CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

JANUARY 14 & 15 2020

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AIDPH
AMERICAN INSTITUTE OF DENTAL PUBLIC HEALTH

CONTENT

1 OPENING REMARKS

David Cappelli
University of Nevada
Las Vegas

Dr. David Cappelli, AIDPH Founder and Chair, opened the colloquium to welcome attendees to an interactive, engaging session focused on recognizing and addressing inequity in dental public health policy.

Dr. Frances Kim, **AAPHD Executive Director,** invited participants to get comfortable and enjoy the learning experience over the next few days of the colloquium. Engagement is key to learning about health equity solutions.

Frances Kim
The American Association
of Public Health Dentistry

DESIRED OUTCOMES

1. Deepen our understanding of health equity and the underlying influences.

2. Explore the intersection of policy and health equity.

3. Identify places for personal growth in supporting equitable systems.

4. Build and strengthen relationships that extend beyond this conference.

CONVERSATION NORMS

1.“Try on” others’ views and experiences

2. It’s ok to disagree

3. It is not ok to blame, shame, or attack

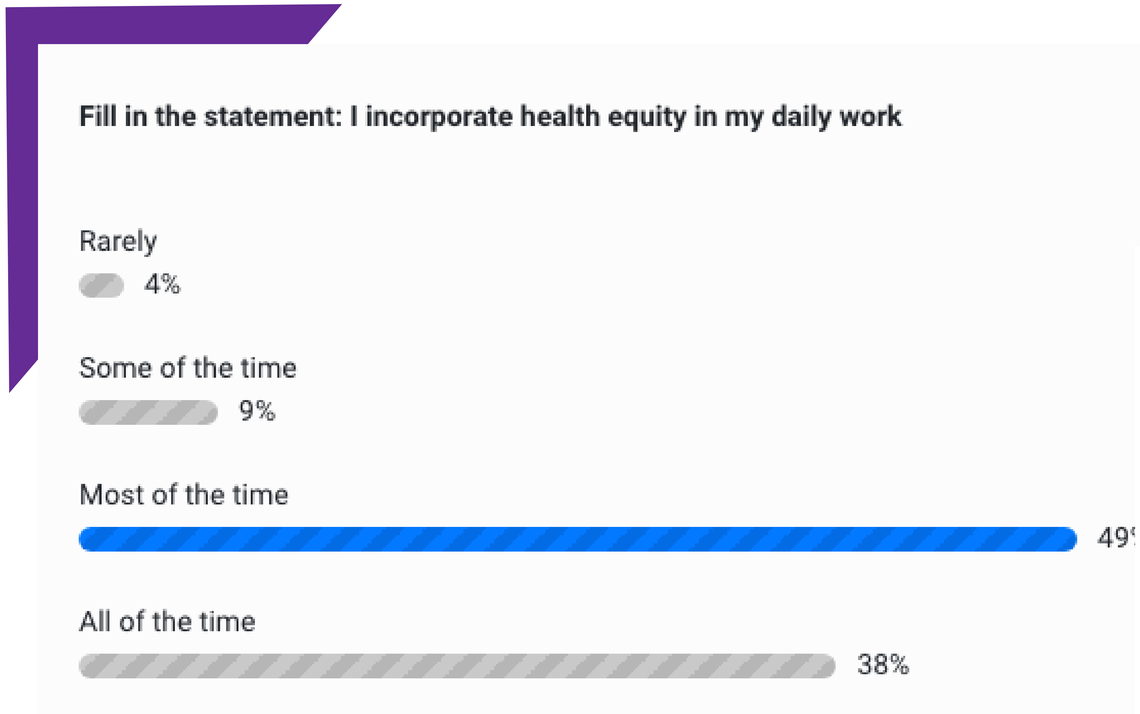
4. Be aware of intent and impact

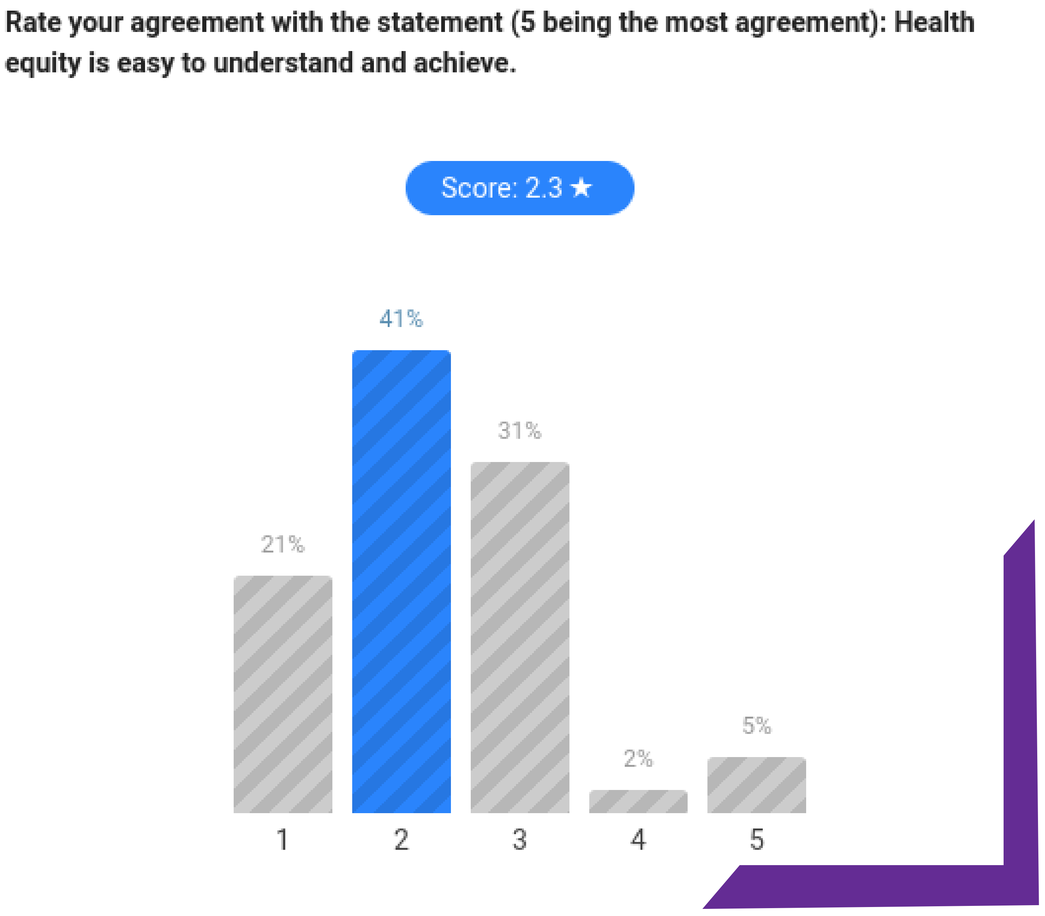
5.Not a safe space but a brave space

6. Democratizing time is a form of equity-practice self-awareness

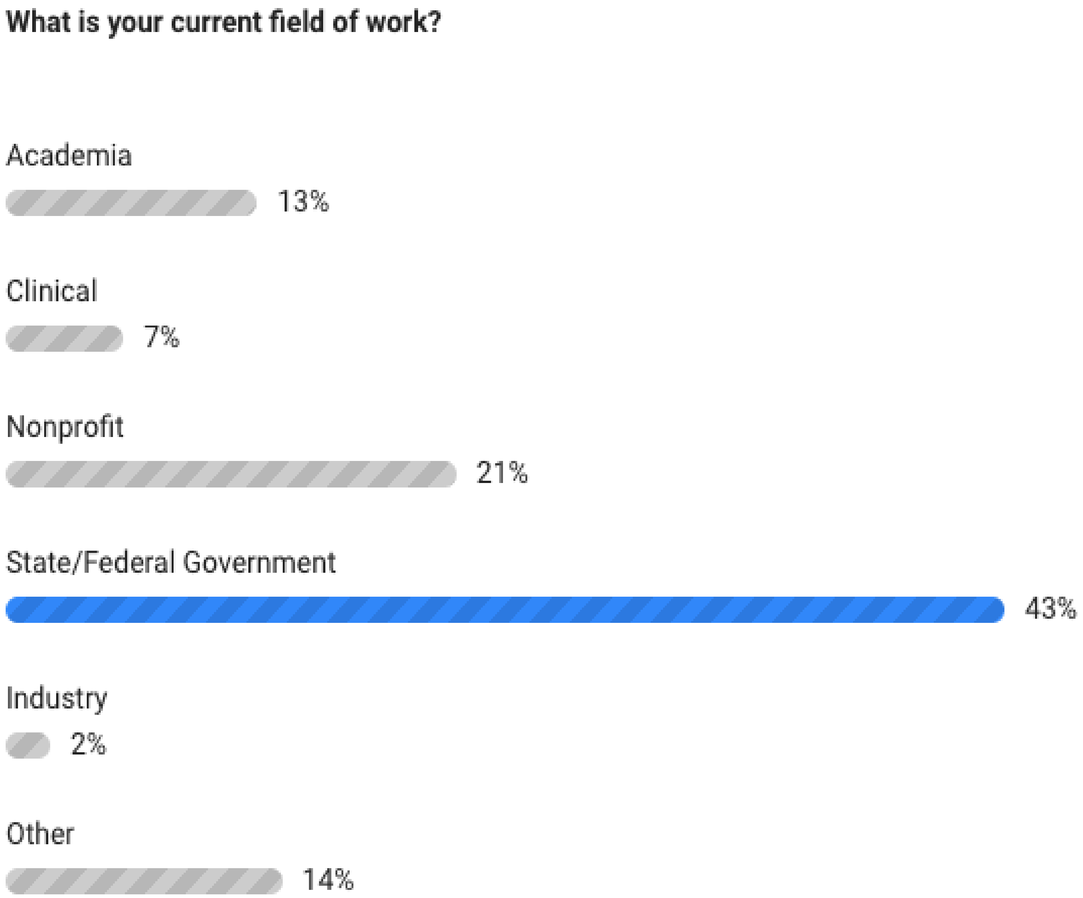
2 ATTENDEES

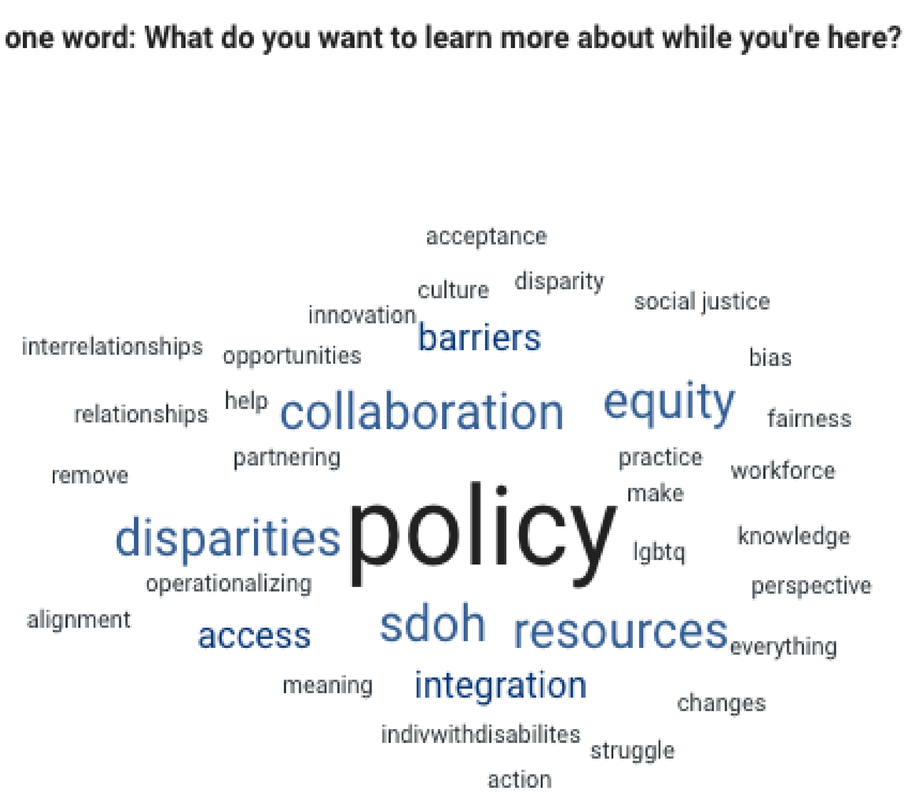
COLLOQUIUM ATTENDEES used Slido, an audience participation software, to provide feedback during presentations and discussion sessions. Attendees were asked if they incorporate health equity in their daily work. Most responded that they incorporate health equity most of the time or all of the time. Attendees were also asked about how easily understood and achievable health equity is. Most responses indicated that attendees felt that health equity was not so easily understood or achieved.





ADDITIONAL OPENING RESPONSES included attendees' current field of work. A large portion of the audience came from state or federal governments, followed by nonprofits. Attendees indicated they were most interested in understanding how to reduce health disparities through collaboration.





3 PRESENTATIONS

SPEAKERS

CANDICE CHEN
Beyond Flexner Alliance

DEREK GRIFFITH
Vanderbuilt University

AMELIE RAMIREZ
SALUD America

TYLER SANSLOW
Fenway Health

DENNIS BOREL
Coalition of Texans with Disabilities

SCOTT HOWELL
Special Care Dentistry Association

LOIS COHEN
Consultant, National Institutes of Health

ALAN MORGAN
National Rural Health Association

GINA THORNTON-EVANS
Centers for Disease Control and Prevention

SOCIAL MISSION: THE ROLE OF HEALTH WORKFORCE IN ADDRESSING HEALTH EQUITY

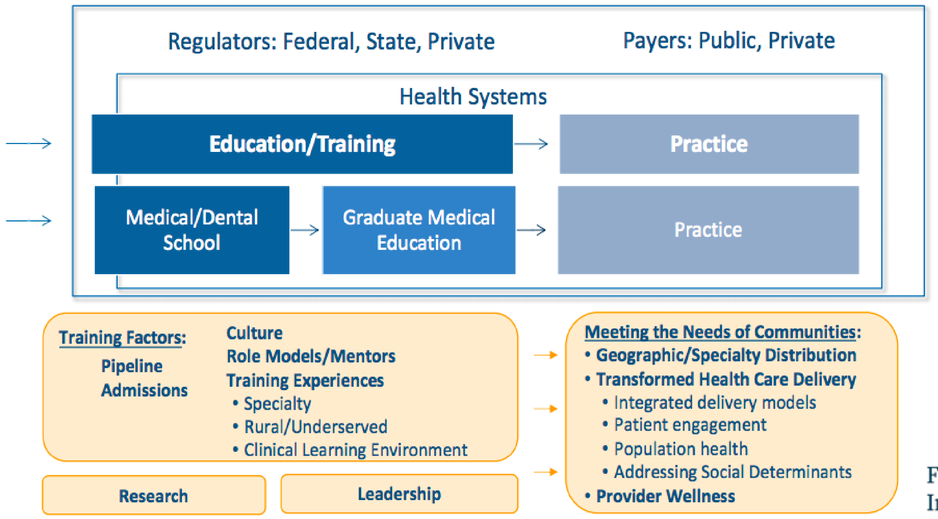
CANDICE CHEN
Beyond Flexner Alliance

Health workforce – the makeup, distribution, selection, education, and training of health care professionals – is an underlying health equity issue. Insufficiencies in different disciplines and specialties, geographic locations, and service to underserved populations negatively affect access and contribute to ongoing health disparities. The behavior of our health professions education programs – the way we recruit, train, and role model for future health professionals – influences career choices and imprints behaviors that can either undermine or advance health equity. Social mission is the contribution of a health professions school in its mission, programs, and the performance of its graduates, faculty, and leadership in advancing health equity and addressing the health disparities of the society in which it exists. This session will focus on the role of health workforce in addressing health equity, health workforce policies that both contribute to health workforce inequities and that aim to address health workforce challenges, and on the role of health professions schools in addressing health workforce equity.

> “Let us hold our health professional education training programs accountable in the research that we do, in the outcomes that we hold them accountable for- that we really hold them accountable for social mission. For what they're actually producing in terms of the high needs of communities -- and they can do it.”

SOCIAL MISSION: THE ROLE OF HEALTH WORKFORCE IN ADDRESSING HEALTH EQUITY

Health Workforce Development

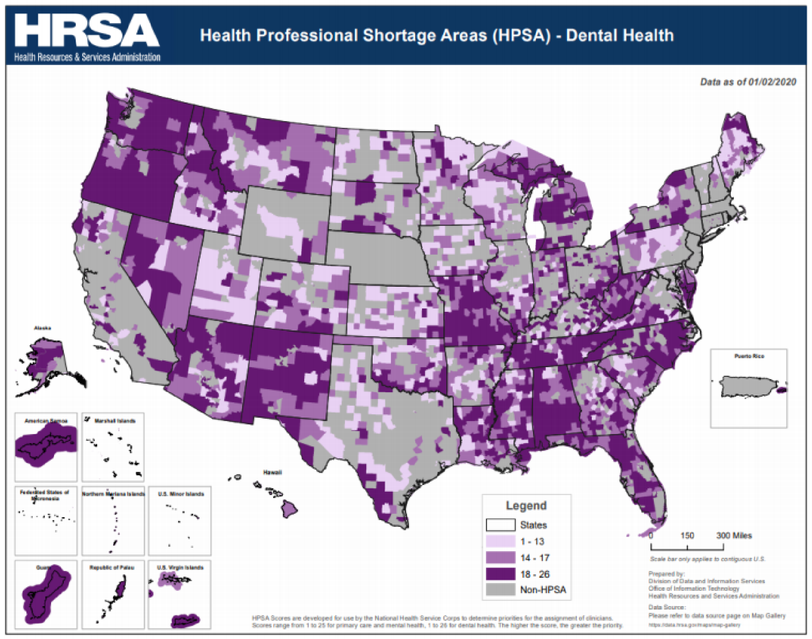


Fitzhugh Mullan Institute for Health Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

National Center for Health Workforce Analysis, 2015

All 50 states and DC are projected to experiences a shortage of dentists.

Increased use of dental hygienists could reduce the projected dentist shortage if they are effectively integrated into the delivery system.



Workforce Diversity

Occupation	White	African-American	Hispanic	Asian/Pacific Islander	American Indian/Alaskan Native
U.S. (2018)	60.7	13.4	18.1	6.0	1.3
Physicians	70.6	5.8	10.0	21.4	0.1
Physician Assistants	79.5	9.1	8.3	8.5	1.0
Registered Nurses	77.7	11.1	5.0	9.1	0.4
Dentists	77.6	3.7	8.1	16.9	0.1
Psychologists	88.2	5.3	11.4	4.1	0.1

Snyder, et al. Facilitating Racial and Ethnic Diversity in the Health Workforce. 2015

Graduate Medical Education

Determines size, specialty distribution, geographic distribution of the physician workforce

2019 Residency Match:

- 17,251 primary care (53.6%)
- Considering future specialization, primary care drops to 30%

Specialty	No. Positions	No. Matches	% U.S.
Orth. Surgery	755	752	91.8%
Dermatology	30	28	76.7%
Family Medicine	4,107	3,827	39.0%
Internal Medicine	8,116	7,892	41.5%
Psychiatry	1,740	1,720	60.6%

Federal Funding

Program	GME Spending
Medicare (2015)	$12.5 B
Medicaid (federal share, 2015)	$2.4 B
Medicaid (state share, 2015)	$1.8 B
Children's Hospital GME (2019)	$0.325 B
Teaching Health Centers GME (2019)	$0.1265 B
VA (2015)	$1.5 B
TOTAL	**$18.65 B**

WHAT DO DENTAL PUBLIC HEALTH PROFESSIONALS NEED TO KNOW ABOUT RACISM AS A PUBLIC HEALTH ISSUE?

DEREK GRIFFITH
Vanderbilt University

In this session, the presenter will highlight the importance of naming racism as a scientific construct, and the significance of dental public health practitioners learning to understand and apply racism as a determinant of population, community and individual oral health. Racism remains a frequently discussed but widely contested determinant of health. This presentation is not about labeling individuals or discussing specific events; rather, the goal is to frame a pattern of outcomes that cannot be adequately characterized by other means. These explanations for patterns become embedded in individual and institutional assumptions, practices and policies that directly and indirectly affect health. Though racism has gained increasing acceptance as a scientific construct, there remains considerable debate and discussion about how racism can be defined in public health and can be applied in public health practice. The presenter will discuss the importance of racism for understanding how we define why there are differences in patterns of health outcomes within, between and across groups over time. Various forms of discrimination share some fundamental commonalities, but racism is unique in important ways that have implications for health. Racism is not a function of individual beliefs or behavior, but a systemic set of beliefs and narratives that endure and adapt over time. As the notion of race has evolved and the suggestion that racism shapes an event or an outcome has become more political and contested, there remains a need to help dental public health professionals have the knowledge and language to effectively engage in discussions of racism as a public health issue. The presenter also will highlight the importance of understanding the implications of framing the root causes of health inequities as racism for how we might intervene to achieve health equity, and maintain equity in oral health and other health outcomes once achieved.

> “If we're part of a system that is perpetually creating these kinds of inequalities and outcomes, what responsibility do we actually have to try to change these kinds of things ... We have to use that lens to look at ourselves as a field to say "What can we do differently?"”

WHAT DO DENTAL PUBLIC HEALTH PROFESSIONALS NEED TO KNOW ABOUT RACISM AS A PUBLIC HEALTH ISSUE?

WHY SHOULD I AS ONE INTERESTED IN ORAL HEALTH CARE ABOUT RACISM?

Racism → Social Determinants of Health (e.g., access to dental care) → Clustering of poor oral health within races or racialized groups (e.g., CVD, cancer, diabetes) → Behavioral Determinants of Oral Health (e.g., oral hygiene practice, sugar consumption, seeking dental care) → Markers of oral health (e.g., dental carries, oral cancers) → Health outcomes (e.g., mortality, morbidity)

VANDERBILT UNIVERSITY

RACISM IS A FUNDAMENTAL CAUSE OF HEALTH INEQUITIES

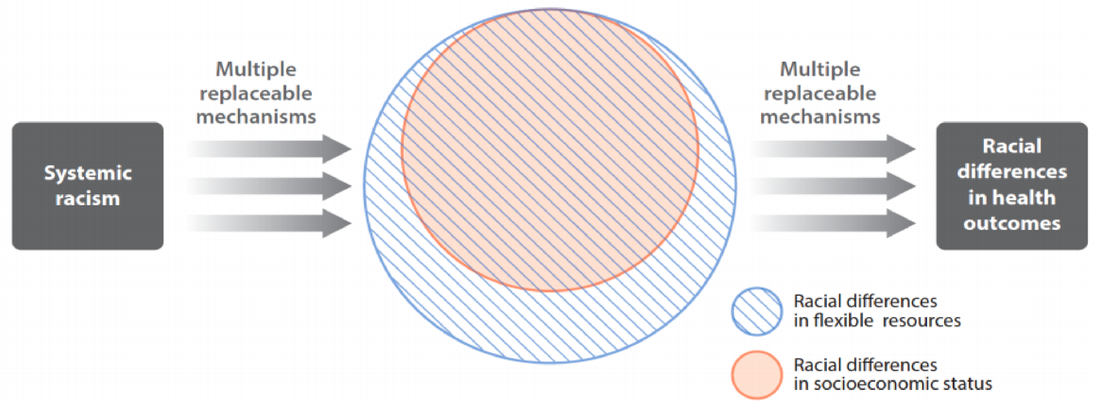


Figure 1

Racism as a fundamental cause of health inequalities: conceptual model.

(Phelan & Link, 2015)

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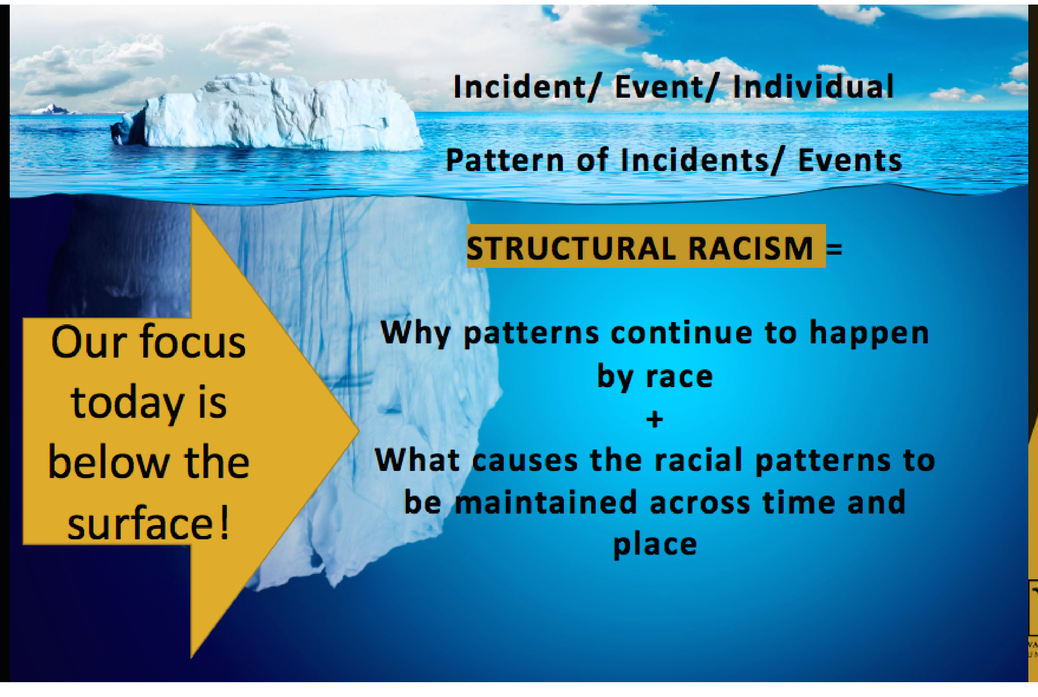

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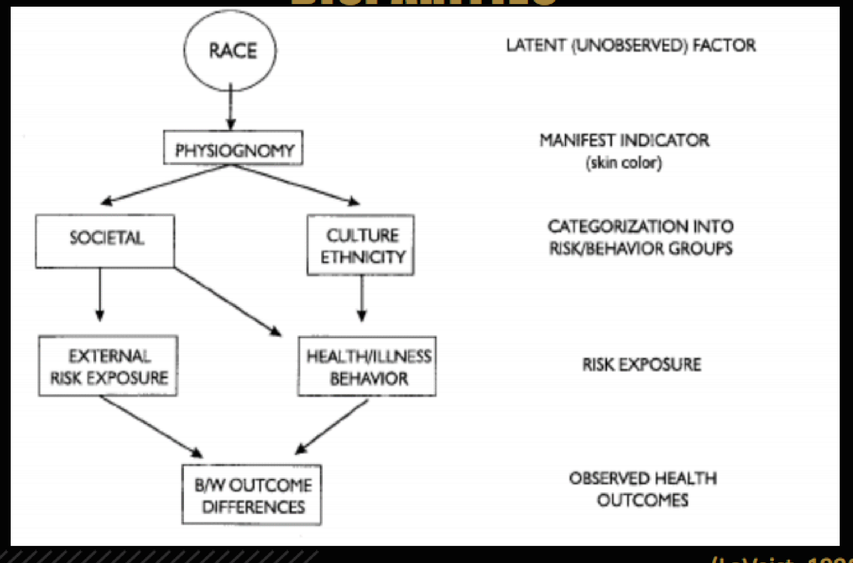
LAVEIST'S CONCEPTUAL MODEL OF RACIAL DISPARITIES



(LaVeist, 1996)

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USING DIGITAL ADVOCACY STRATEGIES TO PROMOTE PUBLIC HEALTH & HEALTH EQUITY

AMELIE RAMIREZ
SALUD America

As public health professionals, we must shift focus from the downstream (individual chronic disease treatment) to upstream (prevention strategies that address social determinants of health and the conditions in which people are born, grow, live, work, and play). About one of every three people will be Latino by 2050. Yet this population often faces“upstream” challenges and conditions of poverty, including low income, employment, child care, health care, and less access to stable housing, safe transit, healthy food, places to play than their peers. Latinos then face “downstream” effects.That’s why we at Salud America! (https://salud-america.org/) developed an online network of 250,000+ Latino health-focused parents, community and school leaders, and health care providers. Salud empowers this network toward behavior change and grassroots advocacy through its adaptable multimedia health equity communication structure, which utilizes digital content curation to rapidly create and disseminate digital, video, and other content on its website, email, and social media. Content includes: culturally relevant, theory-driven peer model stories and videos on healthy change, news on policy and system changes, etc.; interactive "action packs" to spur community organizations toward big on-the-ground healthy changes; multimedia campaigns to engage people to raise their voice for system change; social media messaging to advance health behaviors on Facebook, Instagram, Twitter, and YouTube; #SaludTues Tweetchats to engage an average of 8 million Twitter users in just 1 hour a week; and the #SaludTalks Podcast, the only podcast focused solely on Latino health equity. We found a strong relationship between the degree of engagement in our communication/content and advocacy actions at four levels (school, local, state, federal).

> “We go out and find real stories of individuals who are making change, and we highlight them. They're our heroes, they are the individuals that know how to make it work in their communities and came up with really great solutions to the community problem.”

USING DIGITAL ADVOCACY STRATEGIES TO PROMOTE PUBLIC HEALTH & HEALTH EQUITY

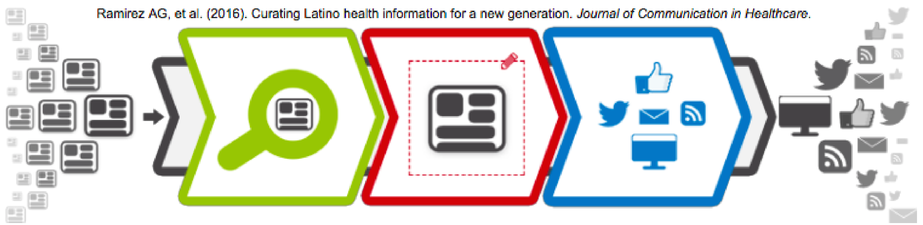
We create Latino-focused content, videos, tools, campaigns, and actions using "digital content curation"

Collect
Our 4 curators search for content by research topics

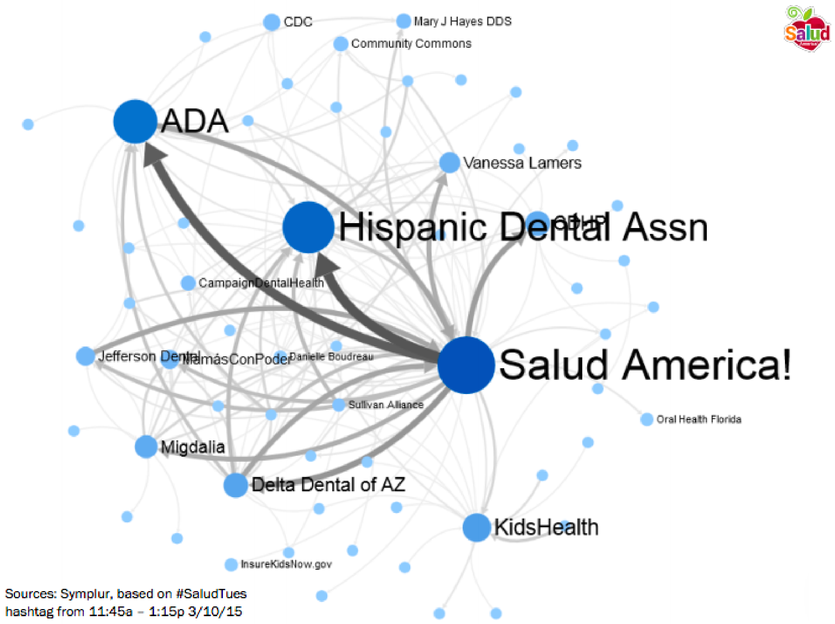
Craft
Tailored content featuring heroes, culture, geography

Connect
Disseminate content via web, email, social, meetings

Ramirez AG, et al. (2016). Curating Latino health information for a new generation. *Journal of Communication in Healthcare.*



#SaludTues Tweetchats average **8 million** impressions on Twitter in 1 hour every week!

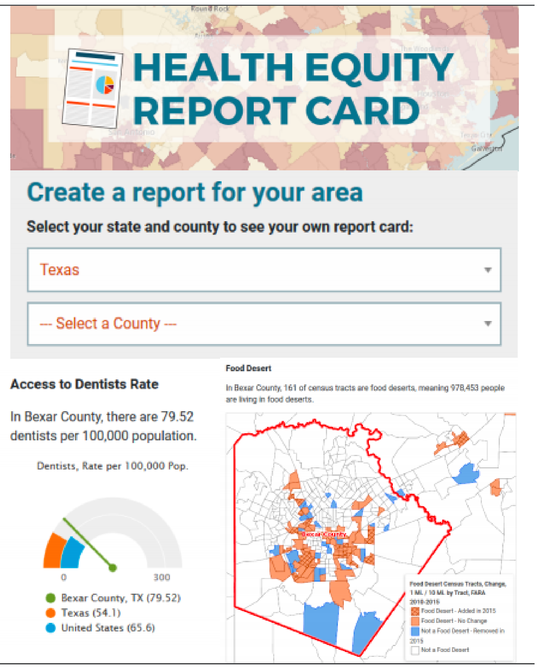


Sources: Symplur, based on #SaludTues hashtag from 11:45a – 1:15p 3/10/15

2,815 page visits to Health Equity Report Cards w/ local health data on:

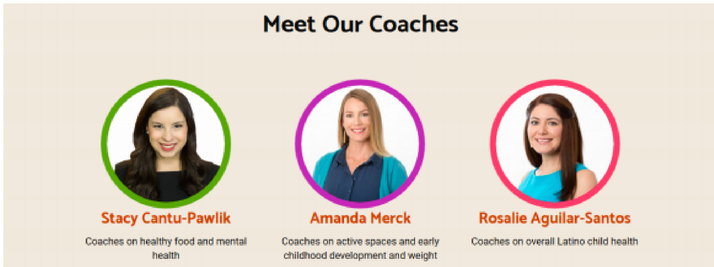
- poverty
- housing
- transit
- health care
- environment
- food access
- healthcare
- schools

salud.to/equityreport



We create Digital Action Packs with FAQs, template materials, customized model emails, to help advocates make on-the-ground healthy changes

For each action pack, we provide technical assistance (via phone and online) from our curators who are experts on their topics



Bandura and Maddux via https://salud.to/berkppt

DENTAL CARE FOR THE LGBTQ+ COMMUNITY: ACHIEVING DENTAL HEALTH EQUITY

TYLER SANSLOW
Fenway Health

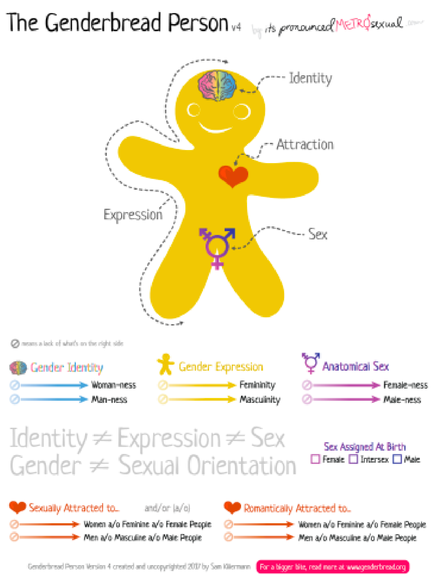
Individuals identifying as lesbian, gay, bisexual, transgender, queer or other (LGBTQ+) have historically struggled with access to oral health care. Progress for the LGBTQ+ community is one of the leading civil rights issues of our time, with They being named as Merriam Webster's 2019 Word of the Year. While public health efforts increasingly focus on reducing health disparities and increasing access to care, many areas still lack dental health equity for LGBTQ+ individuals. It is critical to understand the language and terminology associated with the LGBTQ+ population in order to address LGBTQ+ health disparities, social determinants of health and access to care. The health needs of the LGBTQ+ population are relatively the same as the general population; it is the nuanced approach, considerations, and practices that differ in providing inclusive care to the underserved LGBTQ+ population.

> “For the LGBTQIA+ population, it's not so much that they're health needs are different from the general population. It's how we approach care for the LGBTQIA+ community.”

DENTAL CARE FOR THE LGBTQ+ COMMUNITY: ACHIEVING DENTAL HEALTH EQUITY

Genderbread Person

- Gender Identity
- Gender Expression
- Anatomical Sex
- Attraction
  - Sexual
  - Romantic



Killerman, S. 2017

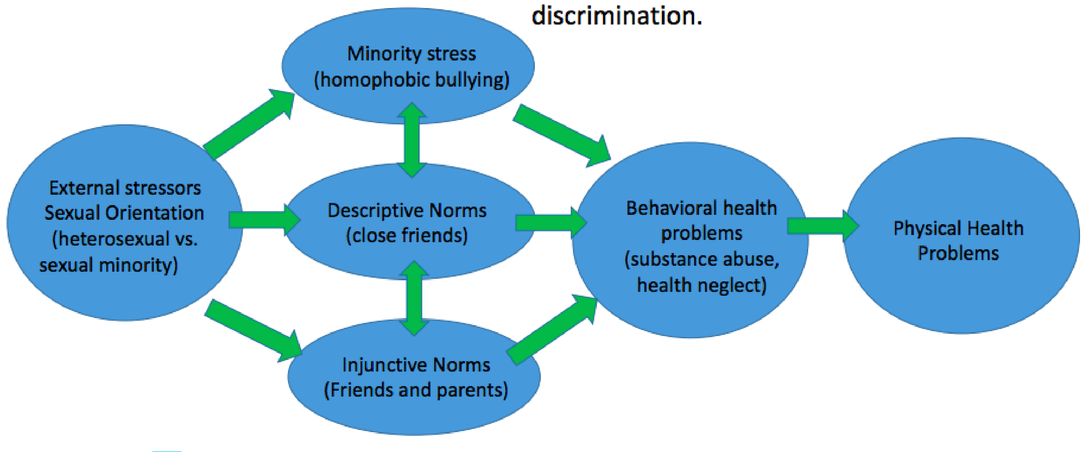
HEALTH DISPARITIES

The 2015 U.S. Transgender Survey[4] found that:

Negative Experience	% of those who had seen a provider in the past year
They had to teach their health care provider about transgender people to get appropriate care	24%
A health care provider asked them unnecessary or invasive questions about their transgender status that were not related to the reason for their visit	15%
A health care provider refused to give them transition-related care	8%
They were verbally harassed in a health care setting (such as a hospital, office or clinic)	6%
A health care provider used harsh or abusive language when treating them	5%
A health care provider refused to give them care not related to the gender transition (such as physicals or care for the flu or diabetes)	3%
A health care provider was physically rough or abusive for the day	2%
They were physically attached by someone during their visit in a health care setting (such as a hospital, office or clinic)	1%
They were sexually assaulted in a health care setting (such as a hospital, office or clinic)	1%
One or more experiences listed	**33%**

INTERSECTIONALITY

The study of intersections between forms or systems of oppression, domination or discrimination.



Adapted from Mereish et. Al

PUTTING WHAT YOU LEARN INTO PRACTICE

- If you are unsure about a patient's name or pronouns:
  - *"I would like be respectful—what are your name and pronouns?"*
- If a patient's name doesn't match insurance or medical records:
  - *"Could your chart/insurance be under a different name?"*
  - *"What is the name on your insurance?"*
- If you accidentally use the wrong term or pronoun:
  - *"I'm sorry. I didn't mean to be disrespectful."*

FENWAY HEALTH

CONFRONTING INEQUITY THROUGH GLOBAL HEALTH POLICIES

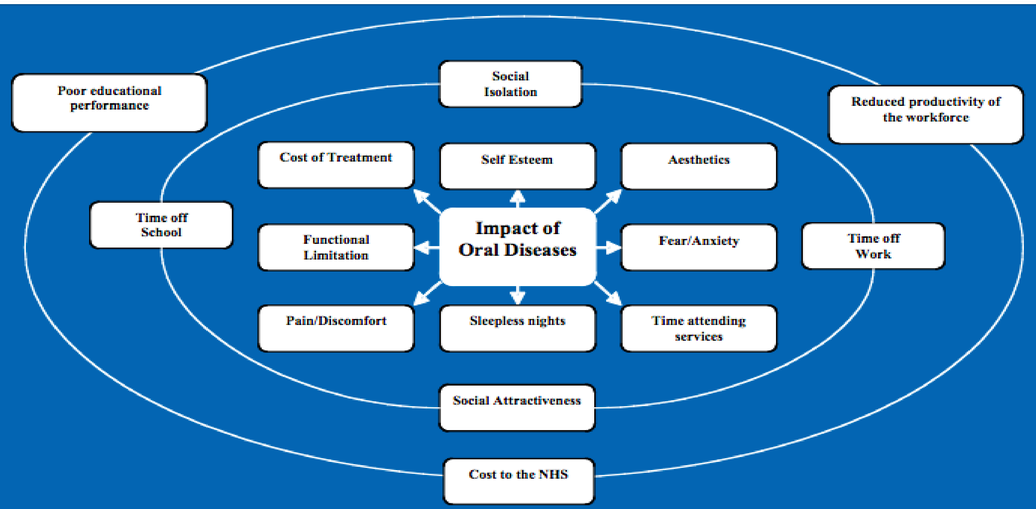
LOIS COHEN
Consultant,
National Institutes
of Health

Addressing oral health inequities through a global health lens, while understanding national, regional and local challenges, is posited as a necessary prerequisite for finding solutions to advance social justice. By examining the historical context for such a global oral health perspective and the specific roles of the World Health Organization and other international entities, we can better grasp how oral health might be integrated into global health movements and associated initiatives and how that integrated approach might be applied at national and sub-national levels. Extant global oral health policies and those in development will be reviewed as well as the basic concepts underlying their existence. The need to build evidence globally and to mobilize both political and social will around the evidence-platform will be explored in order to understand how policies are both formulated and promulgated effectively.

> “We all know that in order to get policy enacted, political action is necessary. And that won't work unless you have all those letter-writing activities and all the social will. That social movement of people who are impacted.”

CONFRONTING INEQUITY THROUGH GLOBAL HEALTH POLICIES

IMPACT OF ORAL DISEASES



Source: Modified from Department of Human Services (1999)

WHO-ICS HYPOTHESES

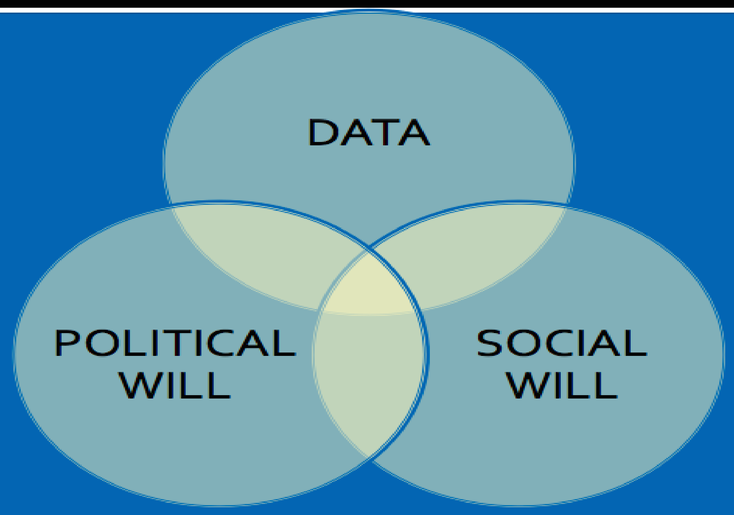
The more available, accessible and acceptable the dental care provided to a population, the more positive is the effect on that population's oral health.

GLOBAL ORAL HEALTH MATTERS!

A movement is launched to advance population health through oral health

- La Cascada Declaration 2016
- *The Lancet* – Oral Health July 21, 2019
- WHO Briefing - Global oral health at the tipping point? December 5, 2019
- Lancet Commission on Global Oral Health

EFFECTIVE HEALTH POLICY



RURAL ORAL HEALTH CARE ACCESS: A NATIONAL POLICY PERSPECTIVE

ALAN MORGAN
National Rural Health Association

Rural health is not simply a small version of urban, but rather a unique health care delivery environment. This session will examine the current state of rural health in America, with a focus on opportunities and barriers for expanding rural oral health care access. Current relevant national policy research and data will explore the current state of rural oral health access, as well as policy options under consideration to address these health care disparities.

> “I hope what I'm painting is a real renaissance happening. Not just in what rural is, but how we deliver healthcare from a rural context. This is really exciting stuff.”

RURAL ORAL HEALTH CARE ACCESS: A NATIONAL POLICY PERSPECTIVE

Rural has an Older, Sicker and Poorer Population

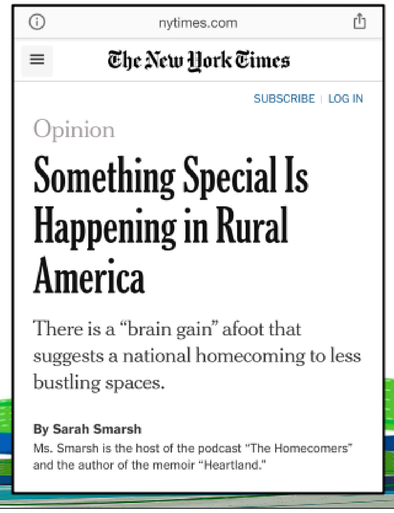
- Nationally, rural households had lower median household incomes:
  - Rural: $49.9K
  - Urban: $66.1K
- 14.7% of rural population is below the federal poverty line, compared with 11.3% of the urban population

Rural has an Older, Sicker and Poorer Population

- The median age of adults living in rural areas is greater than those living in urban:
  - Rural: 51 years
  - Urban: 45 Years
- Rural areas have higher rates of several health risk factors/conditions:
  - Obesity, Diabetes, Smoking

The State of Rural America

U.S. Census show that after a modest four-year decline, the population in nonmetropolitan counties remained stable from 2014 to 2019 at about 46 million. (2014-2019 rural adjacent to urban saw growth.)


nytimes.com

The New York Times

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Opinion

Something Special Is Happening in Rural America

There is a "brain gain" afoot that suggests a national homecoming to less bustling spaces.

By Sarah Smarsh

Ms. Smarsh is the host of the podcast "The Homecomers" and the author of the memoir "Heartland."

Celebrate the greatness of rural health care!

- Rural independence; rural work ethic; rural innovation; rural providers doing more with less.
  - ✓Higher quality
  - ✓Higher patient satisfaction
  - ✓Cost-effective
  - ✓Fewer Resources

HEALTHY PEOPLE 2020 AND BEYOND - NEW DIRECTIONS

GINA THORNTON-EVANS
Centers for Disease Control and Prevention

Healthy People 2030 marks the fifth iteration of this national initiative to monitor the health of the nation. Objectives related to oral health were first introduced in 1979 focusing on fluoridation and dental caries. The Healthy People initiative has evolved over time starting with approximately 200 objectives and currently containing over 1400 objectives for Healthy People 2020. The current goals of HP 2020 focus on achieving health equity and eliminating disparities. This presentation will focus on the historical aspects of this initiative and the evolution of the oral health objectives. Also, discussion of strategies for emerging issues and the role of the social determinants of health will be addressed.

> “Times have really changed in terms of resources and that’s played a major impact. Just being able to work with individuals like you who are very passionate about oral health at the state and local levels and are trying to leverage as much as you can, with respect to oral health … We want to support any way we can really help people to get excited about Healthy People 2030”

HEALTHY PEOPLE 2020 AND BEYOND - NEW DIRECTIONS

LEADING HEALTH INDICATORS – 12 TOPICS, 26 INDICATORS

- Access to Health Services
- Clinical Preventive Services
- Environmental Quality
- Injury and Violence
- Maternal, Infant, and Child Health
- Mental Health
- Nutrition, Physical Activity, and Obesity
- *Oral Health*
- Reproductive and Sexual Health
- Social Determinants
- Substance Abuse
- Tobacco

GOALS FOR HEALTHY PEOPLE 2030

- **Overarching Goals**
- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- *Eliminate health disparities, achieve health equity*, and attain health literacy to improve the health and well-being of all.
- *Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.*
- Promote healthy development, healthy behaviors and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

PROPOSED HEALTHY PEOPLE 2030 ORAL HEALTH OBJECTIVES

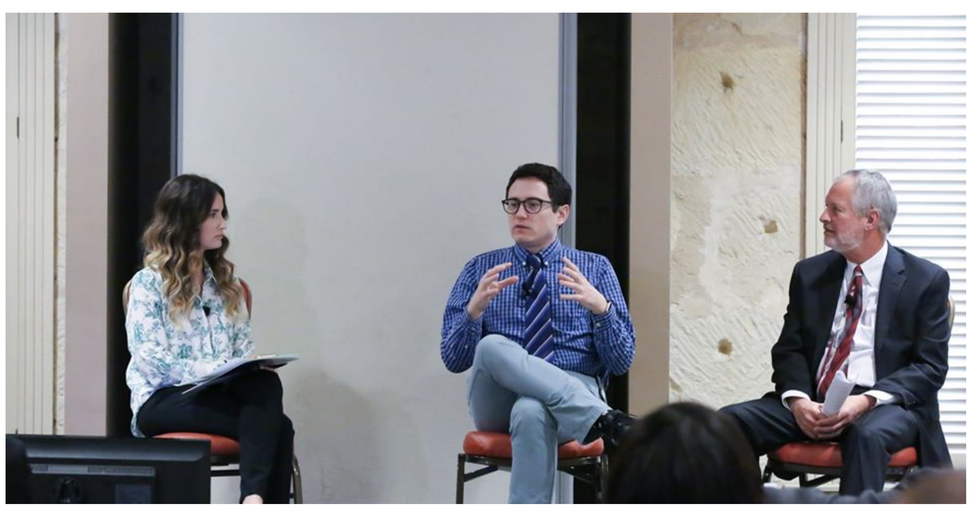
Objective Number	Objective Statement	Data Source
OH-2030-01	Reduce the proportion of children and adolescents aged 3 to 19 years with lifetime tooth decay experience in their primary or permanent teeth	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-02	Reduce the proportion of children and adolescents aged 3 to 19 years with active and currently untreated tooth decay in their primary or permanent teeth	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-03	Reduce the proportion of adults aged 20 to 74 with active or currently untreated tooth decay	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-04	Reduce the proportion of adults aged 75 years and older with untreated root surface decay	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-05	Reduce the proportion of adults aged 45 and older who have lost all of their natural teeth	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-06	Reduce the proportion of adults aged 45 and older who have moderate and severe periodontitis	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-07	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage	National Program of Cancer Registries (NPCR), CDC/NCCDPHP; Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI
OH-2030-08	Increase the proportion of children, adolescents, and adults who use the oral health care system	Medical Expenditure Panel Survey (MEPS), AHRQ
OH-2030-09	Increase the proportion of low income youth who have a preventive dental visit	National Survey of Children's Health (NSCH), HRSA/MCHB
OH-2030-10	Increase the proportion of children and adolescents aged 3 to 19 who have received dental sealants on one or more of their primary or permanent molar teeth	National Health and Nutrition Examination Survey (NHANES), CDC/NCHS
OH-2030-11	Increase the proportion of the U.S. population served by community systems with optimally fluoridated water systems	Water Fluoridation Reporting System (WFRS), CDC/NCCDPHP
Objective Number	**Objective Statement**	
OH-2030-D01	Increase the number of states and the District of Columbia that have an oral and craniofacial health surveillance system	

PROPOSED HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH OBJECTIVES

Objective Number	Objective Statement	Baseline Statement	Target	Target-Setting Method	Data Source
SDOH-2030-1	Increase the proportion of children living with at least 1 parent employed year round, full time	76.4 percent of children aged 17 years and under were living with at least 1 parent employed year round, full time in 2016	84.1 percent	Projection	Current Population Survey (CPS), Census and DOL/BLS
SDOH-2030-2	Increase the proportion of high school completers who were enrolled in college the October immediately after completing high school	69.8 percent of high school completers were enrolled in college the October immediately after completing high school in 2016	74.6 percent	Projection	Current Population Survey (CPS), Census and DOL/BLS
SDOH-2030-3	Reduce the proportion of persons living in poverty	12.7 percent of persons were living below the poverty threshold in 2016	9.9 percent	Projection	Current Population Survey (CPS), Census and DOL/BLS
SDOH-2030-4	Reduce the proportion of families that spend more than 30 percent of income on housing	35.3 percent of families spent more than 30 percent of income on housing in 2015	26.1 percent	Percent Improvement	American Housing Survey, HUD and Census
SDOH-2030-5	Reduce the proportion of children who have ever experienced a parent who has served time in jail	8.2 percent of children aged 17 years and under had ever experienced a parent or guardian serving time in jail in 2016	5.7 percent	Percent Improvement	National Survey of Children's Health (NSCH), HRSA/MCHB
SDOH-2030-6	Increase employment among the working-age population	73.3 percent of the working-age population aged 16 to 64 years were employed in 2017	77.6 percent	Percent Improvement	Current Population Survey (CPS), Census and DOL/BLS

SERVING INDIVIDUALS WITH DISABILITIES

PANEL DISCUSSION



More than 50 million Americans are diagnosed with a disabling condition with 25 million considered severely physically limiting. Individuals with disabilities experience a dispropotionate burden of inequity- particularly within the health care system. Access to care and limitations in clinical skills often lead to complicated care delivery within this special population. This session will focus on promoting advocacy, elevating clinical knowledge, and innovating health delivery to meet the needs of individuals with disabilities.

Terminology is important. How we identify and refer to ourselves, and also how we refer to individuals in this community, is ever evolving. What are words and phrases that we should and should not be using when providing care or advocating within the community?

Individuals with disabilities can experience many barriers to accessing care. As abled individuals, we often don't consider the particular needs of this population. How can we better understand some of the barriers to care?

What are some solutions to barriers to care for individuals with disabilities?

There has been a lot of progress over the past decade in getting support for individuals with disabilities, but we know there's more work still to do. What policy opportunities should we consider now? What are some policy successes?

RACE, ETHNICITY & CULTURE IMPACT ON HEALTH AND ORAL HEALTH

PANEL DISCUSSION

Culture, race, and ethnicity intersect in the delivery of health care from both the patient and provider perspective. Our culture is influenced through both our social and physical environment and is directly connected to political determinants of health. Failing to account for these deeply rooted identities and values creates health inequity. Understanding and awareness of how our internal and external identities connect to health outcomes help us promote culturally responsive care and support equitable policies.

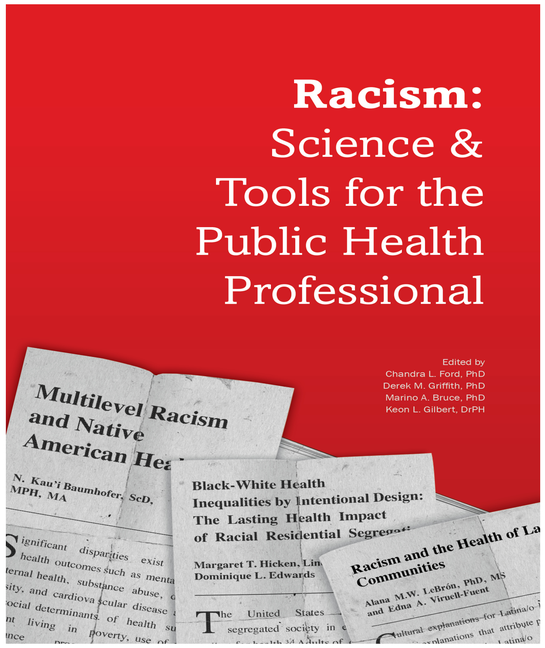
How are race, ethnicity and culture connected and related to health outcomes?

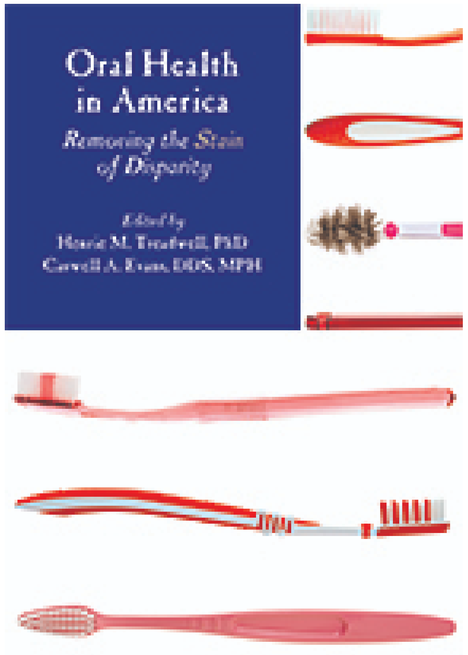
What policies facilitate health equity when considering culturally responsive care?

What are some opportunities to implement best practices that address the broader social determinants of health.

BOOK SIGNING WITH ORAL HEATH EQUITY AUTHORS

IN PARTNERSHIP WITH APHA PRESS





Dr. Derek M. Griffith is a Professor of Medicine, Health and Society, and he is the Founder and Director of the Center for Research on Men's Health at Vanderbilt University. Trained in psychology and public health, Dr. Griffith's program of research focuses on developing and implementing behavioral and policy strategies to achieve equity in health and well-being by race, ethnicity, and gender. He has been the principal investigator of research grants from the American Cancer Society, the Robert Wood Johnson Foundation, other foundations, and several institutes within the National Institutes of Health. Dr. Griffith is a contributor to and editor of two recent books –Men's Health Equity: A Handbook(Routledge, 2019), and Racism: Science and Tools for the Public Health Professional (APHA Press, 2019) –and he has co-authored or provided expert review of reports from the American Psychological Association, Promundo-US, and the World Health Organization. Dr. Griffith was given the Tom Bruce Award by the Community-Based Public Health Caucus of the American Public Health Association in recognition of his research on "eliminating health disparities that vary by race, ethnicity and gender."

Caswell A. Evans, Jr., D.D.S., M.P.H., is currently the Associate Dean for Prevention and Public Health Sciences at the University of Illinois, Chicago College of Dentistry; he is also a faculty member in the UIC School of Public Health. Previously he served as the Executive Editor and Project Director for Oral Health in America: A Report of the U.S. Surgeon General. For twelve years, Dr. Evans was Director of Public Health Programs and Services, for the Los Angeles County Department of Health Services. He is a member of the National Academy of Medicine, National Academy of Sciences. He is a past president of the American Public Health Association, the American Association of Public Health Dentistry, and the American Board of Dental Public Health. Dr. Evans is Chairman of DentaQuest Foundation Board. He also serves on the Chicago Board of Health and the boards of the Institute of Medicine of Chicago and the Children's Dental Health Project. He proudly serves as one of the founding board members of the American Institute of Dental Public Health.

4 DISCUSSION SESSIONS

IDENTITY SIGNS ACTIVITY

DISCUSSION SESSION

As dental public health professionals seeking to improve inequities in policy and service delivery, it is important to understand how our identities and those of individuals in our communities interact. We all have different identities that interact internally, in relation to others, in relation to institutions, and in relation to systems. Each identity has the ability to influence how we operate in systems, including places of advantage and disadvantage.

This activity called on participants to self-identify in a variety of situations, to demonstrate the importance of recognizing and understanding personal identities. These challenges included questions about privilege, others' perceptions, and how their identities related to others' identities and experiences. Then participants reflected on the exercise, using sli.do. Generally, participants responded that the activity was somewhat surprising and caused them to reflect on their own identities.

The part of my identity that I wish I knew more about is _____?

The part of my identity that people notice first about me is _____?

The part of my identity that I am most aware of on a daily basis is _____?

The part of my identity that garners me the most privilege is _____?

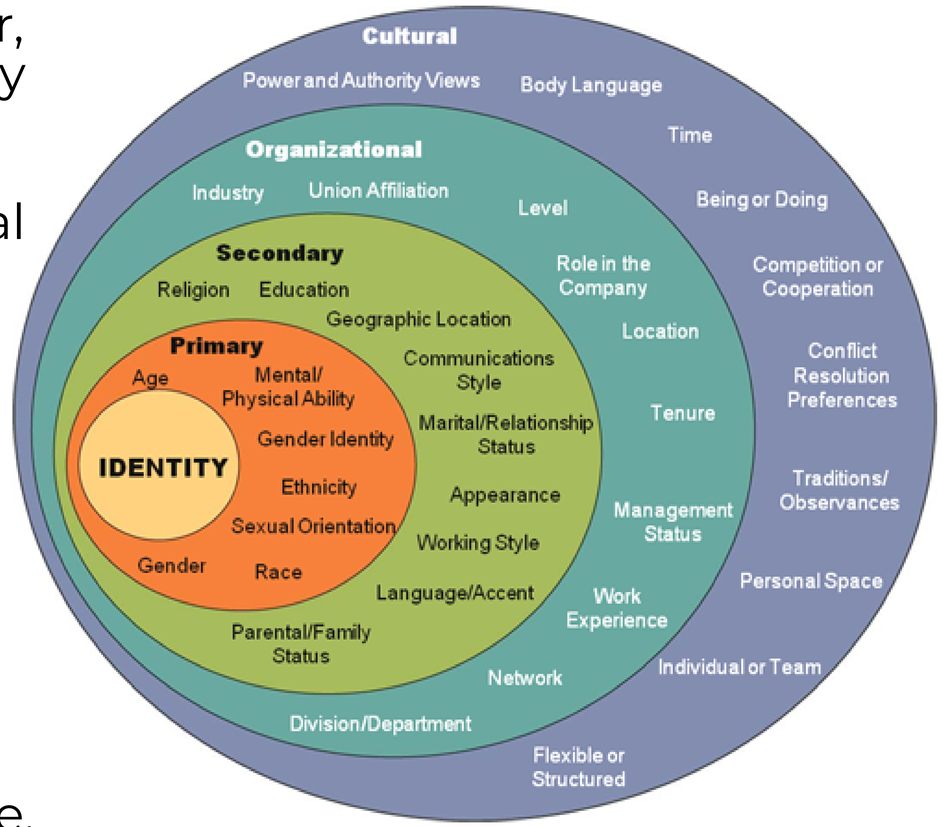
The part of my identity that I believe is the most misunderstood by others is _____?

IDENTITY SIGNS ACTIVITY

DISCUSSION SESSION

An “Intersectionality Health Equity Lens” For Social Justice

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.



Lopez, N. and V. L. Gadsden. 2016. Health Inequities, Social Determinants, and Intersectionality.NAM Perspectives.Discussion Paper, National Academy of Medicine, Washington, DC. doi:10.31478/201612a

VIGNETTE ACTIVITY

DISCUSSION SESSION

Groups of participants were given different clinical vignettes to consider and discuss. Each vignette represented situations where stereotypes and uneven power dynamics have contributed to identity-based microaggressions against one of the people involved. Topics included race, age, gender, religion, socioeconomic status, immigration status, and primary language. The groups discussed each vignette in-depth and reported out verbally to the larger group.

Participants were asked to reflect on how the vignette made them feel and how it might have made the subjects feel. This practice of reflection and perspective-taking helped by bringing mindfulness to the discussion of identities.

Participants reflected on the identities of all individuals, organizations, and institutions involved in each situation to determine how they might be contributing to the interactions.

Participants examined the contexts of prejudice, power and privilege that make each vignette possible.

Participants were prompted to discuss and identify steps and considerations they would take when faced with similar tough situations.

VIGNETTE ACTIVITY

DISCUSSION SESSION

Vignette 6B:

You are a black female attending oral surgeon. Your white female department chair wants to put together a diversity, equity, and inclusion workshop to promote a more culturally competent clinical workforce. The workshop will be held for one hour over the noon lunch break on a Friday. The chair of your department approaches you to ask if you can provide commentary on how black oral surgeons feel about diversity and inclusion and how to provide treatment to patients of color. They request that you make the presentation no more than seven minutes to ensure everyone can be out of the workshop before lunch is over.

Questions:

How do people feel when they read or hear this vignette?

Thinking of the dimensions of diversity, what identities of the patient, provider, organization, or institution may be contributing to the interaction?

What are the contexts of prejudice, power, and privilege that make this situation possible?

Vignette 3B:

You are a white female dentist working with your team on patient service. A Black male patient rolls into your office in a wheelchair, sees your Muslim female hygienist wearing a hijab, and requests to see another provider. When you pull aside the patient to discuss the issue private, they disclose that they do not want to be seen by someone of a different religion.

Questions:

How do people feel when they read or hear this vignette?

Thinking of the dimensions of diversity, what identities of the patient, provider, organization, or institution may be contributing to the interaction?

What are the contexts of prejudice, power, and privilege that make this situation possible?

How do you respond to the patient as a provider? How do you respond to the hygienist?

Vignette 4B:

You are a black male dentist working with a young mixed-race female patient aged 14. The mother of the female patient is black. After the patient is provided with a routine dental examination and cleaning, you proceed to ask if the patient has received a vaccination for human papillomavirus (HPV). The patient's mother becomes upset and quickly answers that they identify as Christian and her daughter is waiting to become sexually active until after marriage making the vaccination unnecessary.

Questions

How do people feel when they read or hear this vignette?

Thinking of the dimensions of diversity, what identities of the patient, provider, organization, or institution may be contributing to the interaction?

What are the contexts of prejudice, power, and privilege that make this situation possible?

How do you respond to the patient as a provider?

Vignette 5A:

You are a white male dentist teaching at a top-tier dental school. In clinic, your black male dental student approaches you to request that you sign off on a treatment plan. As you review, you notice that the student has noted the patient is non-compliant with treatment. You ask the student why this patient has not been compliant with treatment and the student mentioned frequently cancelled appointments, late appointments, and little progress on previous treatment plans. The patient has stated they do not want a follow up appointment. You approach the black female patient and request a conversation. As she tells you about her life, she discusses that she is transgender, unemployed, does not have reliable housing or transportation and often experiences high anxiety when visiting the dentist. You note that these things are not included in her patient medical history.

Questions:

How do people feel when they read or hear this vignette?

What are the contexts of prejudice, power, and privilege that make this situation possible?

What unique barriers do transgender patients face that impact their ability to receive care?

How will you approach providing care for the patient and educating the dental student?

BUILD YOUR IDEAL COMMUNITY

DISCUSSION SESSION

This discussion session grouped diverse participants together to brainstorm and envision an ideal community, focused on the health and wellness of its residents. Participants considered social determinants of health, policies regarding health equity and sustainability.

Clear elements of holistic health, environmental support, and integrated person-centered care were visible in nearly every ideal community. Participants suggested ways to reduce barriers to accessing care, cultivating hope within their ideal community, and a particular focus on dismantling systems of oppression.

What are the necessary elements to include in your community?

Consider the social determinants of health. How can you address this disparity?

What policies should be implemented to support health equity?

How will you support long-term sustainability of health and wellness?

BUILD YOUR IDEAL COMMUNITY

DISCUSSION SESSION

#AIDPH

COLLOQUIUM

2020

CIRCLES OF CONNECTIVITY

DISCUSSION SESSION

Participants were each given 1 of 8 different health equity factors to consider and reflect upon. Then they gathered in groups to discuss the relationship between each health equity factor, and how they result in historical legacies of privilege, entrenched power dynamics, and potential for change. Groups reported out via sli.do

The eight health equity factors were: Policy Leadership, Impact of Funding, Power, Historical Legacy, Hope, Neighborhood, Connecting with Self, and Connecting with Others.

Impact of Funding

"How can we learn and be in relationship with community and listen to community in a way where you are working hard to kill power dynamics?"

Power

"Building power needs to happen to bring change on the determinants of health. That is not somebody else's power, it is everyone's. Sometimes people talk about power as someone else having it, but it's about the triple aim of health equity – organizing people, power, and narrative."

Neighborhood

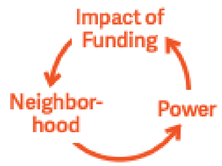
"I don't think we pay enough attention to looking at healing communities."

"Develop the infrastructure of the community from the bottom up and that serves to develop short- and long-term solutions."

CIRCLES OF CONNECTIVITY

DISCUSSION SESSION

Loop 2



A significant barrier to achieving health equity is the misalignment that exists between what neighborhoods need and want for residents to be healthy and what funders invest in according to the focus of their strategic priorities. This results in both unequal power dynamics between philanthropic organizations and their intended beneficiaries, and initiatives that do not address local needs. As such, funders are making efforts to more meaningfully engage communities in their strategy, design, and funding decisions. This engagement can provide insights that allow for more relevant funding, which in turn can strengthen the power of neighborhood to influence policies and practices.

Loop 1

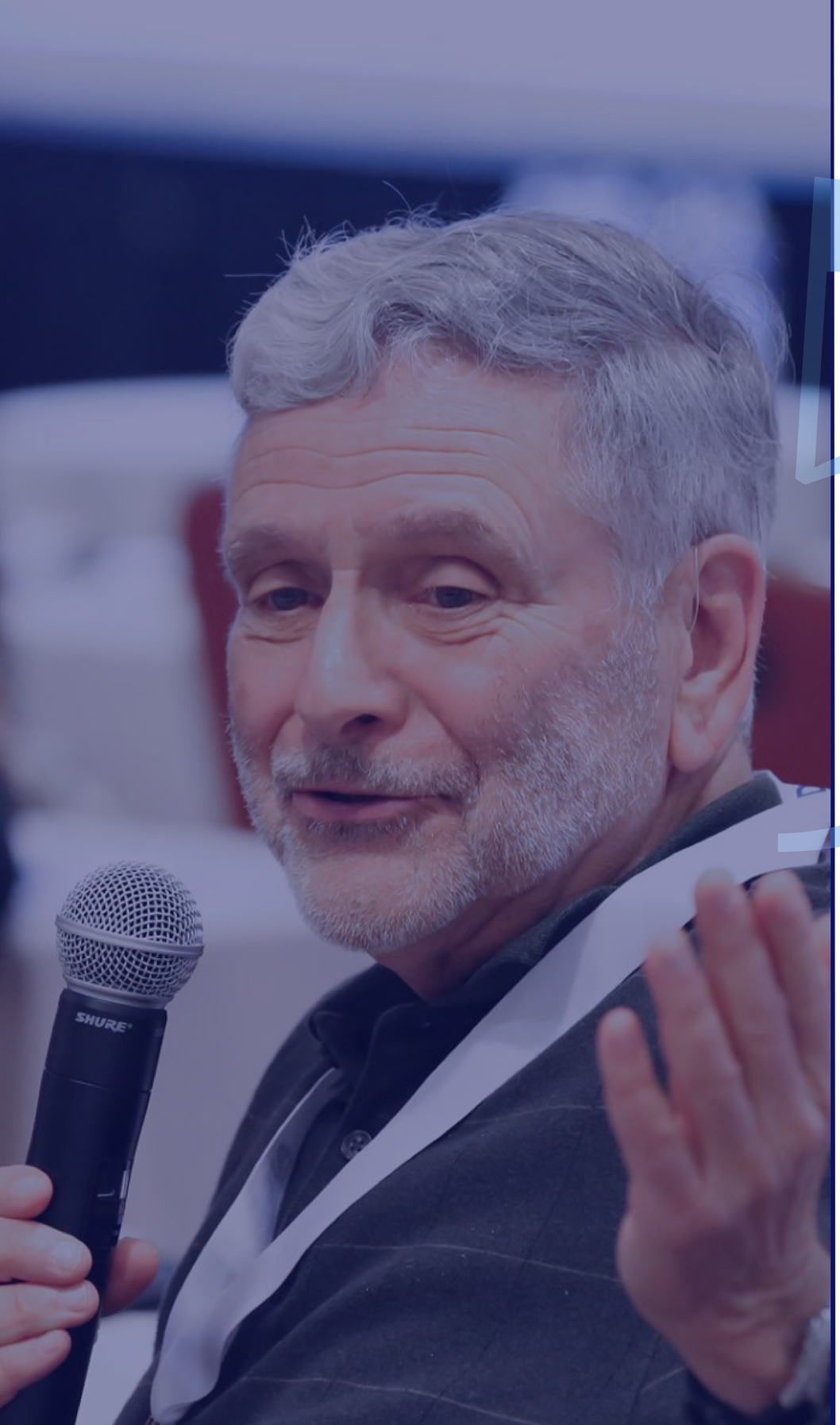
The historical legacies that have produced systemic racism can, in turn, lead to the creation of a wide range of policies that inadvertently entrench concentrated inequities in certain neighborhoods across the US. This reality can be reversed when policy-making institutions and policy makers intentionally uncover their blind spots and see the impact of their decisions. This process can give rise to the development of game-changing policies that explicitly respond to the unique needs of different neighborhoods and dismantle the consequences of harmful historical legacies.

Neighborhood to hope to connecting with others to historical legacy These connections result in motivation to change

Historical legacy to power to policy leadership Lack of community involvement due to historical oppression leads to fewer policy leaders to impact change

Community in entire process of research with a CBPR and CHNA driven intervention. Communities and collaboration are key! Stay human and grassroots for equitable change.

All interconnected - spiderweb



5 CLOSING REMARKS

"We hope that this gathering has strengthened your network and deepened your understanding of health equity. We look forward to partnering with each of you as we look for ways to promote oral health equity through policy as a community."

-David Cappelli,
AIDPH Board Chair

"The time we have spent together has been personally impactful to me and the work that I do. I hope you'll consider how to use the information you've learned from the speakers and each other so that you can meaningfully new opportunities as we move collectively through our work in health equity."

-Annaliese Cothron
AIDPH Director of Operations

Thank you for leaning into the discomfort and staying on your learning edge to tackle these important conversations and discover collaborative solutions for advancing health equity through oral health policy.

Attendees were provided an opportunity to reflect on one final question:

How do you **personally plan** on changing your professional practices to support better **health equity**?

SPEAKER INFORMATION

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Candice Chen
Beyond Flexner Alliance

Dr. Candice Chen is an Associate Professor in the Fitzhugh Mullan Institute for Health Workforce Equity in the Milken Institute School of Public Health at the George Washington University. Her research focuses on the role of health workforce and health professions education programs in addressing the priority needs of underserved communities. She was previously the Director of the Division of Medicine and Dentistry in the Bureau of Health Workforce at the Health Resources and Services Administration, where she led programs to enhance training in primary care, oral health, and geriatrics, including graduate medical education programs in children's hospitals and Teaching Health Centers. Dr. Chen is a board-certified pediatrician. She received her medical degree from Baylor College of Medicine and her Masters of Public Health from the George Washington University with a concentration in Community Oriented Primary Care.

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Derek Griffith
Vanderbilt University

Dr. Derek M. Griffith is a Professor of Medicine, Health and Society, and he is the Founder and Director of the Center for Research on Men's Health at Vanderbilt University. Trained in psychology and public health, Dr. Griffith's program of research focuses on developing and implementing behavioral and policy strategies to achieve equity in health and well-being by race, ethnicity, and gender. He has been the principal investigator of research grants from the American Cancer Society, the Robert Wood Johnson Foundation, other foundations, and several institutes within the National Institutes of Health. Dr. Griffith is a contributor to and editor of two recent books –Men's Health Equity: A Handbook(Routledge, 2019), and Racism: Science and Tools for the Public Health Professional (APHA Press, 2019) –and he has co-authored or provided expert review of reports from the American Psychological Association, Promundo-US, and the World Health Organization. Dr. Griffith was given the Tom Bruce Award by the Community-Based Public Health Caucus of the American Public Health Association in recognition of his research on "eliminating health disparities that vary by race, ethnicity and gender."

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Amelie Ramirez
Salud! America

Dr. Amelie Ramirez, Chair and Professor of Population Health Sciences and Director of the Institute for Health Promotion Research at UT Health San Antonio. Amelie G. Ramirez, DrPH, is an internationally recognized health disparities researcher at UT Health San Antonio. She has 30 years of experience conducting behavioral and communications projects to reduce cancer, increase screening rates and clinical trial participation, prove the efficacy of patient navigation for cancer patients, prevent tobacco use, and improve healthy lifestyles among U.S. Latinos. Dr. Ramirez currently directs the Salud America!national multimedia program to empower its vast network of 250,000 community leaders to drive healthy policy and system changes to promote health equity and support for Latino families (www.salud-america.org and @SaludAmerica on social media). Dr. Ramirez also conducts breast cancer disparities research on quality of life and survivorship issues, and directs Quitxt, a bilingual tobacco-cessation service for young Latino adults using mobile-phone text messages; the service yielded a strong 21% quit rate among enrollees at follow-up. Dr. Ramirez is a Susan G. Komen Scholar, a member of the National Advisory Council on Minority Health and Health Disparities of the National Institute on Minority Health and Health Disparities (NIMHD), and a member of the scientific advisory board for LIVESTRONG. Dr. Ramirez, a native of Laredo, Texas, earned MPH and DrPH degrees from UT Health Science Center at the Houston School of Public Health.

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Tyler Sanslow
Fenway Health

Dr. Tyler Sanslow is a general dentist at Fenway Health, a community health center in Boston, MA, with the mission of caring for the LBGTQIA community. Dr. Sanslow is also pursuing an MPH online through University of Massachusetts Amherst. He graduated in 2017 from the University of Kentucky College of Dentistry with awards for Community and Public Health Dentistry, Geriatric Dentistry and Prosthodontics. He is an NHSC loan repayment participant and was awarded the AAPHD Herschel S. Horowitz scholarship to pursue a Dental Public Health residency. He is an active member of organized dentistry and serves at the Boston District Dental Society Editor. Dr. Sanslow has provided dental care in numerous community health settings, rural and urban: an Indian Health Service clinic in Minnesota, health clinics in Ecuador, various community health clinics in Kentucky and western Massachusetts. Before dental school, he worked as a dental assistant at a pediatric practice in his hometown of Lexington, KY.Dr. Tyler speaks Spanish and was a grade school teacher before attending dental school: he taught English at an elementary school in Spain and Spanish at a K-12 school in Kentucky. His passion for public health stems from childhood, where he traveled to public health departments across the state of Kentucky with his aunt, a public health doctor. His dental goals include improving access to and quality of care for the LGBTQIA community and making dentistry greener and more sustainable.

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Scott Howell
Special Care
Dentistry Association

Dr. Scott Howell is an assistant professor and Director of Teledentistry at A. T. Still University, Arizona School of Dentistry & Oral Health (ATSU-ASDOH). He graduated from the dual degree, DMD/MPH, program at ATSU-ASDOH in 2014. After dental school, he spent one year at Swedish Medical Center in Seattle treating patients with complex medical conditions and patients with intellectual and developmental disabilities. After the residency, he went back to ATSU-ASDOH to develop a teledentistry program and help expand the school's interprofessional education curriculum. Interested in learning more about tackling barriers to care for underserved populations, he completed a dental public health residency at UT Health San Antonio in 2019. Dr. Howell is a firm believer in the power of organized dentistry. He works with the American Dental Association's Center for Evidence-Based Dentistry, has written a white paper on teledentistry with the Association of State and Territorial Dental Directors, and has advocated for changes in Arizona health laws as a member of the Arizona Dental Association's council of government affairs. He began working with the Special Care Dentistry Association (SCDA) while in dental school and is currently in his second year of a three-year term as treasurer for SCDA.

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Dennis Borel
Coalition of Texans with Disabilities

With 20 years as one of the Coalition of Texans with Disabilities' lead advocates, Dennis Borel is frequently called on for research, policy analysis, and recommendations to the Texas Legislature and state agencies on issues surrounding disabilities. He is recognized as a policy expert on access to health care and dental care, Medicaid managed care, access to medicines and pharmaceuticals, and civil rights. In these and many other areas, he has successfully advocated for positive change in government policy and practice. Honors for Dennis' advocacy work include the University of Michigan's national James Neubacher Award for promoting rights and increasing opportunities for people with disabilities; the National Advocacy Award from the National Council on Independent Living; and the Texas Health and Biosciences Institute's Luminary Award for his leadership and dedication into the life science industry in Texas. In addition, Dennis has over 30 years of experience in senior nonprofit management. Programs he has managed have received numerous state recognitions and national awards, including from HUD, the Points of Light Foundation, the New York Interactive Film Festival, the Barbara Jordan Media Awards, and the Peter F. Drucker Foundation for Nonprofit Management. Dennis is a former high school teacher and served as a Peace Corps volunteer in Morocco.

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CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Lois Cohen
National Institutes of Health

Lois K. Cohen, PhD serves as a consultant & Paul G. Rogers Ambassador for Global Health Research since her retirement from U.S. government service in 2006. She is a sociologist whose research and health science administration career included service as the Director of Extramural Research, Associate Director for International Health and Director of the WHO Collaborating Center for Dental, Oral & Craniofacial Research and Training, National Institute of Dental & Craniofacial Research, National Institutes of Health. Having authored more than 150 articles in peer-reviewed journals and edited four books on the social sciences and dentistry, she co-directed the WHO International Collaborative Studies of Oral Health Systems. Having served on several journal boards among them the Journal of the American Dental Association, she co-chairs the Friends of the Organization for Safety, Asepsis, and Prevention, and serves on the boards of several nonprofit organizations. She provides consultation to the NIH, the World Health Organization and its regional offices in Africa and the Americas, the Canadian Institutes for Health Research, various universities and professional associations including the American Dental Association, the FDI World Dental Federation, the American Dental Education Association and others in the area of global health through oral health.

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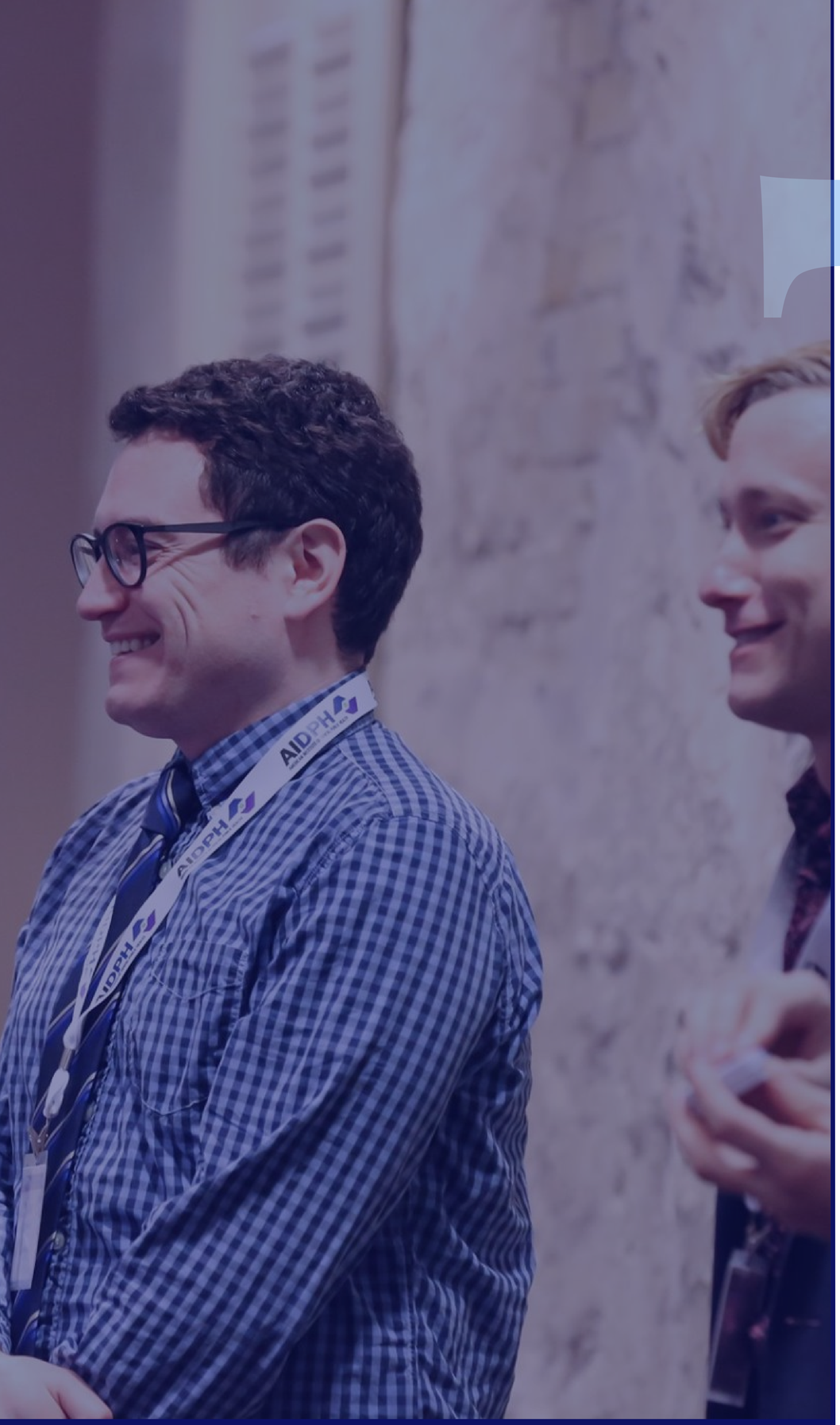
CONFRONTING INEQUITY THROUGH ORAL HEALTH POLICY

Alan Morgan
National Rural
Health Association

Alan Morgan is recognized among the top 100 most influential people in healthcare by Modern Healthcare Magazine, Alan Morgan serves as Chief Executive Officer for the National Rural Health Association. He has more than 29 years of experience in health policy at the state and federal level and is one of the nation's leading experts on rural health policy.Mr. Morgan served as a contributing author for the publication, "Policy & Politics in Nursing and Health Care," and for the publication, "Rural Populations and Health." In addition, his health policy articles have been published in: The American Journal of Clinical Medicine, The Journal of Rural Health, The Journal of Cardiovascular Management, The Journal of Pacing and Clinical Electrophysiology, Cardiac Electrophysiology Review, and in Laboratory Medicine. Mr. Morgan served as staff for former US Congressman Dick Nichols and former Kansas Governor Mike Hayden. Additionally, his past experience includes tenures as a health care lobbyist for the American Society of Clinical Pathologists, the Heart Rhythm Society, and for VHA Inc. He holds a bachelor's degree in journalism from University of Kansas, and a master's degree in public administration from George Mason University.



7 APPENDIX

CONFERENCE AGENDA: TUESDAY

Tuesday, January 14, 2020

6:45 am - 7:30 am:	**Breakfast and Registration**
7:30 am - 8:00 am:	**Welcome**
8:00 am - 9:00 am:	**Keynote Address:**
	Social Mission: The Role of Health Workforce in Addressing Health Equity
	Candice Chen, MD, MPH
9:00 am - 9:30 am:	**Break**
9:30 am - 10:30 am:	**What Do Dental Public Health Professionals Need to Know About Racism as a Public Health Issue?**
	Derek Griffith, PhD
10:30 am - 11:00 am:	**Discussion Session**
11:00 am - 12:30 pm:	**Lunch**
12:30 pm - 1:30 pm:	**Using Digital Advocacy Strategies to Promote Public Health & Health Equity**
	Amelie Ramirez, DrPH
1:30 pm - 2:30 pm:	**Dental Care for the LGBTQ+ Community: Achieving Dental Health Equity**
	Tyler Sanslow, DMD, MPH
2:30 pm - 3:00 pm:	**Discussion Session**
3:00 pm - 3:30 pm:	**Break**
3:30 pm - 4:30 pm:	**Panel Discussion: Serving Individuals with Disabilities**
	Dennis Borel; Scott Howell, DDS; Allan Castro
4:30 pm - 5:00 pm:	**Discussion Session**
5:00 pm:	**Adjourn**

CONFERENCE AGENDA: WEDNESDAY

Wednesday, January 15, 2020

7:00 am - 7:45 am: **Breakfast and Registration**

7:45 am - 8:00 am: **Welcome**

8:00 am - 9:00 am: **Keynote Address:**
Confronting Inequity Through Global Health Policies
Lois Cohen, PhD

9:00 am - 10:00 am: **Rural Oral Health Care Access: A National Policy Perspective**
Alan Morgan, MPA

10:00 am - 10:30 am: **Discussion Session**

10:30 am - 11:00 am: **Break**

11:00 am - 12:00 pm: **Panel Discussion: Race, Ethnicity and Culture Impact on Health and Oral Health**
Derek Griffith, PHD; Amelie Ramirez, DrPH; Candice Chen, MD, MPH; Lois Cohen, PhD

12:00 pm - 1:00 pm: **Healthy People 2020 and Beyond—New Directions**
Gina Thornton-Evans, DDS, MPH

1:00 pm: Conclusion

PARTNERS IN PLANNING

The American Institute of Dental Public Health (AIDPH) was created to promote and disseminate evidence-based oral health scholarship to advanced education students in dental public health. The mission of AIDPH is to foster professional excellence and advance innovation in the education and practice of dental public health. AIDPH creates educational and service-learning experiences in academic leadership, federal service, and culturally responsive care to support current and future members of the dental public health workforce. Along with the annual colloquium and internships, AIDPH supports an online resource center with over 2,000 references. Our podcast, Anecdotal Evidence, invites conversations with national thought leaders on emerging public health topics including women in health leadership, medical-dental integration, and rural health. A mentorship program, created within AIDPH, partners newly graduated DPH residents with seasoned professionals to guide the new graduates through the early stages of their career. AIDPH serves as a platform for evidence-based dental public health scholarship with special focus on dental public health informatics, health equity, cultural competency, diversity in the oral health workforce, and addressing the oral health needs of the underserved.

The American Association of Public Health Dentistry (AAPHD) provides a focus for meeting the challenge to improve oral health. AAPHD membership is open to all individuals concerned with improving the oral health of the public. Founded in 1937, AAPHD accepts the challenge to improve total health for all citizens through the development and support of effective programs of oral health promotion and disease prevention. The mission of AAPHD is to develop partnerships with members and stakeholders that have an interest in public health dentistry, translate evidence into policies and programs, and develop talent and leadership in the field of public health dentistry. AAPHD is also the sponsoring agency of the American Board of Dental Public Health which is the national examining and certifying agency for the specialty of Dental Public Health.

2020 COLLOQUIUM SPONSORS

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This event is sponsored from a grant provided by the Health Resources and Services Administration (HRSA) Post-Doctoral Training in General, Pediatric, and Public Health Dentistry (D88HP28510)

ACCESS THE FULL CONFERENCE MATERIALS

You can access the full video presentations and presenter slides on the AIDPH website.

Visit www.AIDPH.org/colloquium to view recordings of all colloquium topics:

Confronting Inequity Through Oral Public Health Policy

Evolving the Dental Public Health Landscape: Interprofessional Practice and Value-Based Care

Precision Public Health and the Future of Dental Public Health

Dental Public Health Informatics: Opportunities in a Changing Environment

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