A Framework for Advancing Oral Health Equity

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Agenda

• Welcome and Introductions
• Overview of Oral Health Equity
• Perspectives from the Field: State Approaches to Advancing Oral Health Equity
  ▶ North Carolina Oral Health Collaborative
  ▶ Connecticut Oral Health Initiative
• Questions & Answers
Welcome and Introductions

June Glover
Program Officer
Center for Health Care Strategies

M. Zulayka Santiago
Director
North Carolina Oral Health Collaborative

Mary Moran Boudreau
Executive Director
Connecticut Oral Health Initiative
About the Center for Health Care Strategies

CHCS is a non-profit policy center dedicated to improving the health of low-income Americans.

Our Priorities and Strategies

**Enhancing access to coverage and services**

**Advancing delivery system and payment reform**

**Integrating services for people with complex needs**

- Best practice dissemination
- Collaborative learning
- Technical assistance
- Leadership and capacity building
Select National CHCS Initiatives

Access to Coverage and Services
- Technical Assistance for State Health Reform Assistance Network
- Charity Care Affinity Group
- Advancing Dental Access, Innovation, and Quality for Medicaid-Enrolled Adults

Delivery System and Payment Reform
- Technical Assistance for the SIM Resource Center*
- Advancing Medicaid ACOs: A Learning Collaborative
- New York State DSRIP Performing Provider Systems Learning Network

Services for People with Complex Needs
- Complex Care Innovation Lab
- Technical Assistance for CMS Integrated Care Resource Center*
- CMS Medicaid Health Homes Technical Assistance *

Leadership and Capacity
- Medicaid Leadership Institute
- DHCS Academy

*Federally-funded initiatives
Focus of CHCS Oral Health Initiatives

- Direct technical assistance to state Medicaid agencies and stakeholders to support their strategies to advance oral health
- Production of publications and tools that increase awareness about the importance of oral health and provide guidance on advancing oral health care access
- Analyses of oral health utilization and expenditures among Medicaid-enrolled adults
Overview of Oral Health Equity
What is Health Equity?

• Health equity is social justice in health, i.e., not denying someone the possibility to be healthy because he or she belongs to a historically disadvantaged group
  
  “Being healthy” requires access to “resources such as quality health care, education, health-promoting physical and social conditions in homes, neighborhoods, and workplaces...”

• Health equity is intertwined with health disparities

Source: Braveman P. What are Health Disparities and Health Equity? We Need to Be Clear. San Francisco, CA: Center on Social Disparities in Health. 2014.
Health disparities are “the metrics we use to measure progress toward achieving health equity”

- A particular type of health difference that is closely linked with economic, social, or environmental disadvantage ...based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (CDC Healthy People 2020)
Factors Driving Health Disparities

- Access to affordable and culturally appropriate health and human services
- Quality education
- Affordable, quality, and healthy housing
- Early childhood development
- Healthy physical environment
- Access to affordable food systems and affordable, healthy foods

Source: King County Equity Impact Review Tool, 2009
Levels of Bias

Macro Level
- Institutional
- Structural

Micro Level
- Interpersonal
- Internal

Source: Race Forward
Macro Levels of Bias

- **Structural bias** is bias across institutions and society. It is the cumulative and compounded result of systematic privilege extended to some people based on race, gender, or other dimensions of identity.

- **Institutional bias** occurs within institutions. It is discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts based on race, gender, or other dimensions of identity.

Source: Race Forward
Micro Levels of Bias

- **Interpersonal bias** occurs between individuals. This is how our personal beliefs affect interactions with others.

- **Internal bias** lies within individuals. These are personal manifestations of bias that influence how we view ourselves and how we expect others to view us.

Source: Race Forward
### Addressing the Levels

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<th>Macro</th>
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<tbody>
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<td><strong>Structural</strong></td>
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<tr>
<td>- Promoting values of equity, inclusion, and access for all</td>
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<td>- Highlighting history, root causes, and cumulative impacts</td>
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<td><strong>Institutional</strong></td>
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<td>- Implementing policies to incentivize system reform</td>
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<td>- Establishing best practices on equity and inclusion</td>
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<th>Micro</th>
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<tr>
<td><strong>Interpersonal</strong></td>
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<td>- Training workforce to be inclusive and culturally competent</td>
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<td>- Holding community events</td>
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<td><strong>Internal</strong></td>
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<tr>
<td>- Raising awareness for behavioral change</td>
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<td>- Mentoring/counseling</td>
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Source: Race Forward
• Support for five teams in states across the country to produce logic models and assess the impact of their programs on oral health equity.
• Teams hailed from CT, MA, NC, PA and SC.
Equity Impact Analysis

1. Are all disparate groups who are affected by the effort participating in the process?
2. How will the proposed effort affect each group?
3. How will the proposed effort be perceived by each group?
4. Does the effort worsen or ignore existing disparities?
5. Based on the above responses, what revisions are needed in the effort under discussion?

Source: Annie E. Casey Foundation, Race Matters: Racial Equity Impact Analysis
Preparing a Logic Model to Advance Oral Health Equity

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<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-Term Outcomes</th>
<th>Long-Term Outcomes</th>
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Questions?

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Perspectives from the Field: State Approaches to Advancing Oral Health Equity
PURPOSE

The North Carolina Oral Health Collaborative convenes diverse stakeholders to identify and resolve consumer-level and systemic barriers to good oral health and to accelerate implementation of policies and practices that reduce oral health disparities and promote improved oral health for all North Carolinians.
Values

Our values are both a way to prioritize our work and a call to action. They express our underlying assumptions about what it will take to improve oral health for all North Carolinians.

• Prevention
• Whole person care
• Equity
• Cultural competence
• Patient engagement
• Efficiency
• Guided by Science and Evidence
Guiding Principles

Our guiding principles are a compass for decision making and provide context about how the work that needs to be done.

- Accountability
- Boldness
- Collaboration
- Commitment
- Impact
3 Focus Areas:
- Health Promotion & Community Engagement
- Access & Health Equity
- Prevention & Early Diagnosis

Frequency of Meetings:
- Full Collaborative: 2x/Year
- Workgroups: Every 6-8 weeks
- CAT: Every month

Representation:
- Statewide
- Grass-tops, Intermediaries, Grassroots
- Social (nonprofits, faith-based)
- Public (universities/colleges, federal, state, and county agencies, schools, elected officials)
- Private (foundations, dentists, doctors, childcare providers, other businesses)
Oral Health Disparities in North Carolina

Number of Dentists per 100,000 Population

- North Carolina: 57.3, 42.3 (2001, 2013)
- U.S.: 60.5, 47.9 (2001, 2013)

Percentage of Dentists Participating in Medicaid for Child Dental Services in 2014

- North Carolina: 27%
- U.S.: 42%
Oral Health Disparities in North Carolina

Percent of kindergartners who come to school with untreated decay:

- 6% of White children in Orange County
- 15% of all children statewide
- 18% of Black children statewide
- 31% of all children in Chowan County and Hertford County (Eastern/rural part of our state)
- 44% of Hispanic children in Vance County
### STRATEGIES
- Public awareness
- Research and policy change
- Capacity-building
- Convening and coalition-building

### RESOURCES
- NCOHC staff, leadership, workgroups and membership
- F4HLI (backbone)
- Funding partners

### OUTPUTS
- State-of-the-State report
- Communications campaigns
- Oral health equity curriculum
- 2017 oral health legislative agenda
- Updated website
- Trainings and webinars

### LONG-TERM OUTCOMES

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<td>1A/B. Increase awareness of the public and non-dental health care providers.</td>
<td>2A. Increase the number of oral health providers that provide high-quality services for underserved/vulnerable populations.</td>
<td>3A. Increase access of children to ongoing oral health preventative treatment services, early diagnosis, and a dental home.</td>
</tr>
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<td>1C/D. Increase the quantity and quality of community advocates for oral health equity.</td>
<td>2B. Increase awareness of primary care providers and dental health providers about the importance of their collaboration to advance oral health.</td>
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<td>1E. Increase the commitment of supportive state legislators to oral health equity.</td>
<td>2C. Increase readiness of dental providers to pilot innovative programs that increase access to oral health care.</td>
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<td>1F. Increase the power and influence of the NCOHC to advance its agenda.</td>
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### IMPACT
North Carolinians recognize dental disease is preventable and can access quality and affordable oral health services to achieve better overall health and well-being.
Theory of Change

Draft, 4/13/16

Vision

Oral health equity for ALL North Carolinians

Impact

Informed public
Informed and engaged advocates
Welcoming and accessible OH care providers
Cavity-free children

Outcomes

Increase awareness of general public
Increase awareness and engagement of community advocates
Increase dentist-champions (emerging and practicing)
Increase oral health providers
Change policies and laws
Increase access to preventative oral health services in community settings

Strategies

Stronger, more inclusive movement for oral health equity

Enhance communications (GYMR and other consultants)
Organizational capacity-building and grassroots organizing:
- Mini-grants
- OH Equity Curriculum
Individual capacity-building and engaging new actors:
- Convenings
- Workgroups
- Scientific Advisory Board
- DOF-ROHC
Build and collect evidence for advocacy:
- State of the State
- Health Impact Assessment
- Report Card
- Data Snapshot
Influence policy development, decisions and implementation:
- Oral Health Agenda
- Oral Health Legislative Day
Highlight innovative service delivery and pilot projects:
- Care Share Network
- Safety Net Solutions
- Teledentistry
- Innovation Bank
“Let people’s experiences be the truths we build our solutions on.”

--Crystallee Crain, PhD
What is the WORK that lies ahead for 2016 and HOW does this address oral health equity?

• Continue growing/strengthening the NCOHC network
• Increase public awareness, community engagement and capacity building
• Research and engage key stakeholders in building the NC Oral Health Agenda
• Prepare for 2017 Oral Health Legislative Day
CONTACT:

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Director, NC Oral Health Collaborative
Phone: 919.821.0485 ext. 233
zulayka.santiago@foundationhli.org
Questions?

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Your questions will be viewable only to CHCS staff.
Mary Moran Boudreau, RDH, MBA
Executive Director
Through advocacy, coalition building and education, COHI works to create a public conscience that results in “Oral Health for All.”

COHI enhances this mission by:

• Leading and collaborating in state oral health advocacy efforts
• Promoting the necessity of oral health to overall health
• Serving as an expert resource on oral health policy
• Publicizing oral health policy analysis and recommendations
History of Connecticut Oral Health Initiative

• Origins
  • Oral Health 2000
  • 2000: Developed own identity
  • 2001: Incorporated and found funding

• History
  • Carr v. Wilson-Coker lawsuit
  • Implementation of settlement
  • Statute that created a permanent Office of Oral Health
Current Oral Health Inequities in Connecticut

• Disparate populations in Connecticut include:
  • Black and Hispanic families
  • Low-income and uninsured adults
  • Older adults
  • Those in urban dwellings
Disparities in oral health access, utilization, and outcomes are particularly prevalent among CT HUSKY/Medicaid enrollees:

HUSKY/Medicaid covers 1 out of 5 residents of the state

Children who have dental caries experience:

<table>
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<tr>
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<th>Non – Hispanic White</th>
<th>Non-Hispanic Black</th>
<th>Hispanic</th>
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<tbody>
<tr>
<td>Kindergarten</td>
<td>22.4%</td>
<td>35.7%</td>
<td>40.6%</td>
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<tr>
<td>Third Grade</td>
<td>33.3%</td>
<td>49.6%</td>
<td>50.4%</td>
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Effect of Race or Ethnicity on Children’s Utilization in HUSKY A

Current Oral Health Inequities in Connecticut

Dental Care for Parents in HUSKY A: 2005 - 2011

Figure 2. Dental Care for Parents in HUSKY A: 2005-2011

Social Determinants Contributing to Disparities

- Unaffordable for many families and older adults
- Lack of continuous coverage
- Medicare not covering dental
- Cultural and linguistic barriers due to lack of competency by professionals
- Oral health education – no mandates in K-12 curriculum
- Problems with state transportation service
- For children, lack of parents receiving care
- Lack of oral health as a priority for health and well-being
Collaboration with State Agencies

- Department of Public Health
  - Healthy CT 2020
  - Dental Sealants
- Department of Social Services
  - Person-Centered Medical Homes
- Office of Health Advocate - State Innovation Model
  - Advanced Medical Home
  - Clinical and Community Integration Plan
  - Quality Measures
- Access Health CT (Health Insurance Exchange)
  - Children’s dental embedded in health insurance
  - Stand-alone policies
Recent/Current Activity on Oral Health Equity

Legislative Advocacy

- Saving Medicaid
  - Adult Dental
  - HUSKY A Parent eligibility
  - Maintaining reimbursement rates
  - Saving Orthodontic coverage
- Amended statute on Public Water Fluoridation
- Cultural Competency training requirement for RDH
Connecticut Oral Health Initiative Logic Model

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<tr>
<td>Judith Blei Governmental Affairs</td>
<td>Develop list of the successes of Dental Medicaid/Medicaid for sharing with</td>
<td>The Appropriations Comm. of CGA does not reduce eligibility for HUSKY A parents as proposed by the Governor</td>
<td>List of Dental Medicaid and Medicaid successes is developed and disseminated</td>
<td>Maintain current utilization rate of dental services by Medicaid enrollees</td>
<td>Maintain access to dental care for low-income and minority families</td>
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<tr>
<td>CT Office of Oral Health</td>
<td>legislators, advocates and press</td>
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<td>CT Department of Social Services</td>
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Lessons Learned – Dental Medicaid

• FOCUS

• Logic model
  • Always return to “Impact”
  • Use outcomes as a checklist for continuous evaluation
  • Limit activities through prioritization
  • Remember to use all resources on the list

• Coalition-building with non-oral health advocates makes bigger impact
Mary Boudreau
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maryb@ctoralhealth.org
Questions?

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Resources

• Oral Health Disparities
  ➤ “Reducing Oral Health Disparities: A Focus on Social and Cultural Determinants.” Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2147600/

• Building Logic Models

• Equity Metrics for Health Impact Assessments
  ➤ “The Society of Practitioners of Health Impact Assessment (SOPHIA) Equity Metrics for Health Impact Assessment Practice.” Available at: http://www.hiasociety.org/documents/EquityMetrics_FINAL.pdf
Thank You

- DentaQuest Foundation
- Mary Boudreau
- Zulayka Santiago
- All of the attendees for joining us
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources

- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries