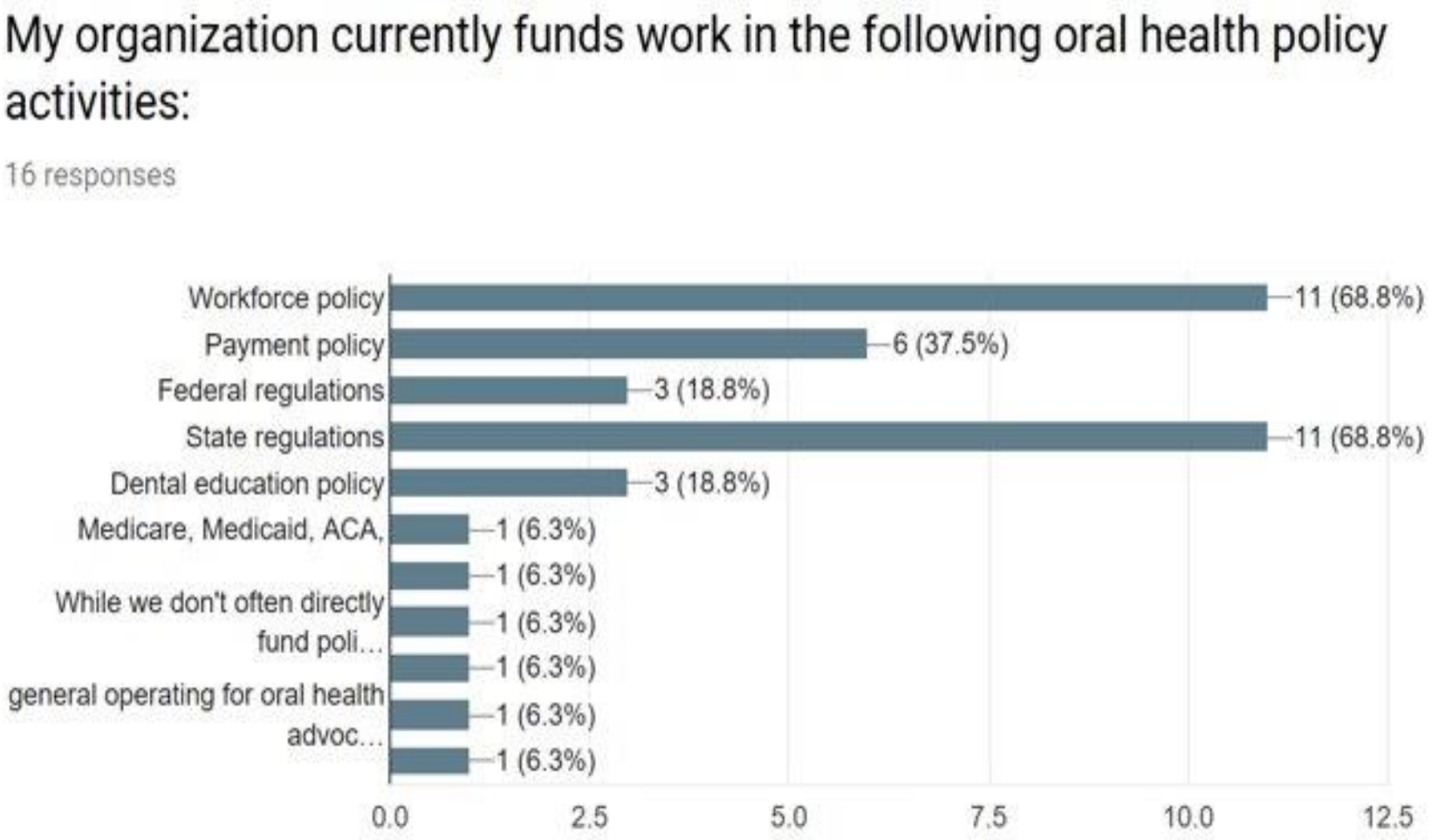
JEFFREY S. KIM, PROGRAM DIRECTOR
THE CALIFORNIA WELLNESS FOUNDATION

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



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 educaiton
YOUR	IDEAS	HERE

E.G., ADVOCACY FIELD BUILDING & EQUITY

CPEHN

California Pan-Ethnic Health Network

Advancing health justice and equity for 25 years

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

DISCUSSION

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 inter-connectedness 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.

AFL ENTERPRISES
DESIGNING SOLUTIONS

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

- The average adult between the ages of 20 and 64 has three or more decayed or missing teeth. ADA.org

- Because of the risk factors for tooth decay, many individuals and communities still experience high levels of tooth decay.

ADA.org

Dental Disease, better known as tooth decay:

"Is the most common chronic disease of children 6 to 11years and adolescents aged 12 to 19 years."

"Is 4 times more common than asthma among adolescents 14 to 17 years."

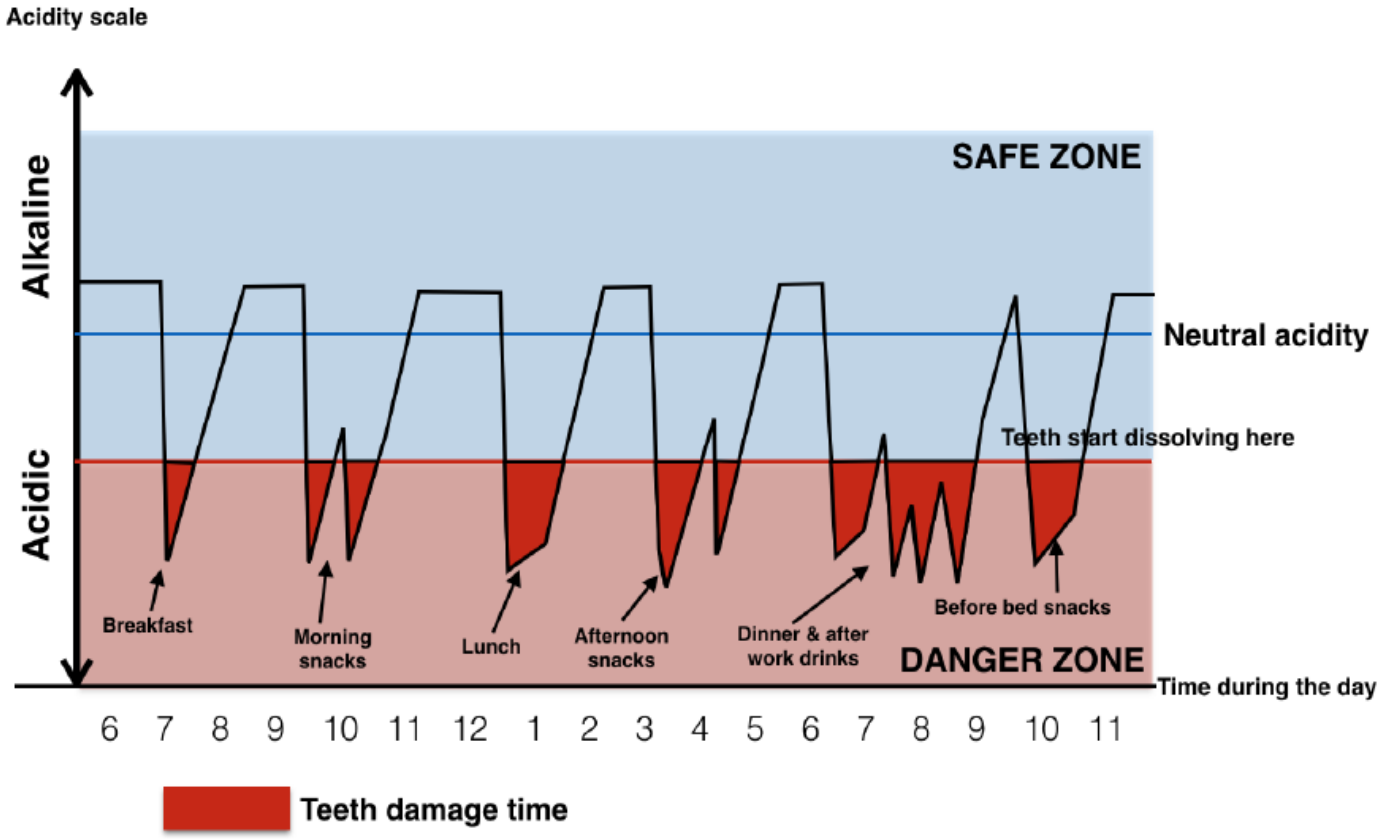
"9 out of 10 over the age of 20 have some degree of tooth decay."

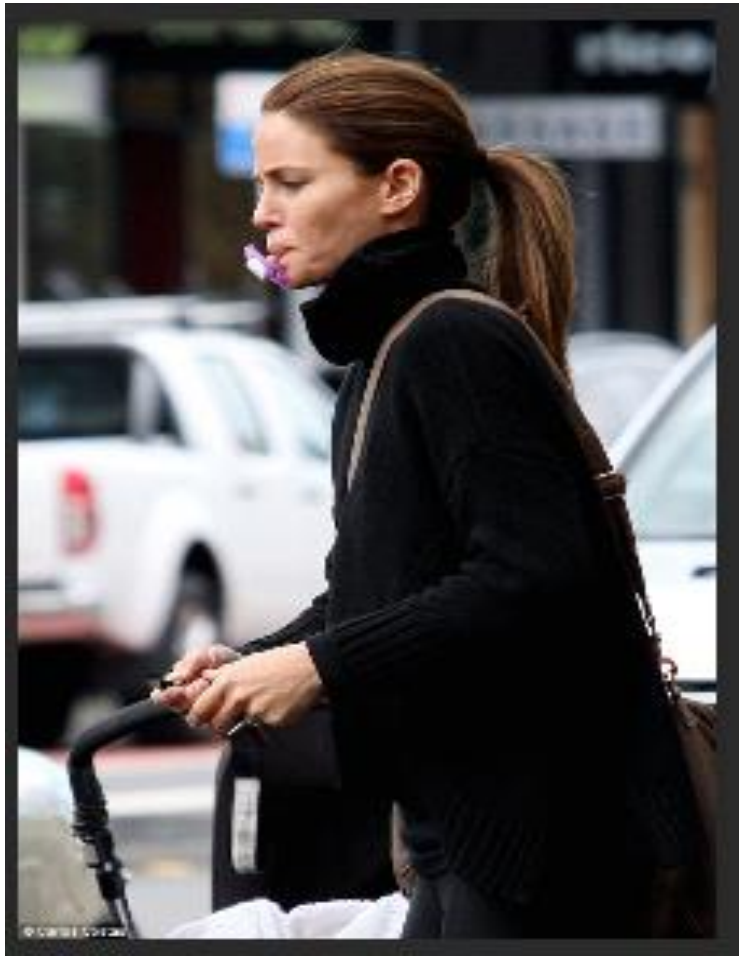
"By age 34, more than 80% of people have had at least one cavity."

"Over $6 billion of productivity is lost each year because people miss work to get dental care."

Source: "Oral Health". Centers for Disease Control and Prevention, updated June, 29, 2017. https://www.cdc.gov/OralHealth/index.html, accessed March 2017.

Dental caries (decay) is an <u>infectious and transmissible</u> disease; dental caries may be the most prevalent of infectious diseases that affect humans

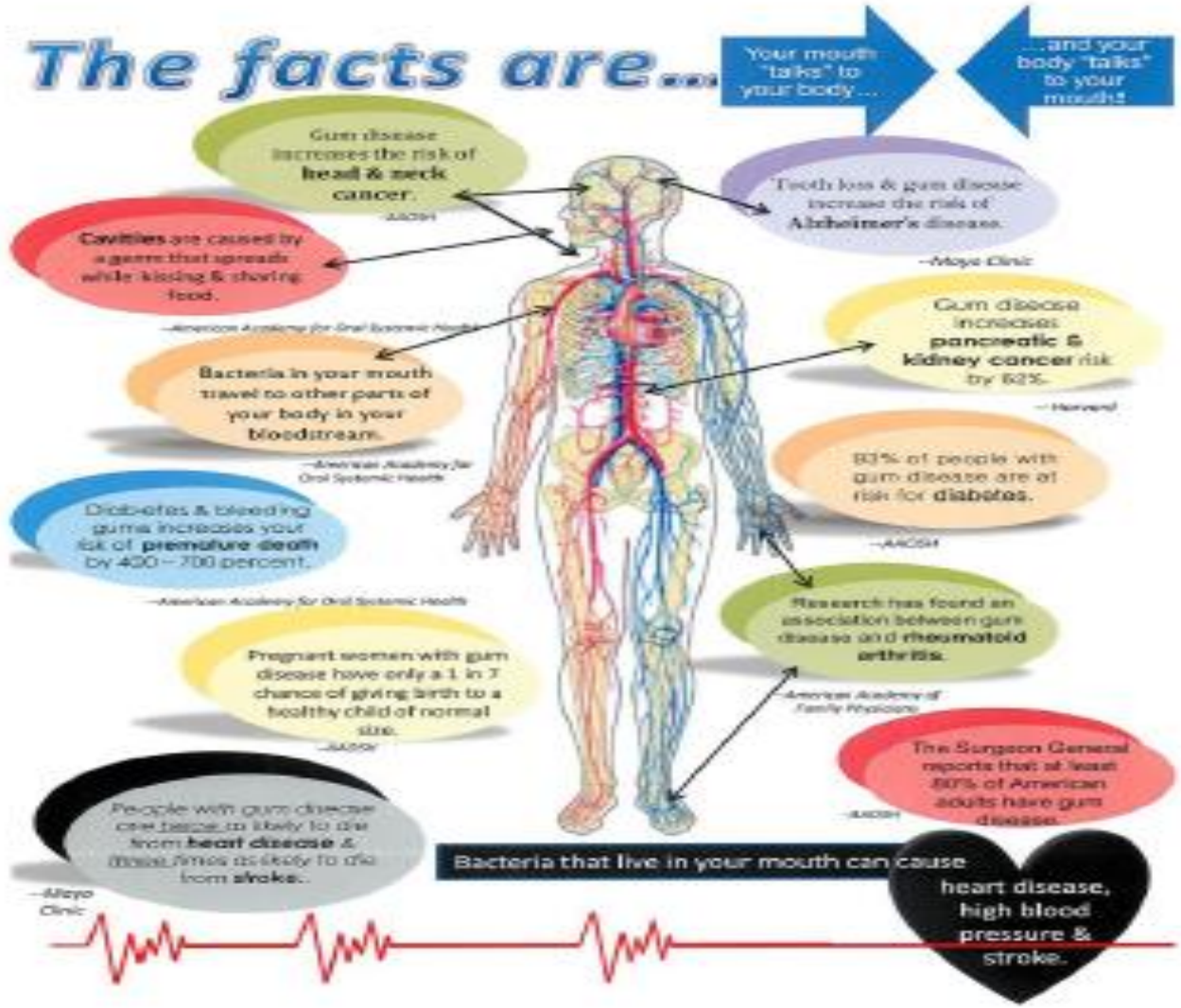




Framing the Issue of Dental Disease:

- 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



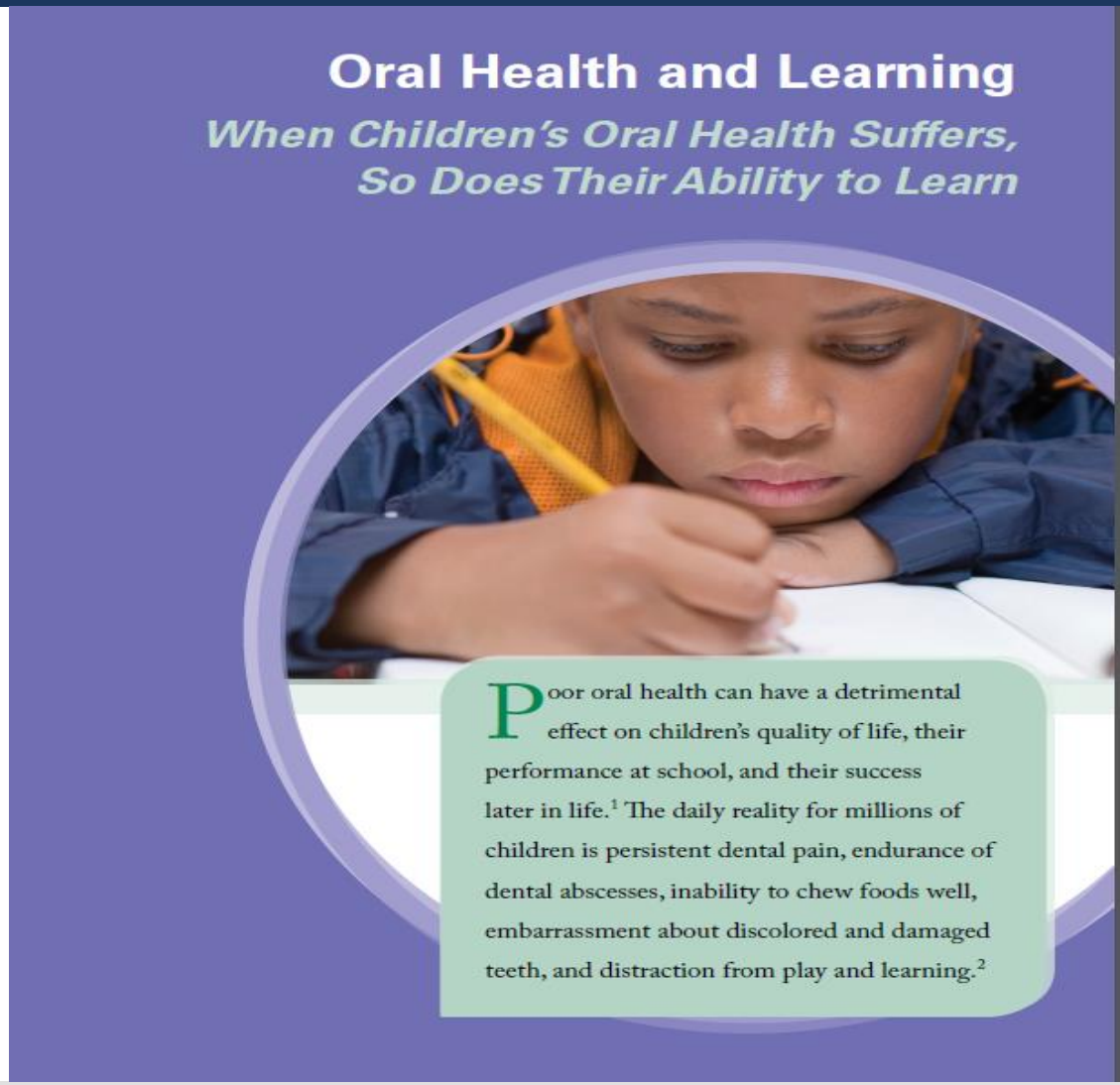
Source: American Academy of Oral Systemic Health, https://www.heritagedentalva.com/files/2014/03/infographic-oralsystemichealth.jpg, accessed July 2017.

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



TN Department of Health

Step 2:

Current Efforts

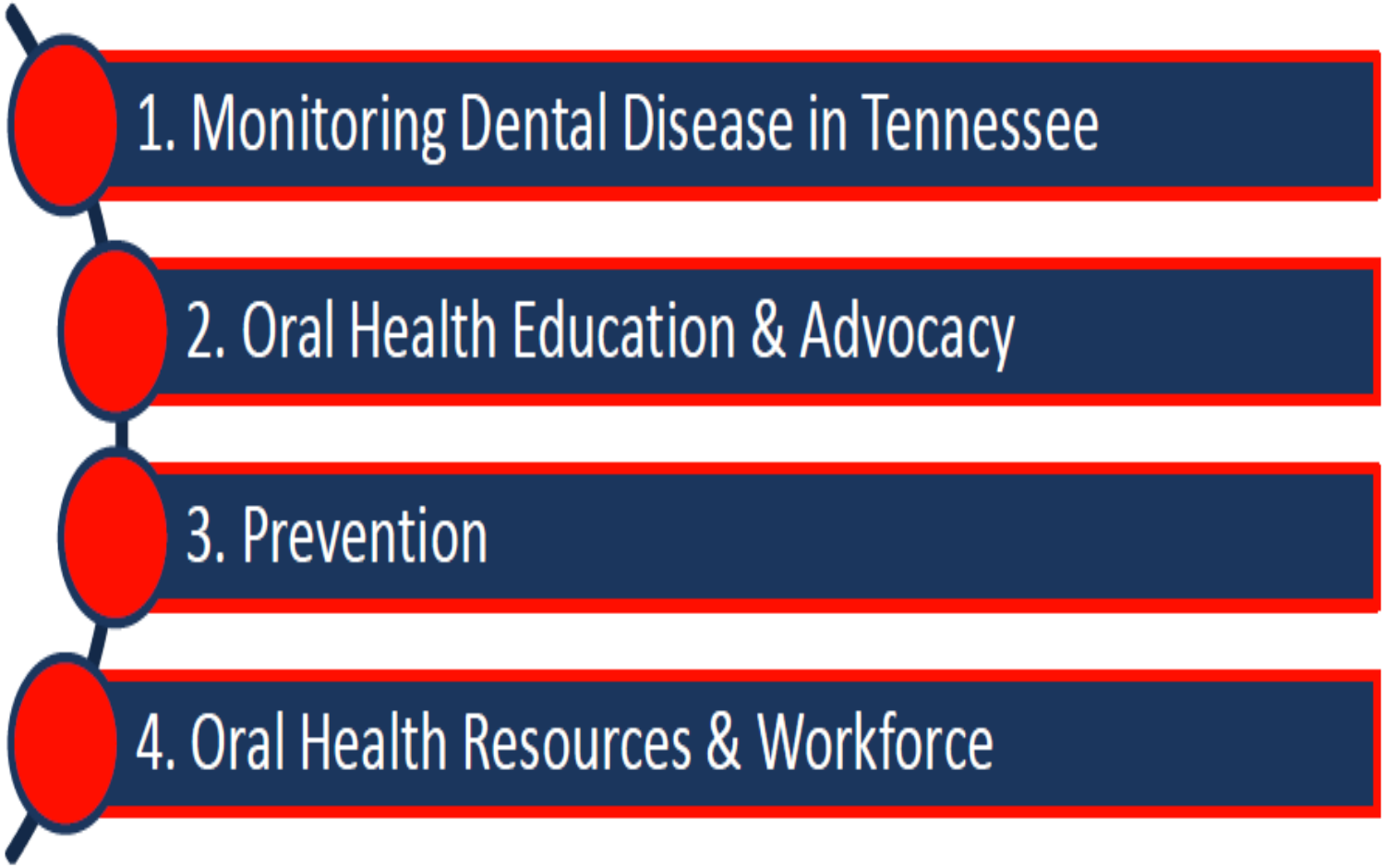
Prevention through:

- -School-Based Programs
- -Dental Clinics
- -Community Water Fluoridation

TN Department of Health

Step 3:

Primary Focus Areas



Step 4:

Recommendations

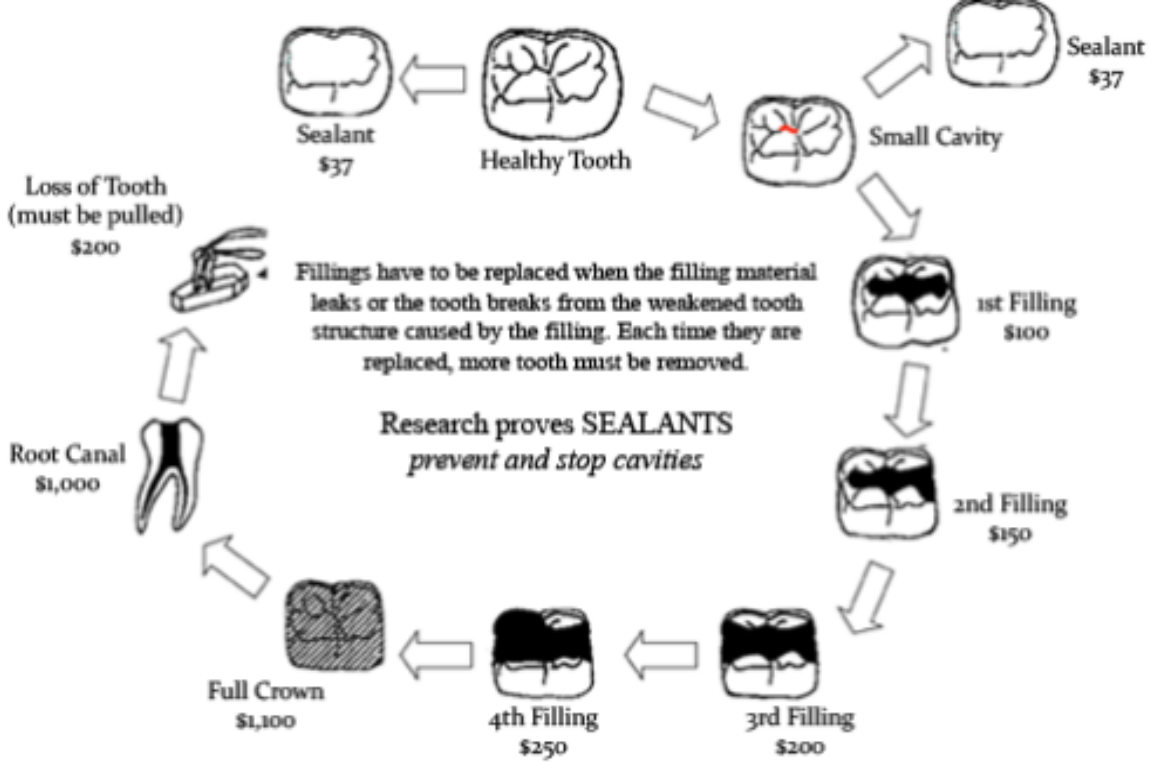
Recommendations:

- 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

TN Department of Health

Let this be the past.
Not our future



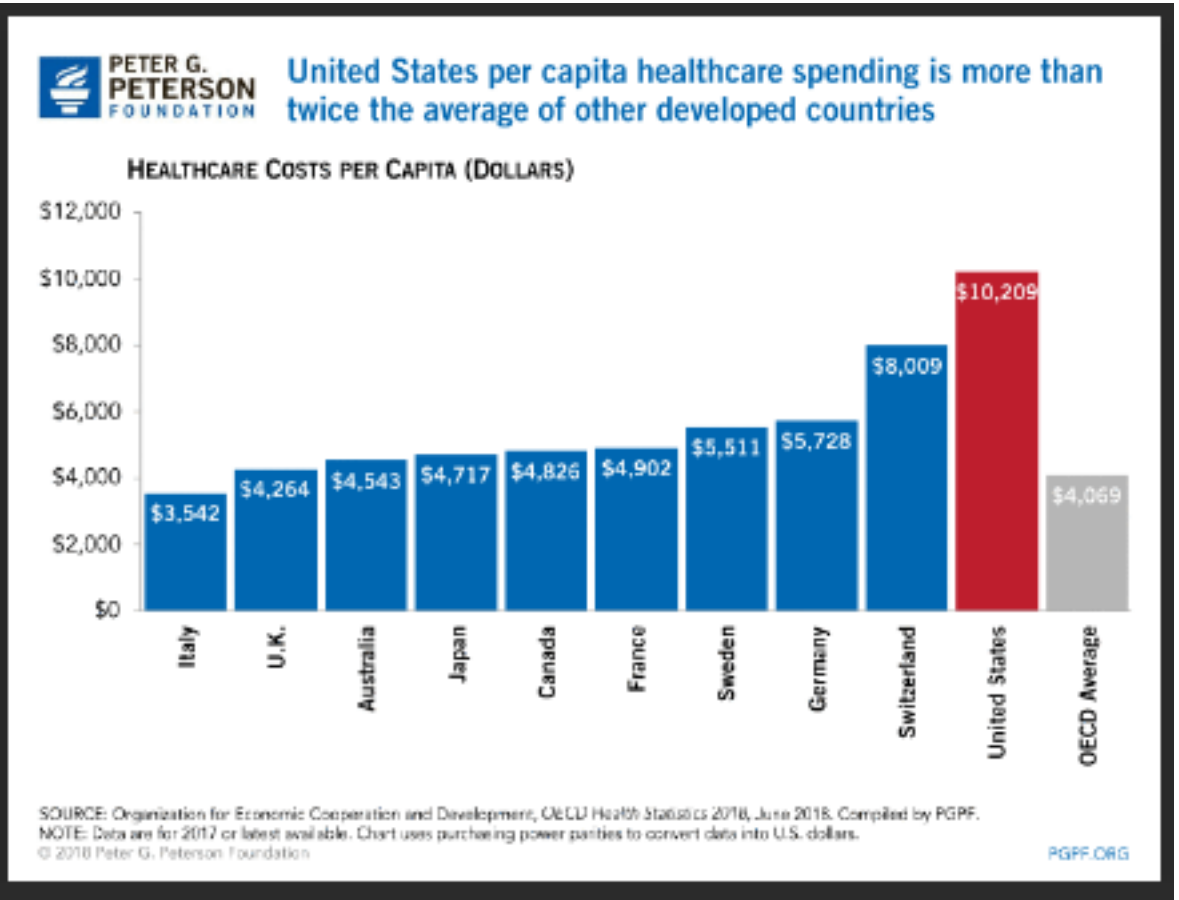
"Dentistry is the only profession that accepts amputation as treatment."

=

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

TN Department of Health



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)

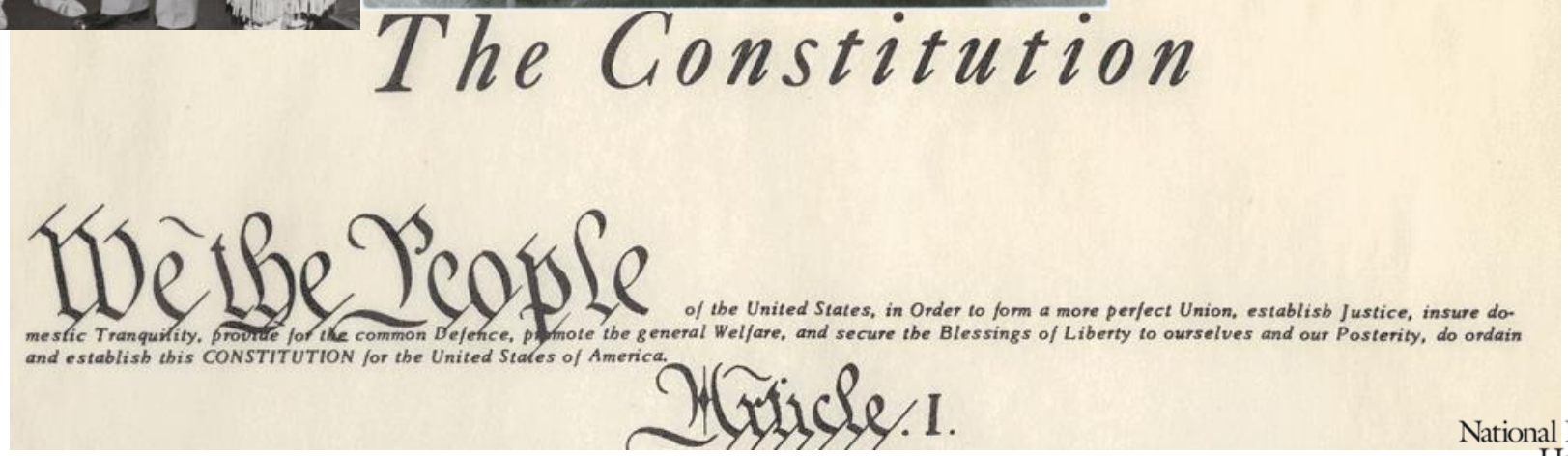
National Indian Health Board

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

National Indian Health Board

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.

National Indian Health Board

IHS provides health care services directly to Tribes

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

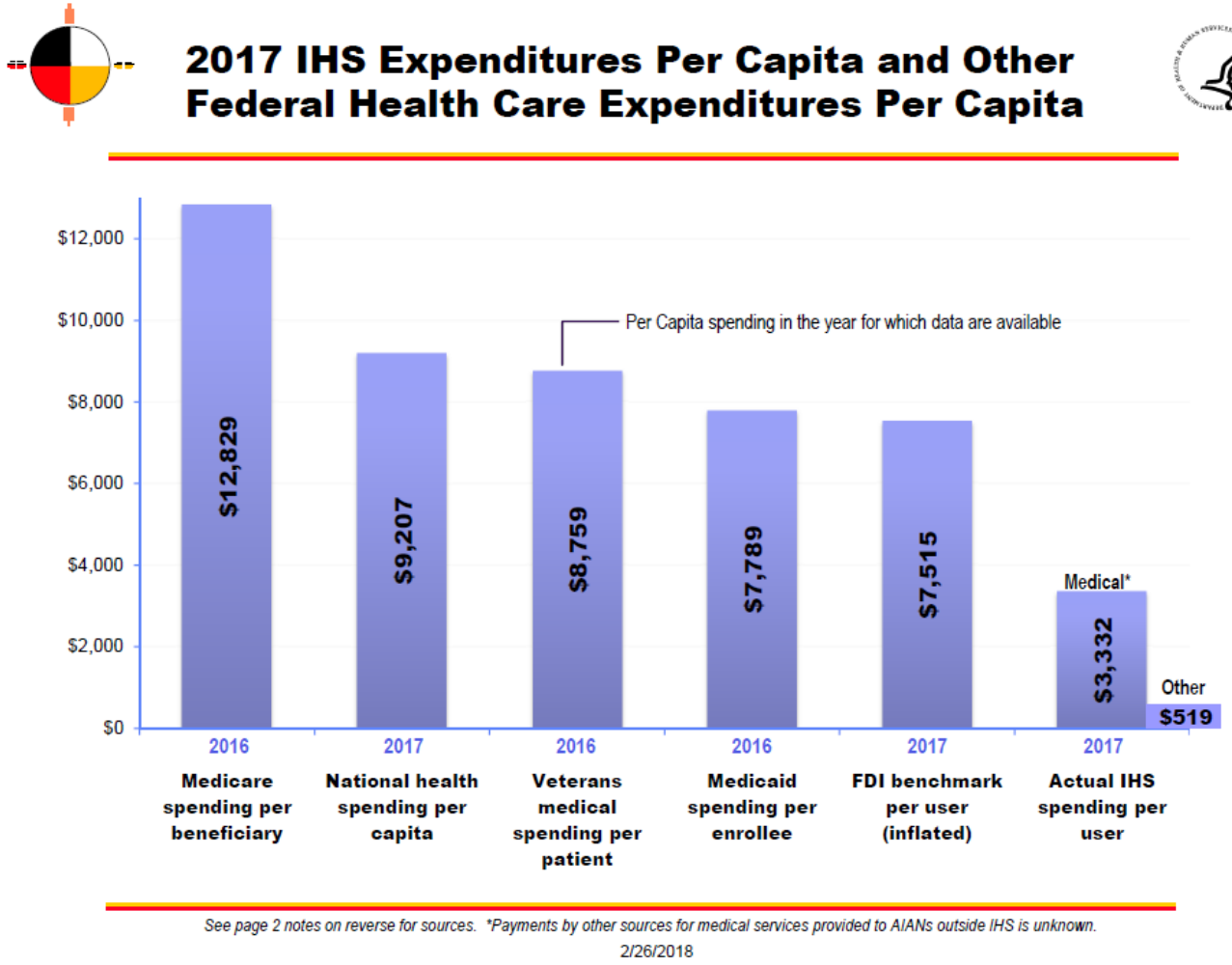
Urban Indian Health programs serve 600,000 AI/ANs

Indian Health System

National Indian Health Board

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.



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Health Equity – An Indigenous Perspective

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Health Disparities: An Indigenous Perspective

MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area
2009-2011 and U.S. All Races 2010
(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 2009-2011	U.S. All Races Rate - 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES	999.1	747.0	1.3
Diseases of the heart (Heart Disease)	194.7	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.0	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular diseases (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	15.3	1.5
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1

* Unintentional injuries include motor vehicle crashes.

- 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!

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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

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The Value of a Smile

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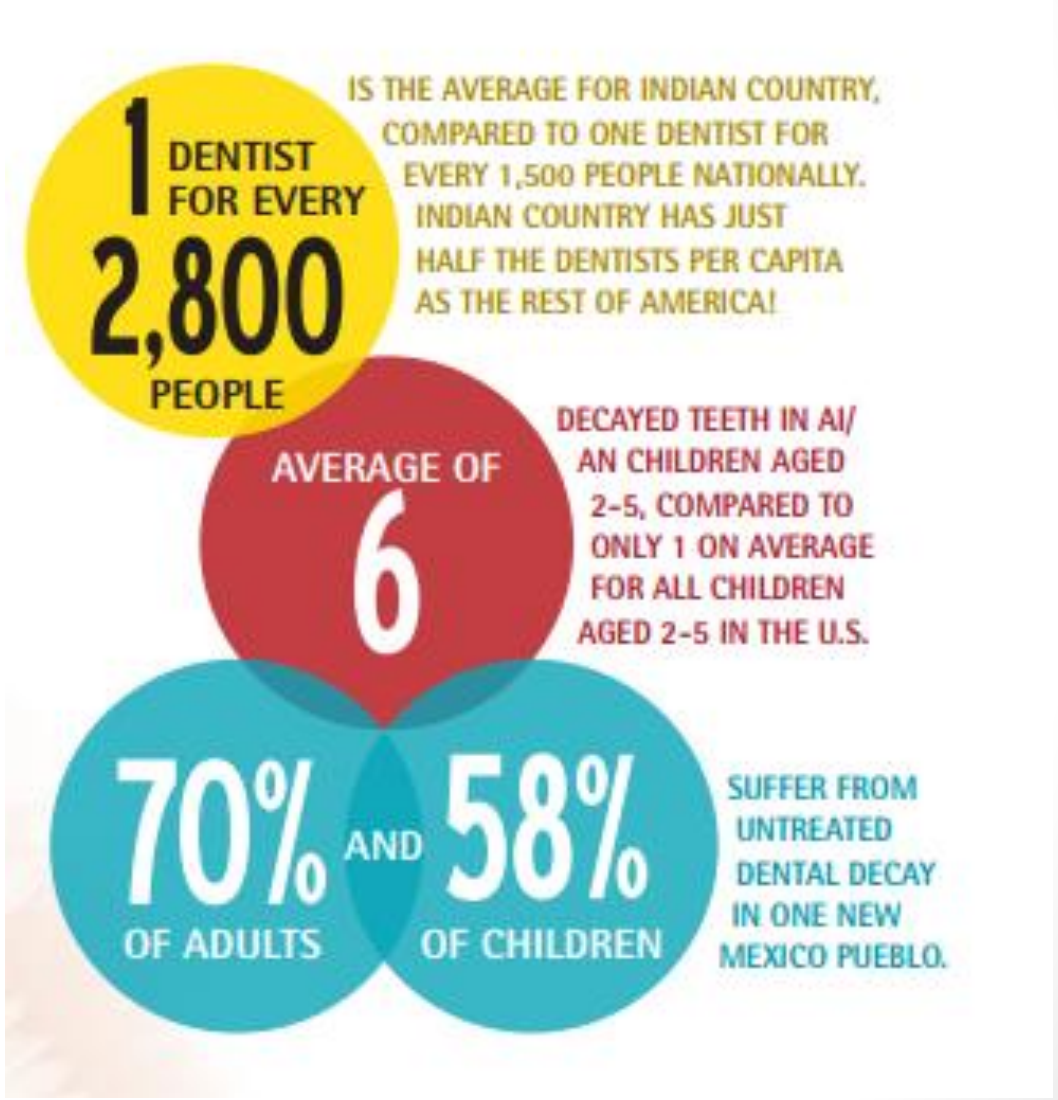
Oral Health Crisis in American Indian/Alaska Native (AI/AN) Communities

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

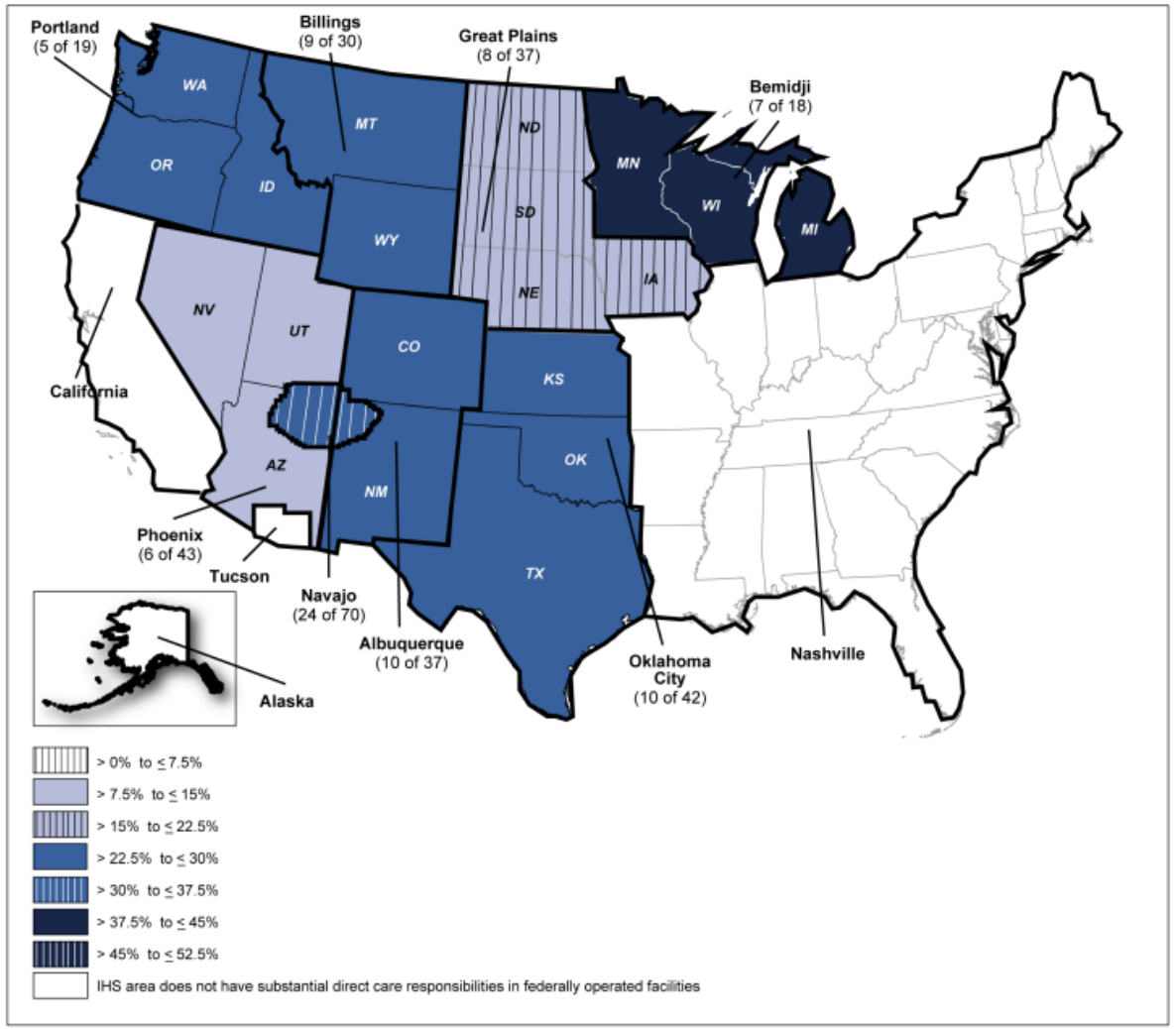
- 46% of AI/AN adults age 65+ had untreated dental caries
  - Compared to 19% of non-Native adults age 65+

- Lack of oral health care services in Tribal communities has impacted generations!



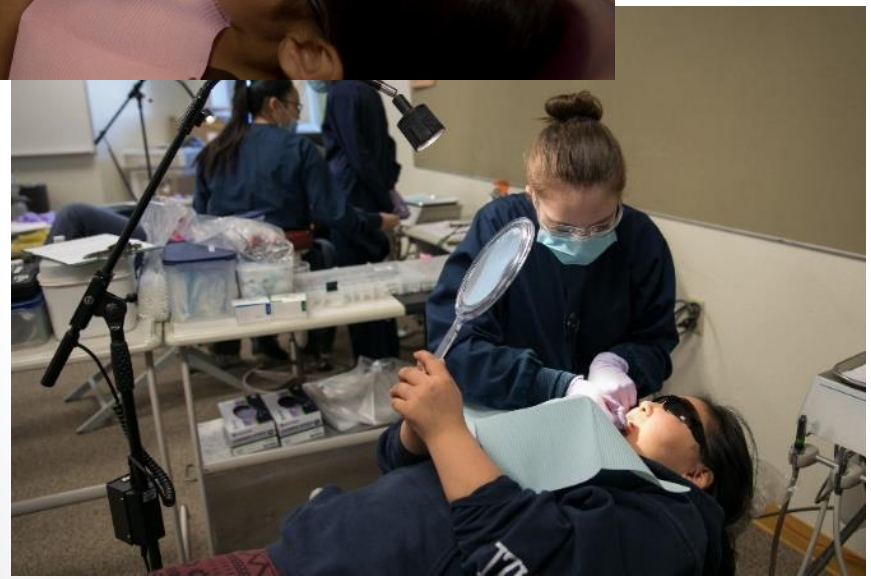
Oral Health Provider Shortage in Indian Health System

Figure 9: Dentist Vacancy Rates in the Eight Indian Health Service (IHS) Areas with Substantial Direct Care Responsibilities, November 2017



Sources: GAO analysis of IHS data; Map Resources (map). | GAO-18-580

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

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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

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

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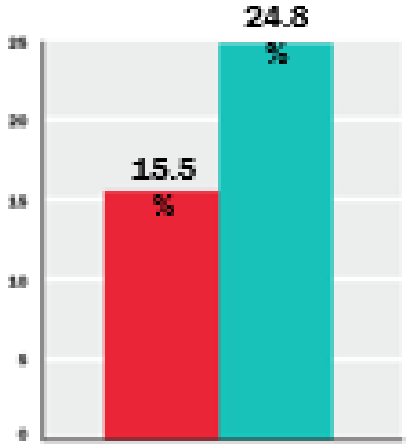
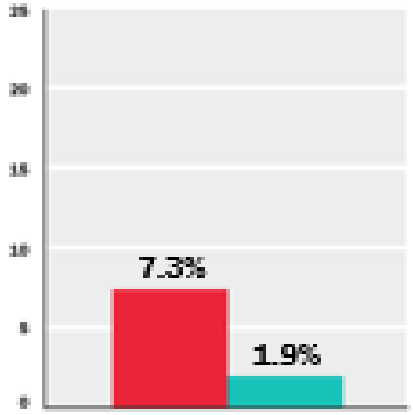
In Communities with Dental Therapists

More kids get preventative care.



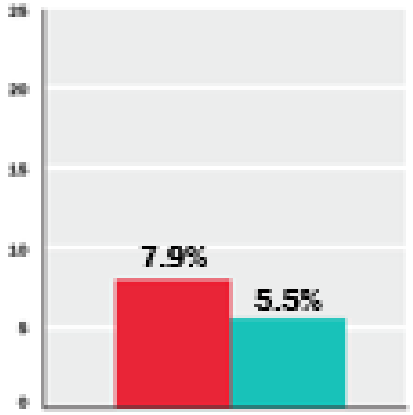
Child Preventative Care

Kids need fewer front teeth extractions.



Child Extraction Rate

Fewer kids need general anesthesia.



Child General Anesthesia Rate

No DT Communities High DT Communities

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Oral Health Delivery in Alaska Before DTs

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

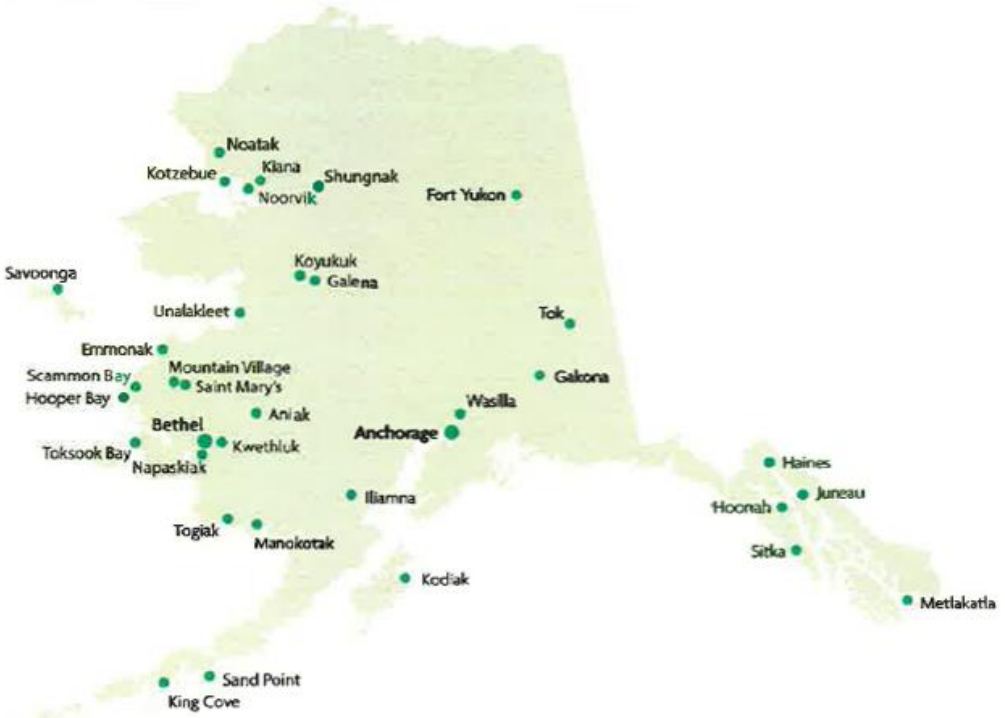
- Valerie Nurr'araaluk Davidson
  - Former Lt. Governor of Alaska
  - Worked with ANTHC to bring DTs to Alaska

- 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

Alaska Dental Therapy Educational Program (ADTEP)



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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.

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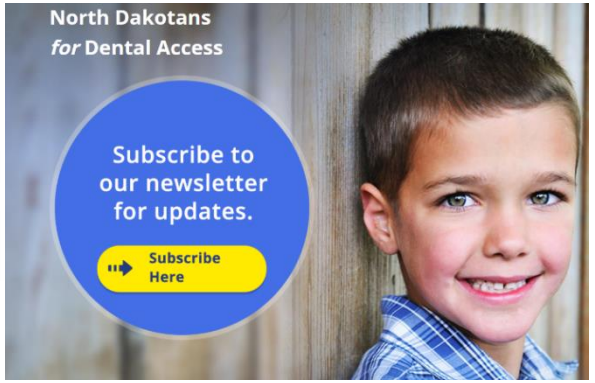
Advocating in State Legislatures

- 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

Native Dental Therapy Initiative

Inter Tribal Council of Arizona, Inc.
21 TRIBAL NATIONS

Health Action New Mexico



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!

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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

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Changing the Narrative of Indian Health

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

Dr. Lowell Styler treated
Services in Sault Ste. Ma
back. Brittany Greeson for

Federal report reveals patient died needlessly in South Dakota IHS hospital

Dana Ferguson, Sioux Falls Argus Leader Published 5:13 p.m. CT Aug. 17, 2018 | Updated 1:30 p.m. CT Aug. 18, 2018

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

Nick Martin
12/05/18 2:01pm • Filed to: NATIVE AMERICANS

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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!

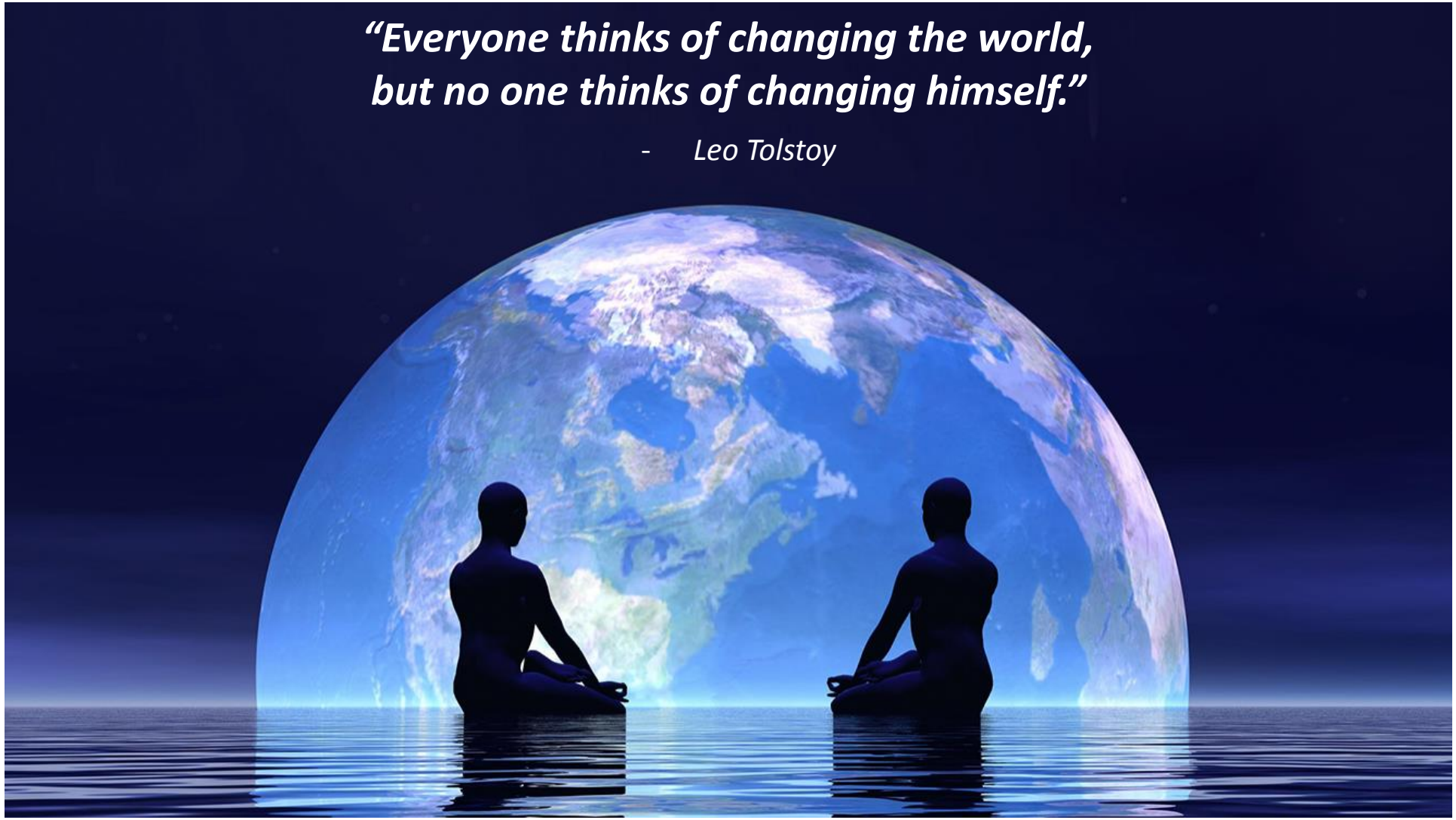
Stacy A. Bohlen

Chief Executive Officer

National Indian Health Board

sbohlen@nihb.org

National Indian Health Board
Tribal Oral Health Initiative


“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

Source: Anatomy of Change, Richard Strozzi Heckler (1993)

Centering Practice:
Breath, posture, mood, commitment

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?

Funders Oral Health Policy Group

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

FOHPG is facilitated by AFL Enterprises

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