Are we unified in approaching oral health equity?  
A national perspective from AIDPH

Introduction

What is health equity?

What is the current health equity landscape?

What are our best opportunities for success?

How will we know we are succeeding?

Conclusions & Recommendations

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Introduction
Our Story

The American Institute of Dental Public Health was founded by Dr. David Cappelli and Ms. Annaliese Cothron in 2015, initially through funding from the Health Resources and Services Administration (HRSA). Seeing gaps in organizational programming and the need to center health equity as a cornerstone of oral health education and training, AIDPH was established to pursue our mission of fostering professional excellence and advancing innovation in the education and practice of dental public health. Ms. Cothron serves as the Executive Director of AIDPH and Dr. Cappelli chairs the Board of Directors.
Housekeeping

Interaction throughout

Questions at the end

Personal pronouns
We acknowledge the Coahuiltecan, Tonkawa, Jumanos, and Lin Apache Indigenous Peoples are the original stewards of the land in San Antonio and honor the enduring relationship that exists between them and their traditional territories. We acknowledge the painful history of genocide and forced occupation of their territory, and we honor and respect the many diverse indigenous people connected to this land on which we gather from time immemorial.
Our Goals for This Session

01 Identify the facilitators and barriers, including upstream and downstream approaches, to supporting oral health equity.

02 Evaluate the current capacity of the oral health workforce to promote oral health equity.

03 Apply systems-change thinking in building solutions that advance equity in oral health.
What is health equity?
What does health equity mean to you?
Providing equal access to care will ensure everyone needs health care resources.
Competing definitions of health equity

**ROBERT WOOD JOHNSON**
Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

**WORLD HEALTH ORGANIZATION**
Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.

**CDC**
Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

**HRSA**
Health Equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.

1. Social and physical facilitators
2. Result in health differences
What is the current health equity landscape?
Oral Health: The Facts

• Oral diseases affect nearly **3.5 billion** people globally. (WHO)

• **More than 25%** of adults have untreated tooth decay and **more than half** have gum disease. (CDC)

• During each year from 2013-2016, **approximately 15.2%** of the U.S. population needed dental care but did not obtain it. (ADA-HPI)

• Over **$2.7 billion dollars** is spent annually in hospital emergency departments for dental conditions. (ADA-HPI)
Oral Health: The Facts

"The appearance of my mouth and teeth affects my ability to interview for a job."

- 35% of adults with Medicaid dental benefits
- 60% of adults without Medicaid dental benefits

PERCENTAGE OF POPULATION WHO VISITED A GENERAL DENTIST IN THE PAST 12 MONTHS – BY POVERTY LEVEL

- Children
  - Below Poverty Line: 38.5%
  - More than 4x Poverty Line: 56.4%

- Adults
  - Below Poverty Line: 19.2%
  - More than 4x Poverty Line: 48.7%

- Seniors
  - Below Poverty Line: 22.3%
  - More than 4x Poverty Line: 60.3%

$153 billion in lost productivity each year due to chronic disease¹
All negative oral health outcomes are more severe for BIPOC communities as a result of racism.
What is a State Oral Health Plan?

• Needs assessment
• Strategies for improving oral health
• Surveillance plan
Equity in State Oral Health Plans

- Of the 50 states, how many have a state oral health plan?
  - 30 are listed on the ASTDD website
- How many have a plan that was developed in the last five years (since 2014)?
  - 18 states have a current plan
- How many states have equity in their plan?
  - 7 states mention equity
  - 7 states have a goal associated with equity

Your homework: Is your state current? Does it include equity?
2020 BROUGHT SOCIAL CONSCIOUSNESS

Nursing
(Koschmann, Jeffers, & Heidari, 2020)

Public Health Education
(Breny, 2020)

Emergency Medicine
(Martin & Hargarten, 2020)

Medical Student Education
(Fadoju, Azap, & Olayiwola, 2021)

Pediatrics
(Valdez, 2020)
ORAL HEALTH?
What are our best opportunities for success?
How We Need to Think and Act Differently

The interviews surfaced four interrelated themes that, when combined, can be leveraged to accelerate progress toward health equity.

Embracing Health Equity as an imperative result that must not be compromised

- Adopting a Systemic View to reveal hidden opportunities to make long-lasting progress
- Leveraging an Equity-Based Approach to remove entrenched barriers and balance out power
- Changing Our Narratives to transform our collective imagination and spur creativity
- Convening Stakeholders to nurture vital relationships and turn new insights and ideas into game-changing solutions
Factors That Impact Health Equity

In addition to the four overarching themes, eight factors that impact health equity repeatedly emerged from the interview process. Rather than thinking about these factors in isolation, interviewees spoke about their interdependence – the relationships among them and how those relationships create or thwart the conditions that make health equity possible.

The interviews revealed the existence of complex power dynamics, certain legacies still playing out from the very founding of the country, and the fragile relationships people have with each other. You may find these factors – and how they influence one another – more or less present, depending on where you live and work.
Where is your position in the process and how can you advance health equity?
How will we know we are succeeding?
Are all disparate groups who are affected by the effort participating in the process?

How will the proposed effort affect each group?

How will the proposed effort be perceived by each group?

Does the effort worsen or ignore existing disparities?

Based on the above responses, what revisions are needed in the effort under discussion?

Other questions: Who holds the power? Are you inspiring hope?
What communities should we be including?

Vulnerable populations include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness. It may also include rural residents, who often encounter barriers to accessing healthcare services. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care. Their health and healthcare problems intersect with social factors, including housing, poverty, and inadequate education.
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When developing or applying an intersectionality health equity lens, the researcher engages in deep self-reflection that contextualizes and recognizes the ways in which race, gender, class, sexual orientation, disability, and other axes of inequality constitute intersecting systems of oppression. Such systems produce very different lived experiences for entire categories of people who are embedded within complex webs and social networks at different levels... Critical self-reflection allows researchers and practitioners to continually and closely examine their own race, gender, class, sexual orientation, disability, language, nativity/citizenship and social position, and their relationship to systems of inequality.

WE NEED TO DEFINE AND MEASURE ORAL HEALTH EQUITY
WE NEED TO ADOPT AN INTERSECTIONAL APPROACH TO ORAL HEALTH EQUITY
WE NEED TO DEDICATE FOCUS TO ANTIRACISM IN HEALTH
QUESTIONS