ORAL HEALTH OHIO

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™

State Oral Health Plan Advisory Committee

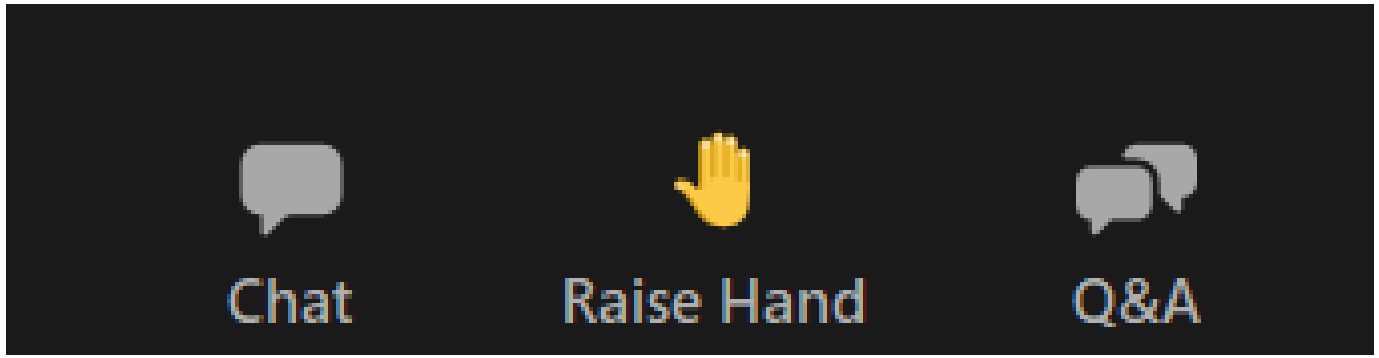
Meeting 1

May 25, 2022

Amy Rohling McGee

President, Health Policy Institute of Ohio
arohlingmcgee@hpio.net

Participating in Zoom



Vision

Ohio is a model of health, well-being and economic vitality.

Mission

To advance evidence-informed policies that improve health, achieve equity, and lead to sustainable healthcare spending in Ohio.

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core funders

bi3 Bethesda Inc.'s grants initiative to *transform* health

CareSource

Cleveland Foundation

The George Gund Foundation

harmonyproject

HealthPath

Interact for Health
A Catalyst for Health and Wellness

Mercy
Care you can believe in.®

Mt. Sinai Health Foundation

The Nord Family Foundation

NCMF
North Canton Medical Foundation

OSBF Ohio State Bar Foundation

Sisters of Charity Foundation of Canton

Sisters of Charity Foundation of Cleveland

Meeting **agenda**

1. Welcome and introductions
2. State Oral Health Plan development process, timeline and role of the Advisory Committee
3. Connections between oral health and overall health and oral health data for Ohio
4. Presentation on the *Oral Health in America: Advances and Challenges* report by Bruce Dye, DDS, MPH
5. Core values and conceptual framework
6. Next steps

Meeting **objectives**

As a result of feedback provided by Advisory Committee members at this meeting, HPIO and OHO will have the guidance on:

- Information to highlight in the SOHP
- Core values
- Conceptual framework

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Marla Morse

Director, Oral Health Ohio

Marla.Morse@oralhealthohio.org

Advisory Committee

Introductions

Discussion question

What encourages you most about this work?

Process, timeline and role of the Advisory Committee

Becky Carroll
Senior Policy Analyst, HPIO

What will be included in the

State Oral Health Plan

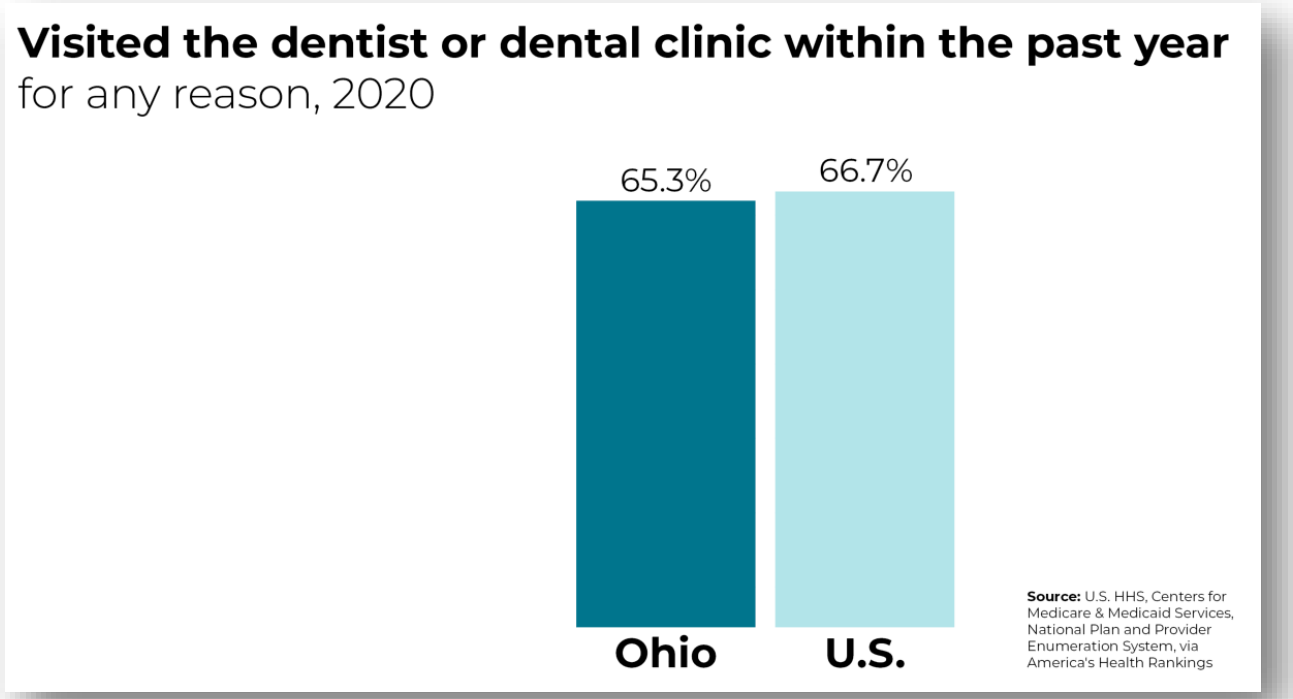
- Assessment of Ohio's oral health strengths and challenges
- Priority outcomes and factors selected with help of the Advisory Committee
- SMART objectives and targets for tracking progress
- Strategies and policy recommendations

Data **sources**

- Secondary data
- Healthcare provider focus groups
- Regional consumer focus groups

Secondary **data**

- Up to 25 metrics: Data for Ohio and the overall U.S. when possible
- Up to 5 metrics broken out by:
  - Race/ethnicity,
  - Income,
  - Education level and/or
  - Disability status



Healthcare provider focus groups

We will gather feedback about:

- Ohio's strengths and challenges related to oral health
- Barriers faced by groups of Ohioans with limited opportunities for good oral health
- What should be prioritized in the State Oral Health Plan
- Policy recommendations

Regional

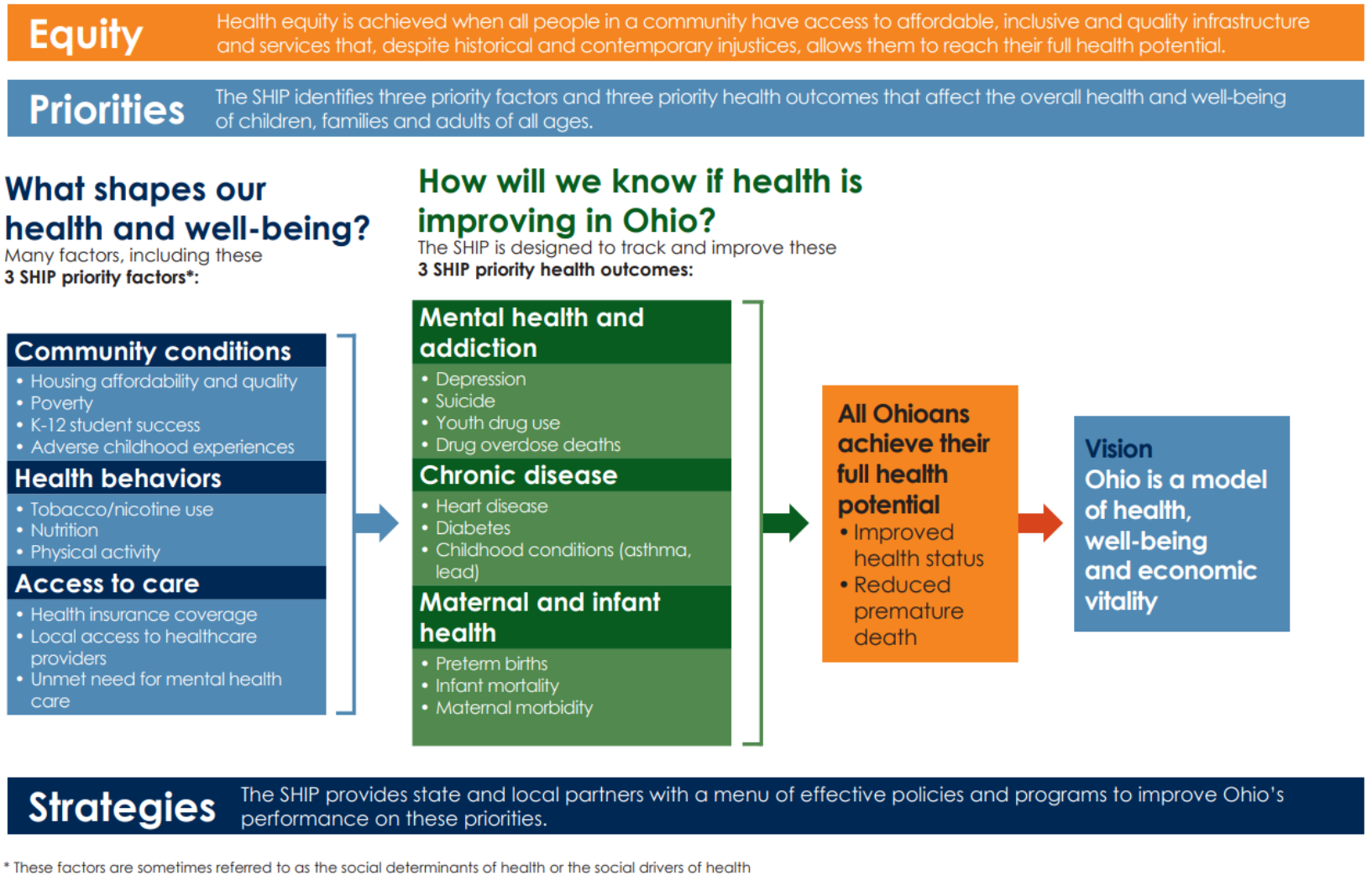
Consumer focus groups

We will gather feedback about:

- What is going well in their community related to oral health
- Barriers to oral health
- What needs to happen to improve oral health for the people in their community

Priority
Selection

State Health Improvement Plan framework

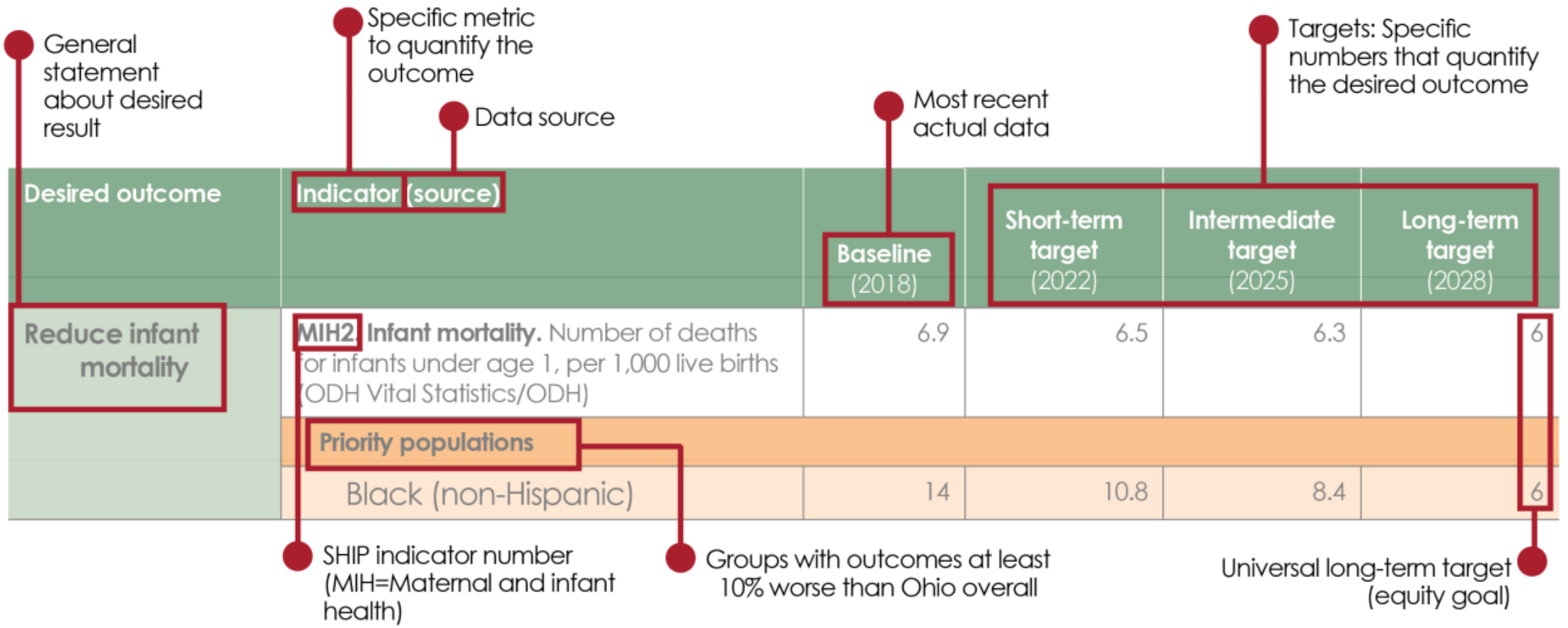


Source: 2020-2022 State Health Improvement Plan, Ohio Department of Health

SMART objectives

Source: 2020-2022 State Health Improvement Plan, Ohio Department of Health

SMART objective and target **example**

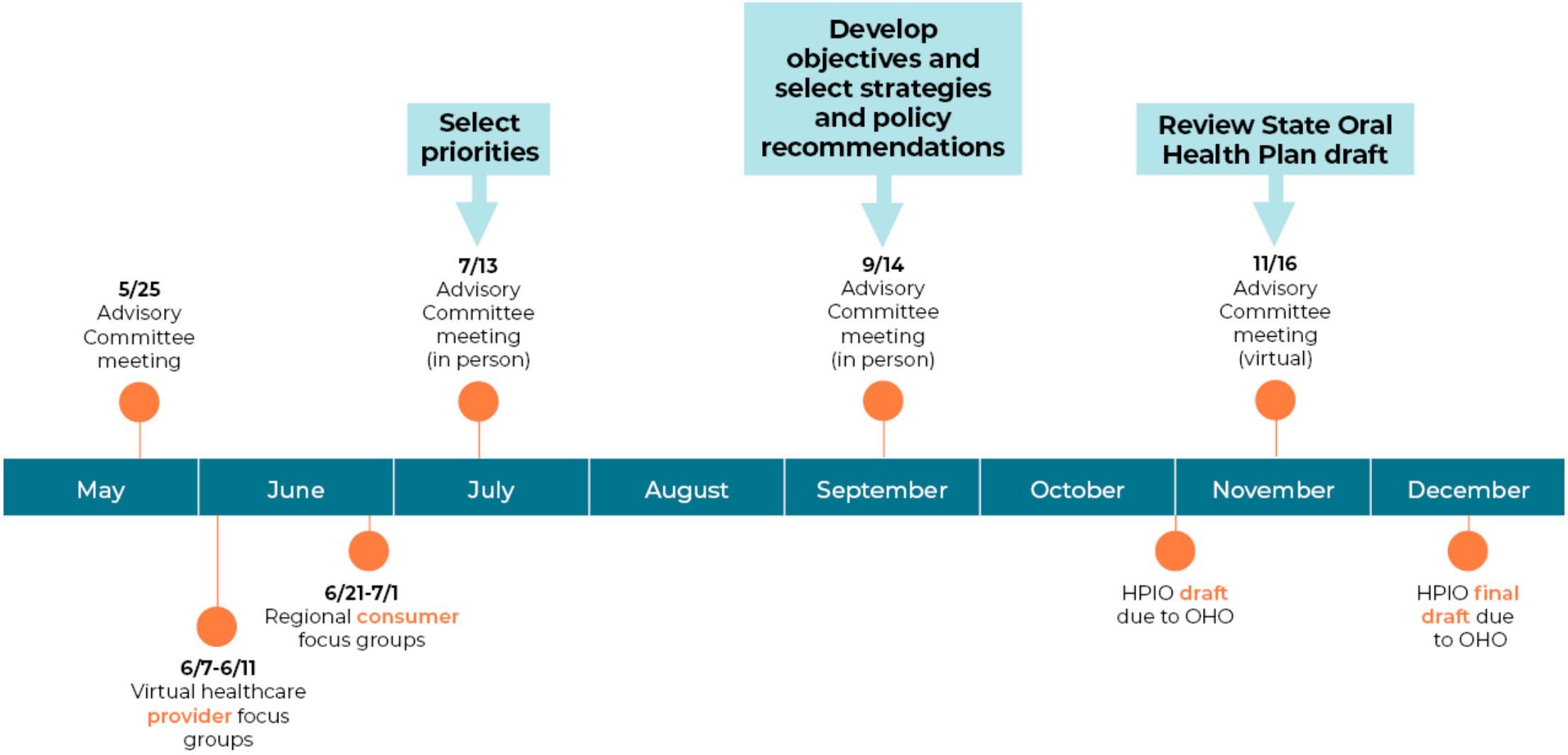


Source: 2020-2022 State Health Improvement Plan, Ohio Department of Health

Strategies and Policy

Recommendations

Project **timeline**



Role of the **Advisory Committee**

- Select up to 25 quantitative metrics to include
- Review data and focus group findings and advise on the themes to include
- Select strategies and recommendations
- Guide the creation of SMART objectives and targets
- Review and provide feedback on the draft State Oral Health Plan

Questions?

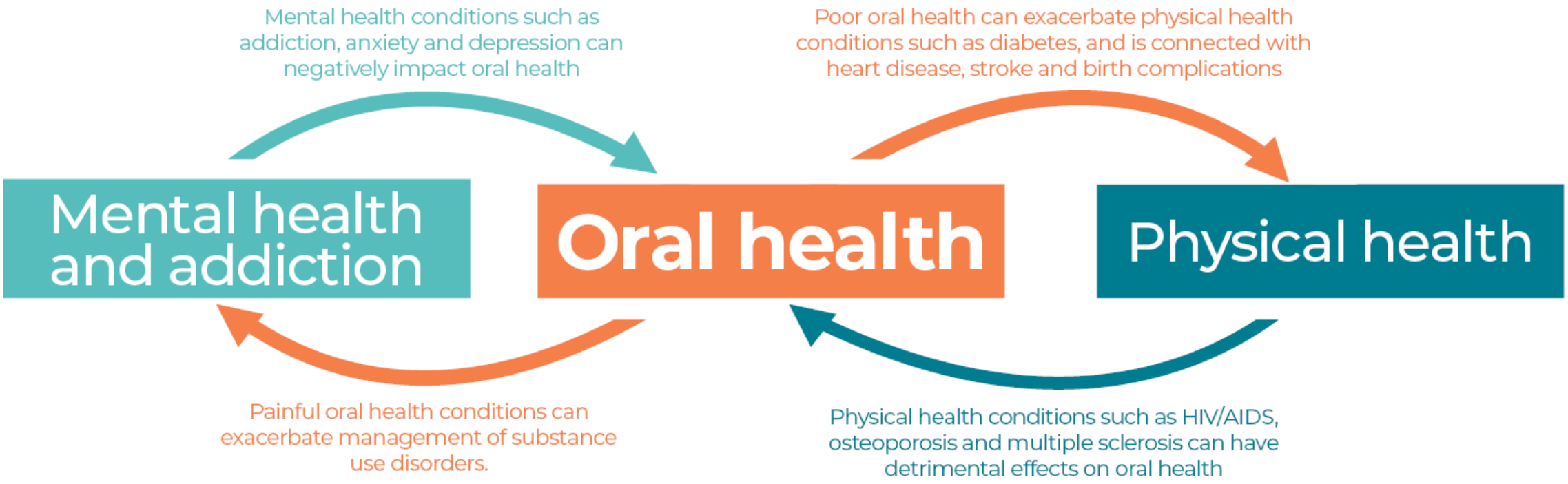
Connections between oral health and overall health and Ohio data overview

Dr. Lexi Chirakos

Health Policy Analyst, HPIO

Oral health **impact chart**

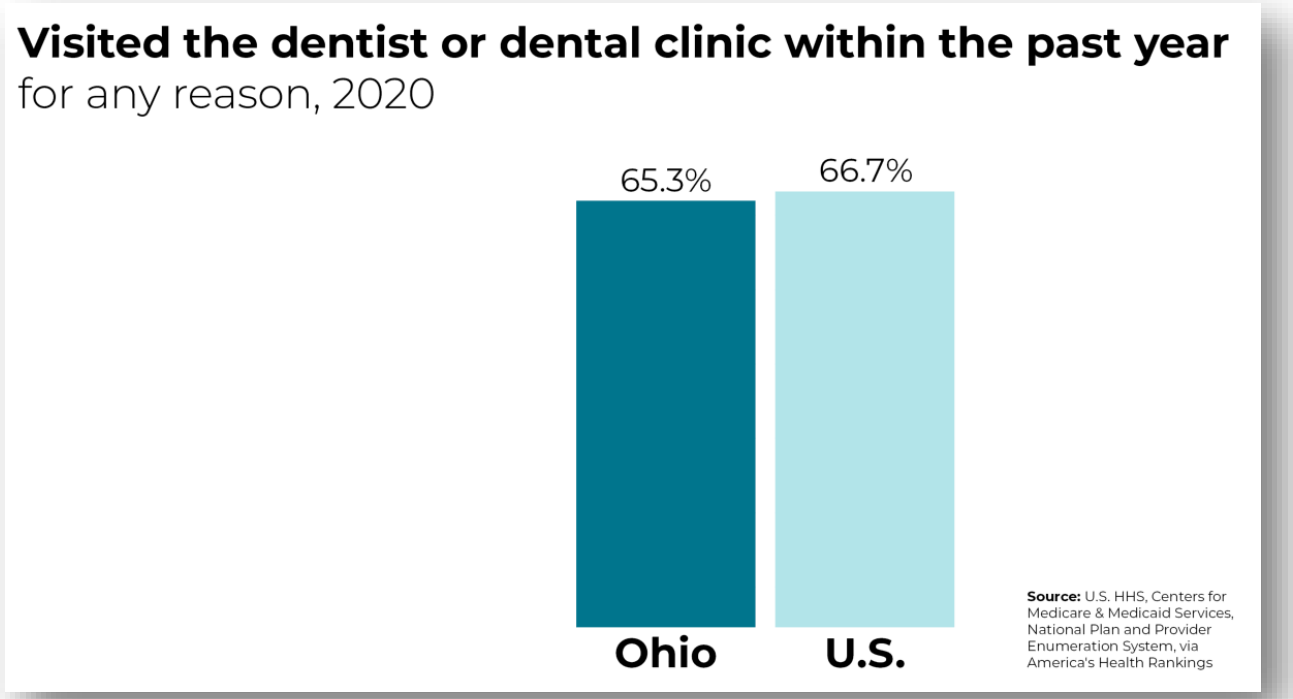
Connections between oral health and overall health



Poverty, toxic stress, discrimination, food security, and care access and affordability are factors that influence oral and overall health

Secondary **data**

- Up to 25 metrics: Data for Ohio and the overall U.S. when possible
- Up to 5 metrics broken out by:
  - Race/ethnicity,
  - Income,
  - Education level and/or
  - Disability status



Visited the dentist or dental clinic within the past year

for any reason, ages 18 and older, 2020

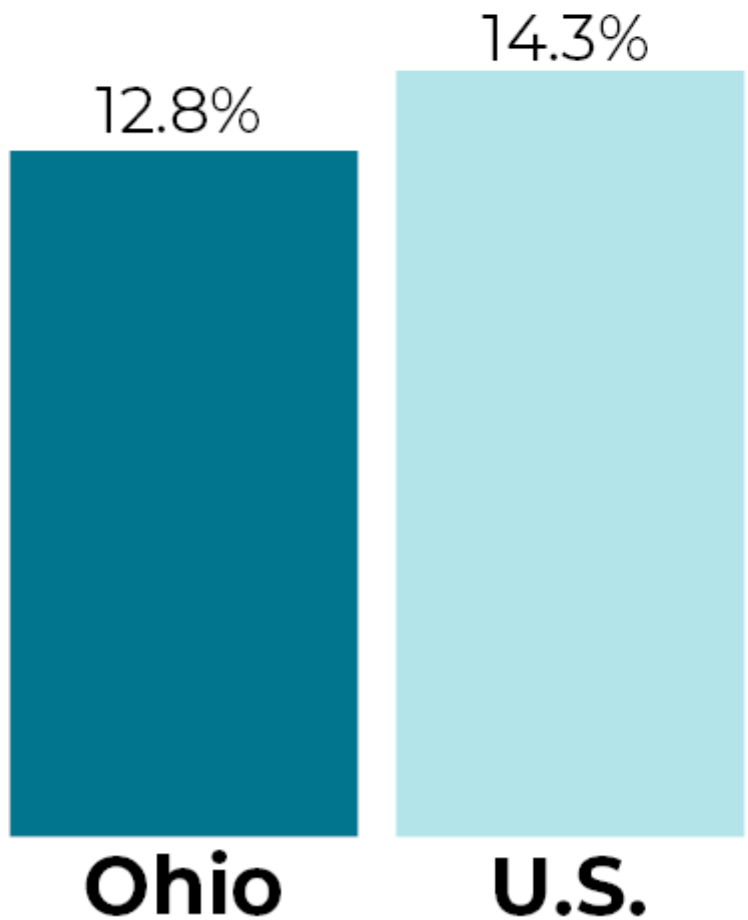
Ohio **worse** than U.S.

Source: Behavioral Risk Factor Surveillance System

One or more oral health problems in past year

such as toothaches, bleeding gums or decayed teeth or cavities, age 1-17 years, 2019-2020

Ohio **better** than U.S.

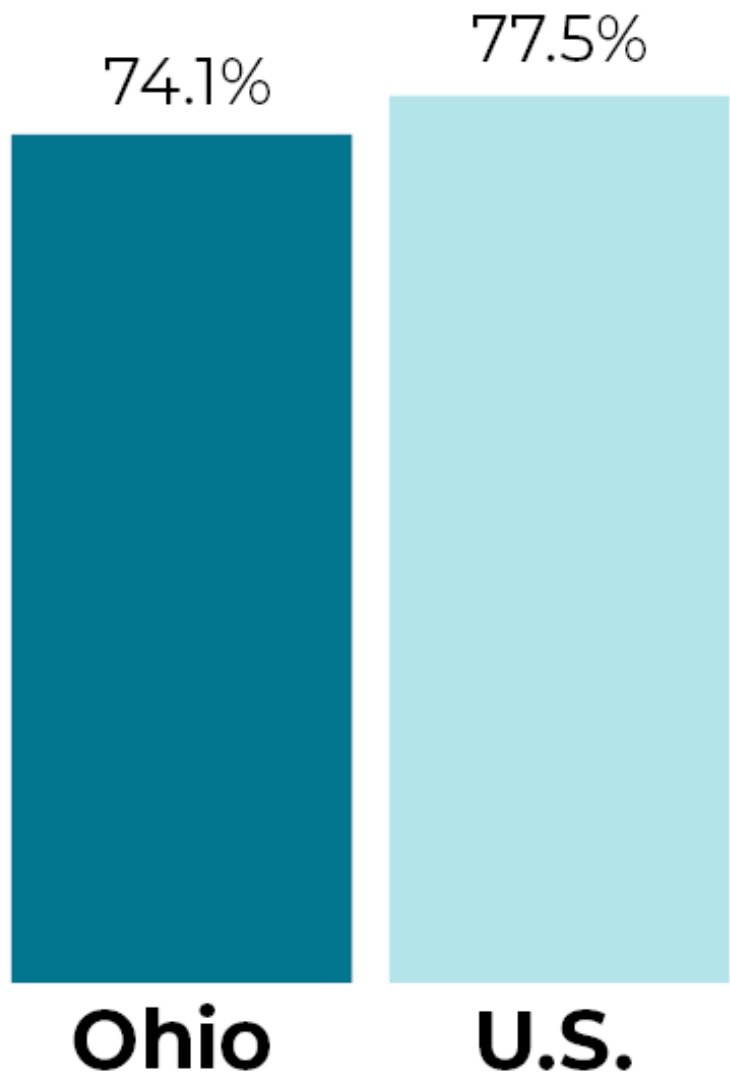


Source: National Survey of Children's Health, 2019-2020

One or more preventive visits in past year

Such as check-ups, dental cleanings, dental sealants, or fluoride treatments, age 1-17 years, Ohio, 2019-2020

Ohio **worse** than U.S.

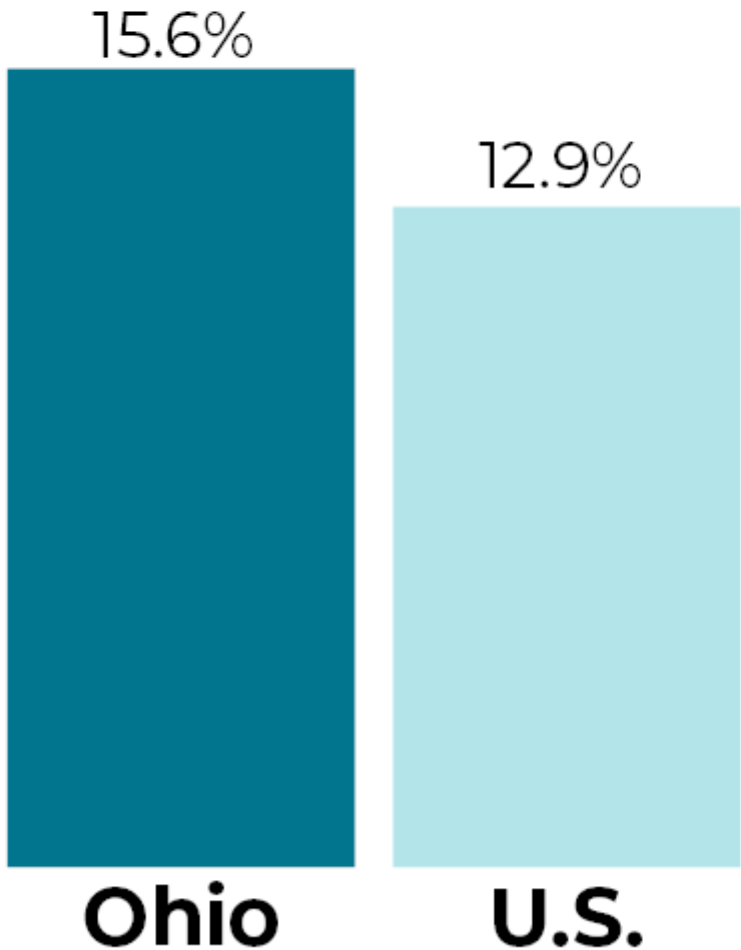


Source: National Survey of Children's Health, 2019-2020

Older adults who have had all permanent teeth extracted

Ages 65+, 2020

Ohio **worse** than U.S.

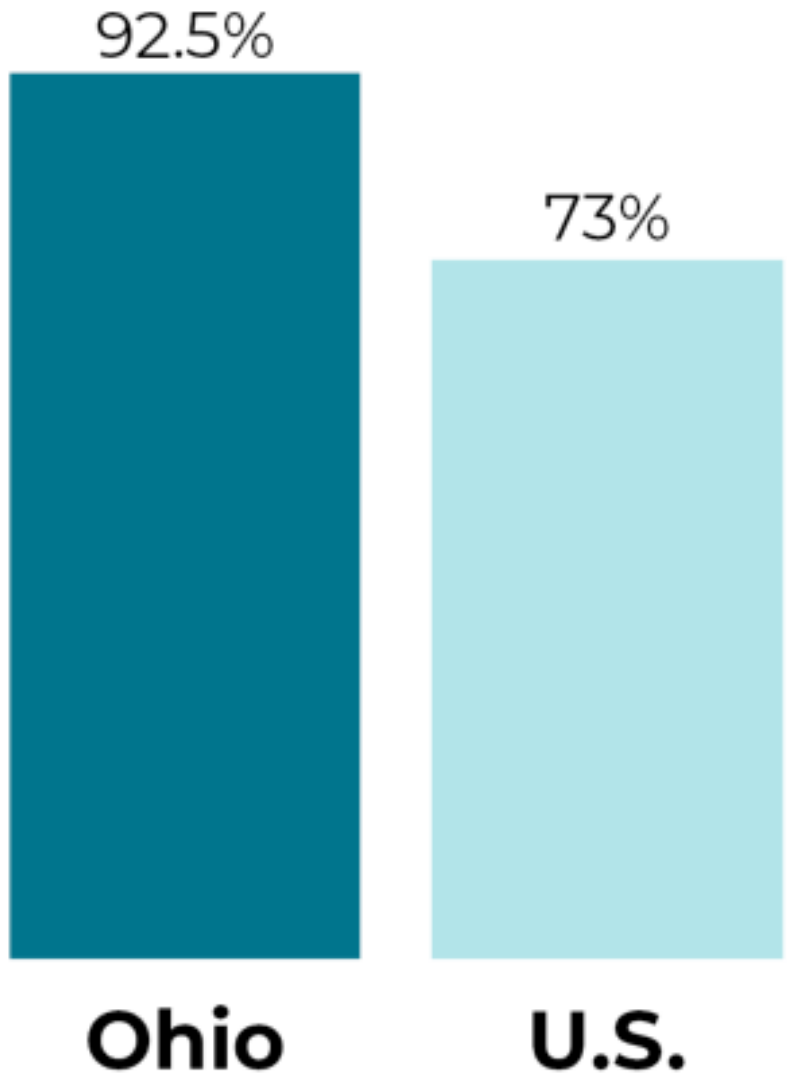


Source: Behavioral Risk Factor Surveillance System

Water flouridation

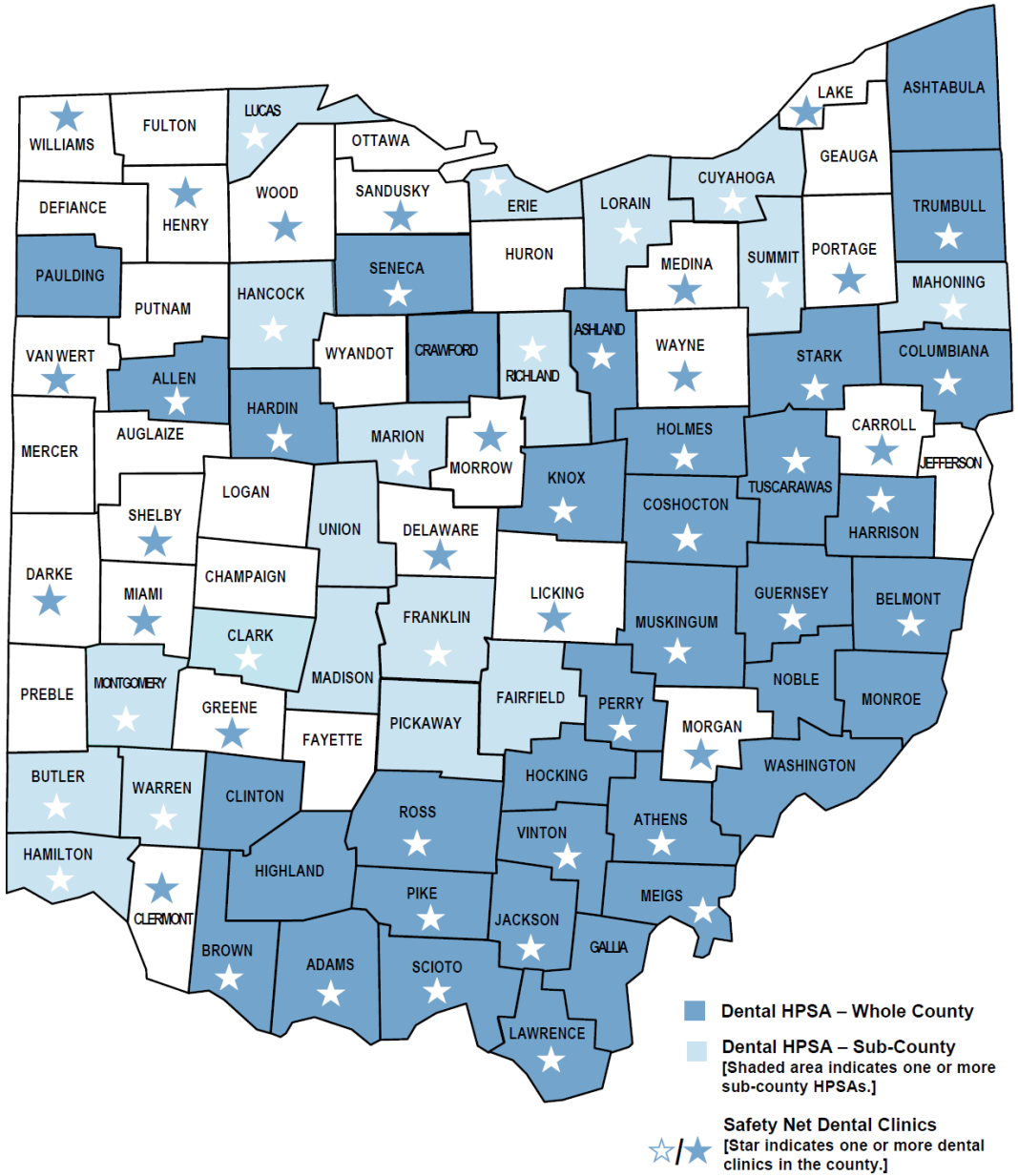
Percent of population served by community water source receiving fluoridated water, 2018

Ohio **better** than U.S.



Source: CDC National Fluoridation Statistics

Safety net dental clinics and Dental HPSAs* in Ohio



**A dental HPSA (health professional shortage area) is a federally designated geographic area, population or facility with a shortage of primary dental health care providers.*

Source: Ohio Department of Health

Discussion question

What surprises you most about this data?

Discussion question

What are the greatest barriers to improvement?

Discussion question

What is most important to highlight in the plan?

Bruce A. Dye, DDS, MPH

Oral Health in America

considerations for

Ohio's next State Oral Health Plan

Bruce A. Dye, DDS, MPH

25 May 2022

Oral Health Ohio Advisory Committee Meeting

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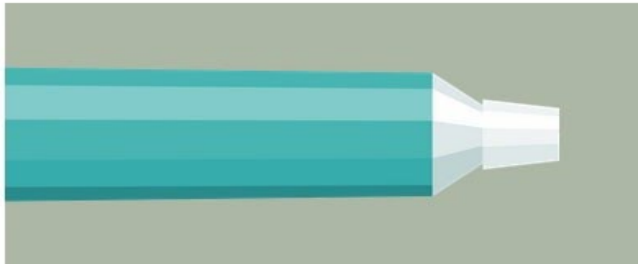
Oral Health in America



Oral Health in America: Advances and Challenges is a follow up to the Surgeon General's Report on Oral Health in America and explores the nation's oral health over the last 20 years.

https://www.nidcr.nih.gov/research/oralhealthinamerica

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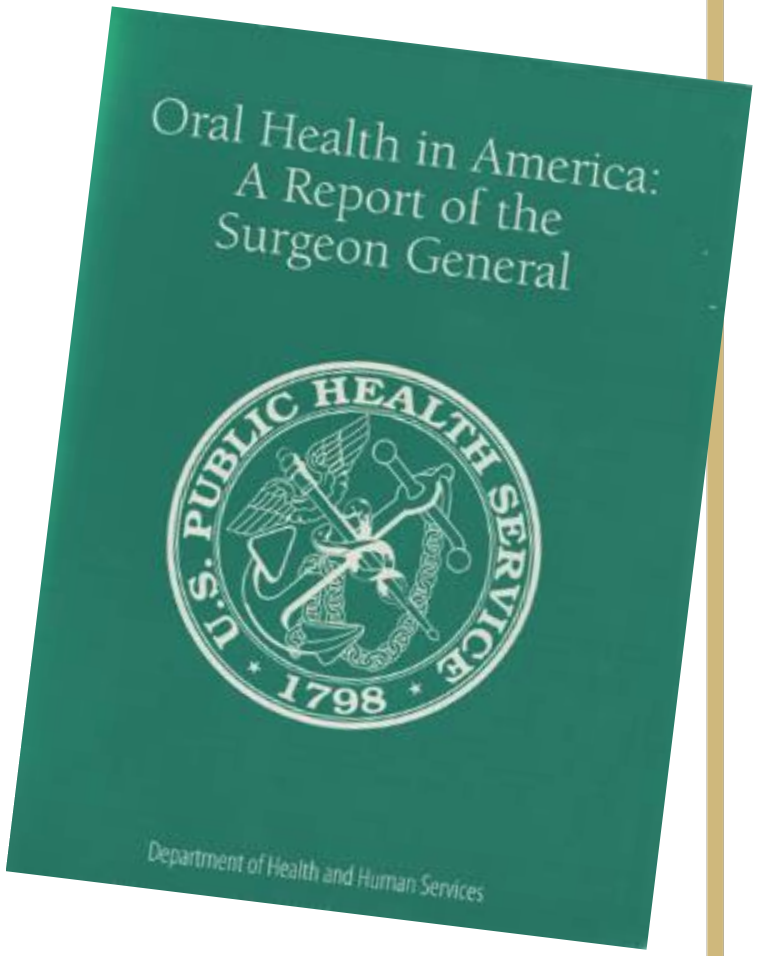
First Surgeon General's Report on Oral Health

Major Message of 2000: Oral Health is more than healthy teeth and is integral to the general health and well-being of all Americans.

- Safe and effective measures exist to improve oral health and prevent disease
- Health risk factors, such as tobacco use and poor dietary practices, affect oral and craniofacial health



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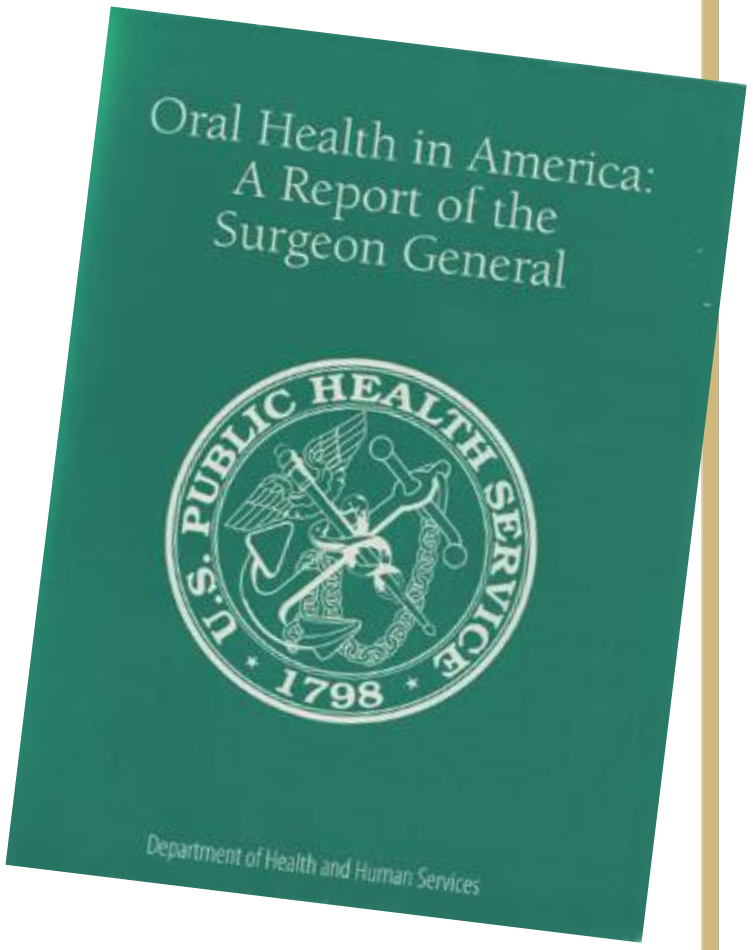
First Surgeon General's Report on Oral Health

Surgeon General Reports are not only a synthesis of the existing knowledge on a topic important to public health …

They are used to inform both research priorities and policy making …

- *To improve patient care and public health outcomes*



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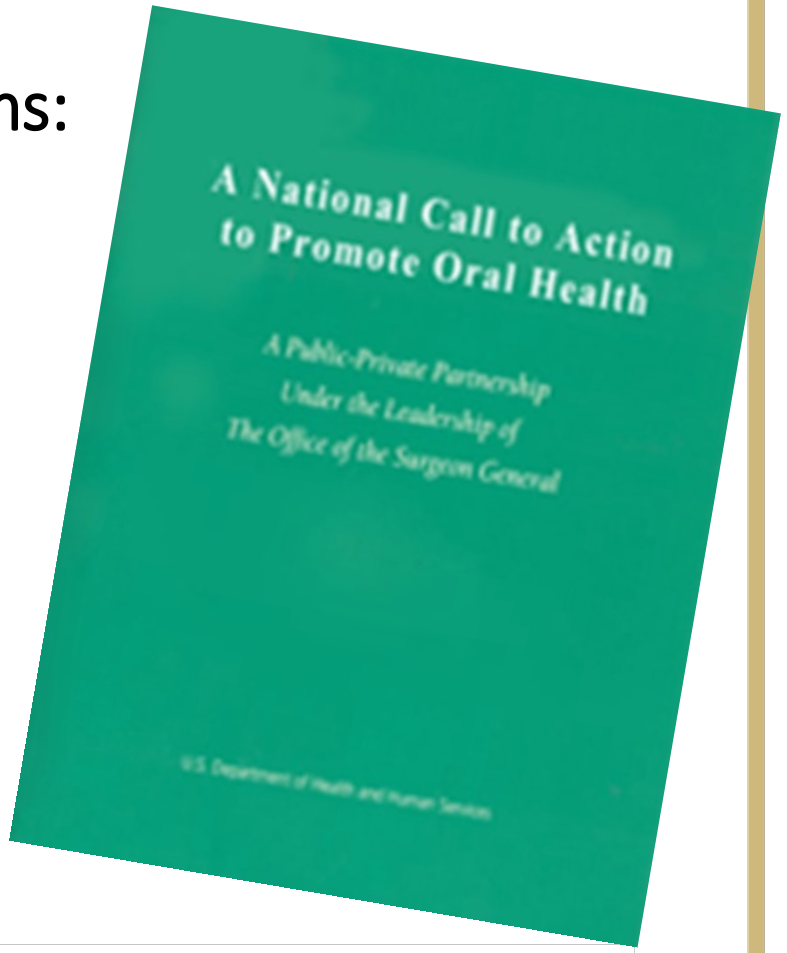
The 2003 Follow-up – a Call to Action

5 Major focus areas representing call-to-action items:

- Change perceptions of oral health
- Replicate effective programs
- Build the science base and accelerate science transfer
- Increase oral health workforce diversity, capacity, and flexibility
- Increase collaborations



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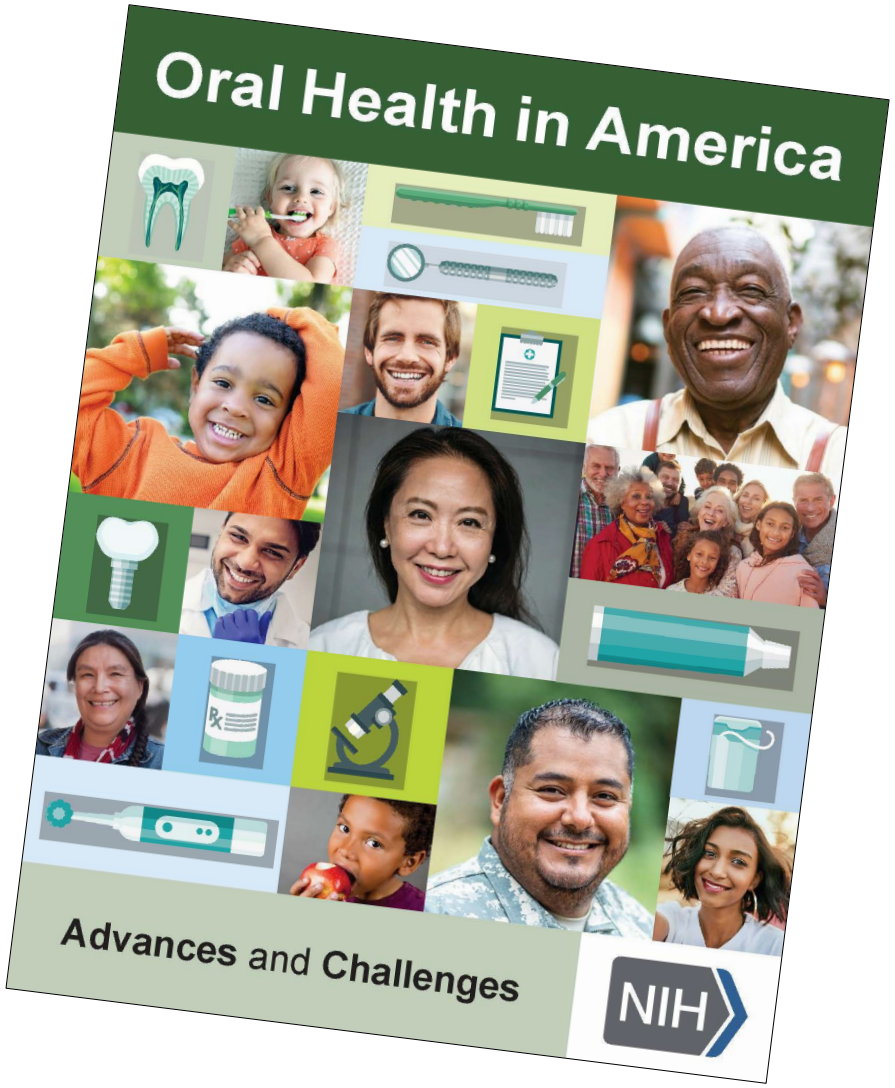
The 2021 Follow-up – Oral Health in America



Hundreds of participants:

- *More than 350 contributors*
- *26 Section and Section Associate Editors*
- *70 Scientific Reviewers,*
- *9 Senior Reviewers,*
- *About 200 professionals contributing descriptions of innovative programs and approaches for addressing OH challenges through public comment,*
- *A project team supporting daily activities consisting of 5-10 staff members (dependent upon work load), and*
- *2 co-Directors / Scientific Editors to navigate the ship*

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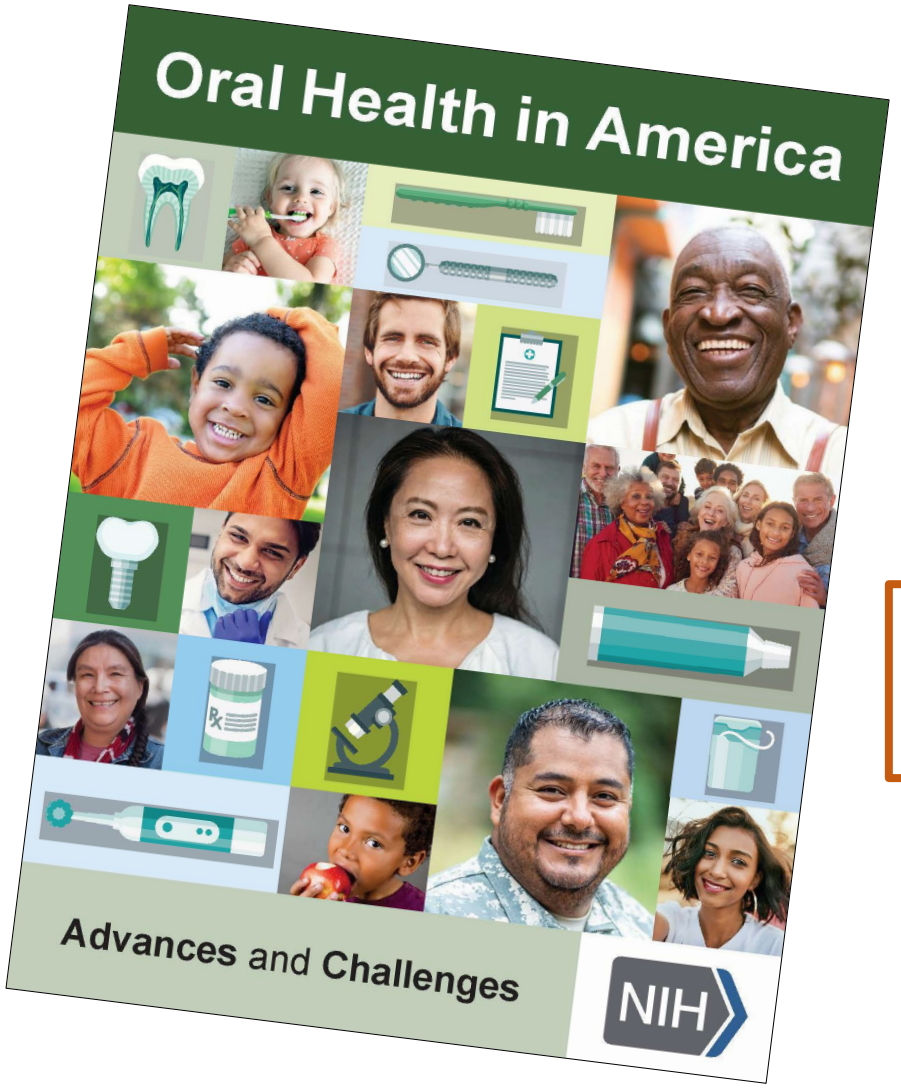
The 2021 Follow-up – Oral Health in America



"…people in the United States experience oral health differently."

Introductory Message

Two decades ago, Surgeon General David Satcher released a major report examining the nation's oral health. This first-time report was considered a public health milestone, emphatic in its assertion that oral health was inextricably linked to overall health and well-being. It also took great care to illuminate the stark disparities and inequities that exist with regard to disease burden and accessing and affording oral health care in this country.

Seventeen years after its publication, Dr. Satcher, along with Dr. Joyce H. Nottingham, partially assessed the progress made since the 2000 report, publishing a paper in the American Journal of Public Health. Based on emerging data, they offered the American people some early perspective in the form of good and bad news. The good, they proffered, was that "our understanding of oral diseases continues to grow." And the bad? Too many Americans still suffered from diseases of the mouth, the majority of which were related to oral health disparities.

That piece, it turns out, was a fitting, if unintended, prologue to this report, which is a sweeping, comprehensive effort to tell the whole story of the state of oral health in America. And, as the title suggests, in the last 20 years, there has been progress in some areas, and in others, a collective realization that far more work needs to be done.

It is our hope and intent that this report will serve as the foundation for that work. Work that—in light of a global pandemic that so plainly shows that the mouth is the gateway to the rest of the body and that those individuals and communities most affected in the pandemic are the same as those who so badly need oral health care—is perhaps more important than it has ever been. As this report describes, there is already promising research completed and underway to better understand the role the oral cavity plays with regard to SARS-CoV-2 transmission and infection. Research, innovation, and new technologies must continue to shine light into the dark corners of this global public health cr[illegible]s.

This report also sheds new light on h[illegible]w people in the United States experience oral health differently based on their age, economic status, and [illegible] number of other social and commercial determinants. And, while good oral health is vitally imp[illegible]ant to the health and well-being of everyone, the report shows that oral health care has not been [illegible] is not, equitably available across America.

Undoubtedly, you will see parallels to the 2000 report. As that document did, NIH, with the support of the Surgeon General, is also putting forth "calls to action" and specific recommendations on how to improve the oral health of our nation. In the following pages, we at the National Institute of Dental and Craniofacial Research, in concert with a vast array of editors and contributors, have painstakingly connected the dots that make up the constellation of amazing oral health research that has occurred since release of the first report at the turn of the century. With the utmost humility, the research team asked: "What have we learned?"

This report is their answer.

Vivek Murthy
Vice Admiral Vivek H. Murthy, MD, MBA
U.S. Surgeon General

Francis S. Collins, MD, PhD
Director, National Institutes of Health

Rena D'Souza
Rena D'Souza, DDS, MS, PhD
Director, National Institute of Dental and Craniofacial Research

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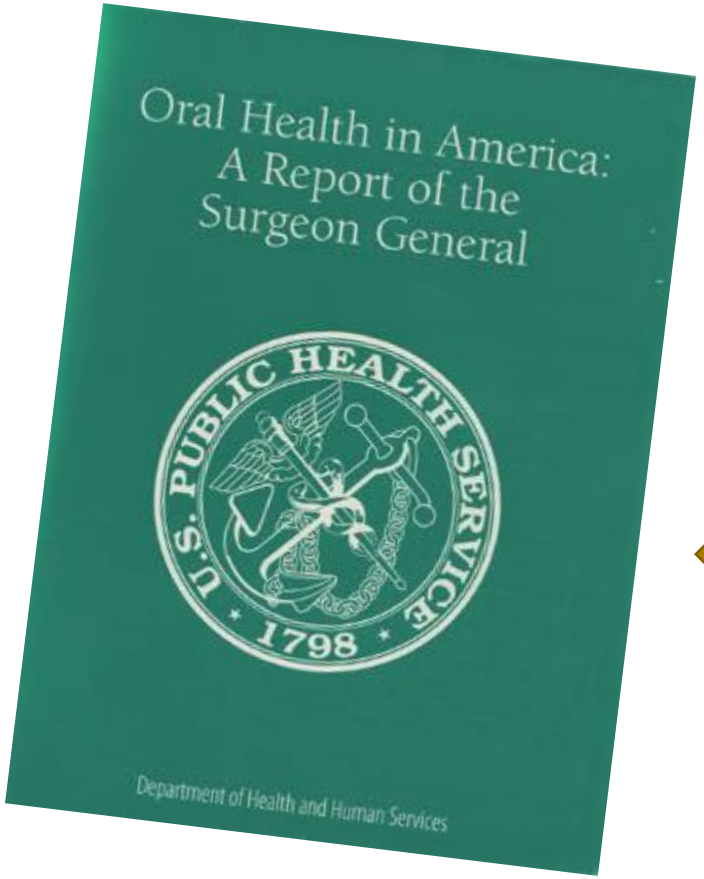
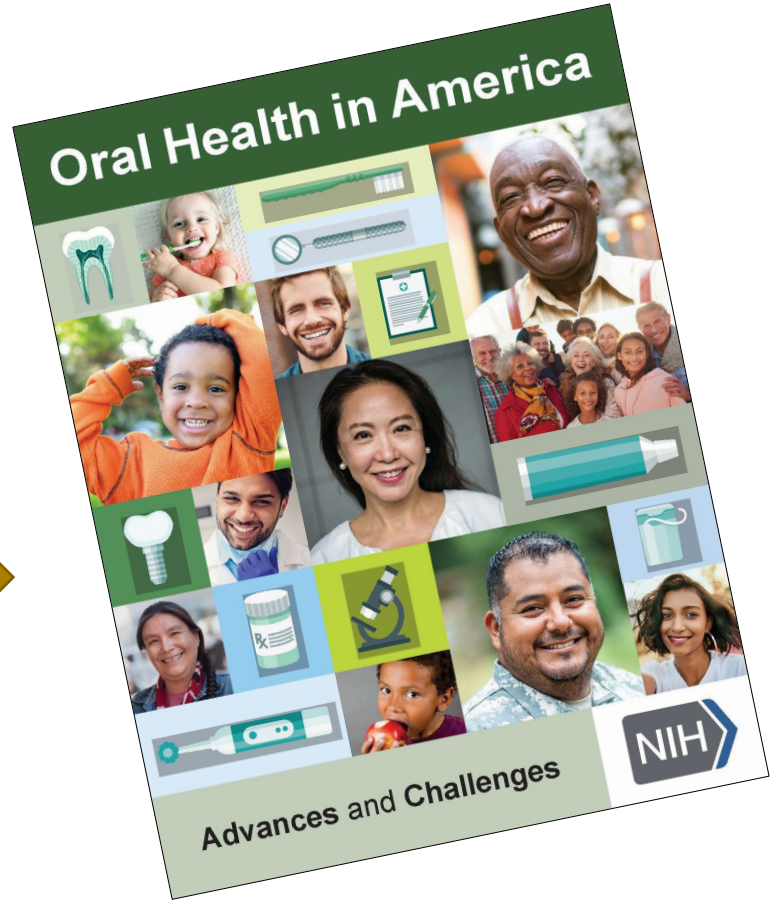
The 2021 Follow-up – Oral Health in America



Oral Health is integral to Overall Health



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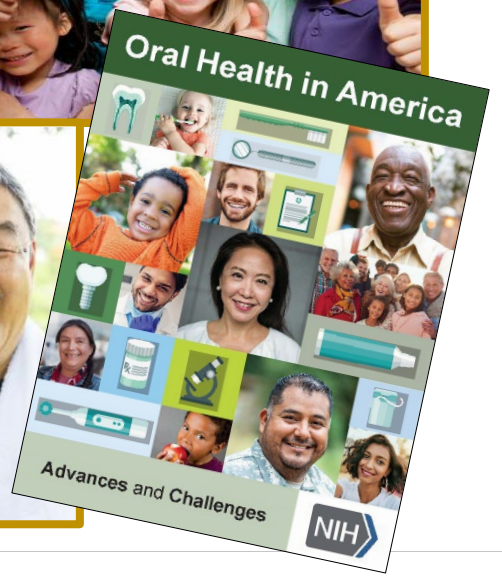
Structure of the Report: Six Sections

1. Effect of Oral Health on the Community, Overall Well-Being and the Economy
2. Oral Health in Children and Adolescents
3. Oral Health in Working-Age and Older Adults



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Structure of the Report: Six Sections

4. Oral Health Integration, Workforce, and Practice
5. Substance Use Disorders, the Opioid Epidemic, High-Risk Behaviors, and Mental Health
6. Emerging Technologies and Promising Science to Transform Oral Health

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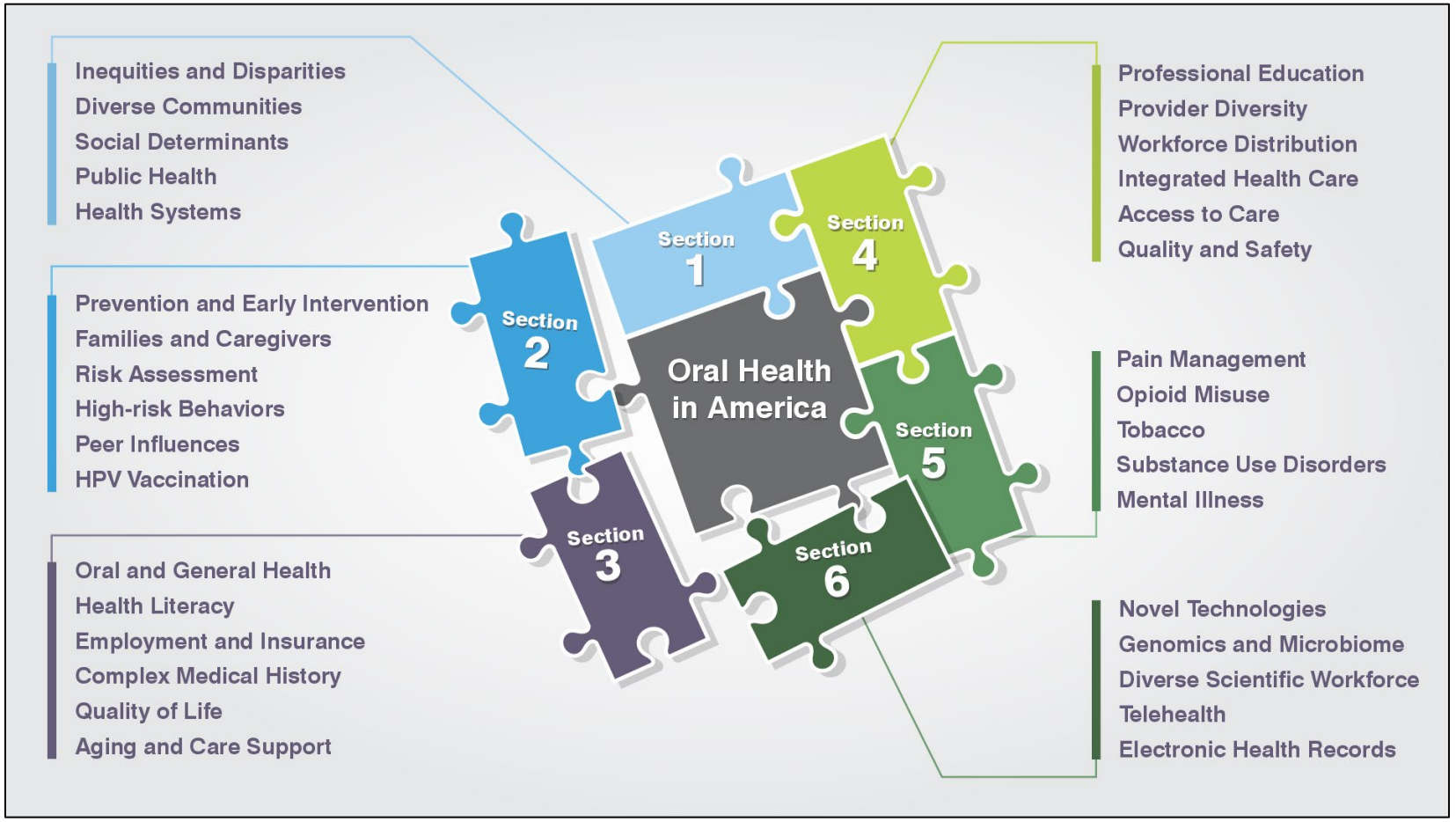
What's in the new Report on Oral Health in America?



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The 2021 Follow-up – Oral Health in America

What are some key epidemiologic data informing the report:

Oral Health in America: Advances and Challenges?

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Oral Health in America

Dental caries

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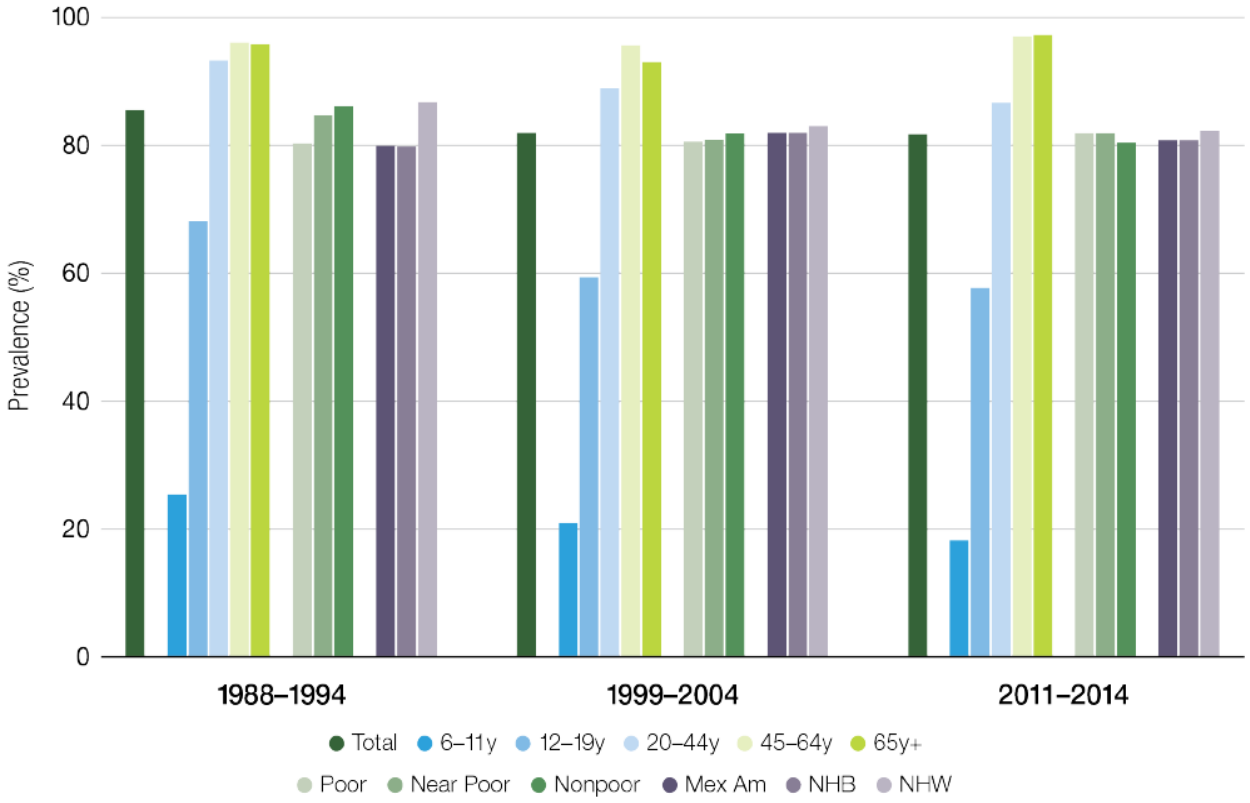
Oral Health in America

Figure 10. Percentage of individuals ages 6 and older with dental caries in permanent teeth by age group, poverty status, and race/ethnicity: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of dental caries (DMFT > 0). NHW = non-Hispanic White, NHB = non-Hispanic Black, Mex Am = Mexican American. FPG = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey, public use data, 1988–1994,1999–2004, 2011–2014.

Across the Lifespan – dental caries prevalence is declining among children/adolescents but remains unchanged for adults

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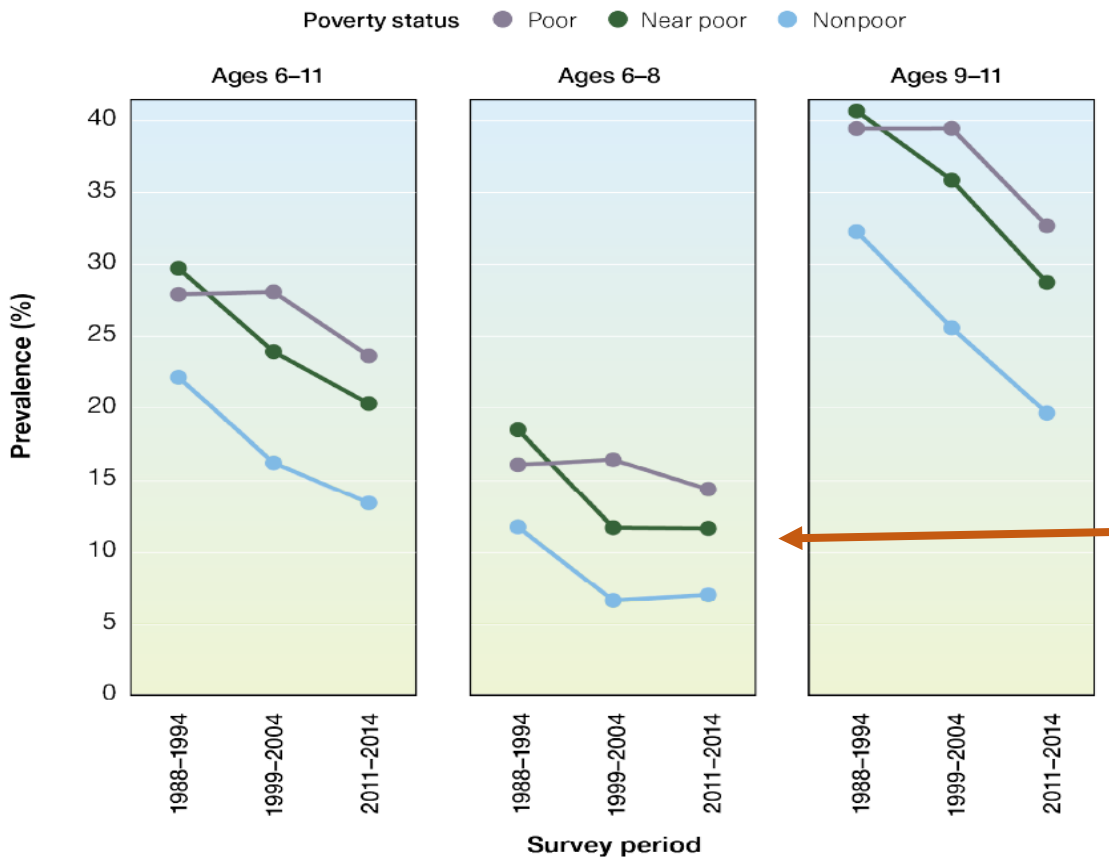
Oral Health in America

Figure 17. Percentage of children ages 6–11 with dental caries in permanent teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of dental caries in permanent teeth (DMFT > 0). **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

The decline in dental caries prevalence for children has benefited everyone regardless of poverty status – But concern is for those 6-8 where it appears a leveling off is occurring

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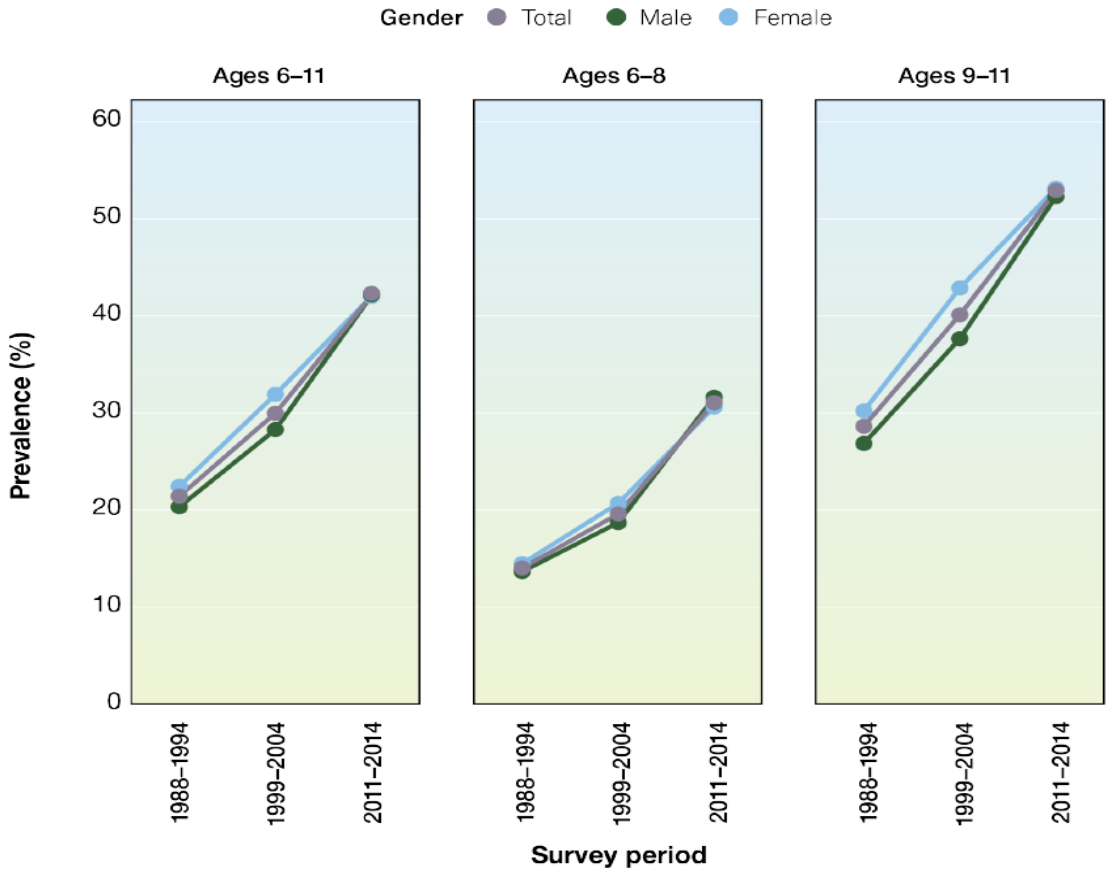
Oral Health in America

Figure 30. Percentage of children ages 6–11 with dental sealants on permanent teeth by age group and gender: United States, 1988–1994, 1999–2004, 2011–2014



Note: Prevalence of dental sealants is having at least one permanent molar tooth sealed.
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994, 1999–2004, and 2011–2014.

There has been a substantial increase in the prevalence of dental sealants for children has benefited everyone regardless of poverty status – But juxtaposed to a less than dramatic decrease in caries prevalence

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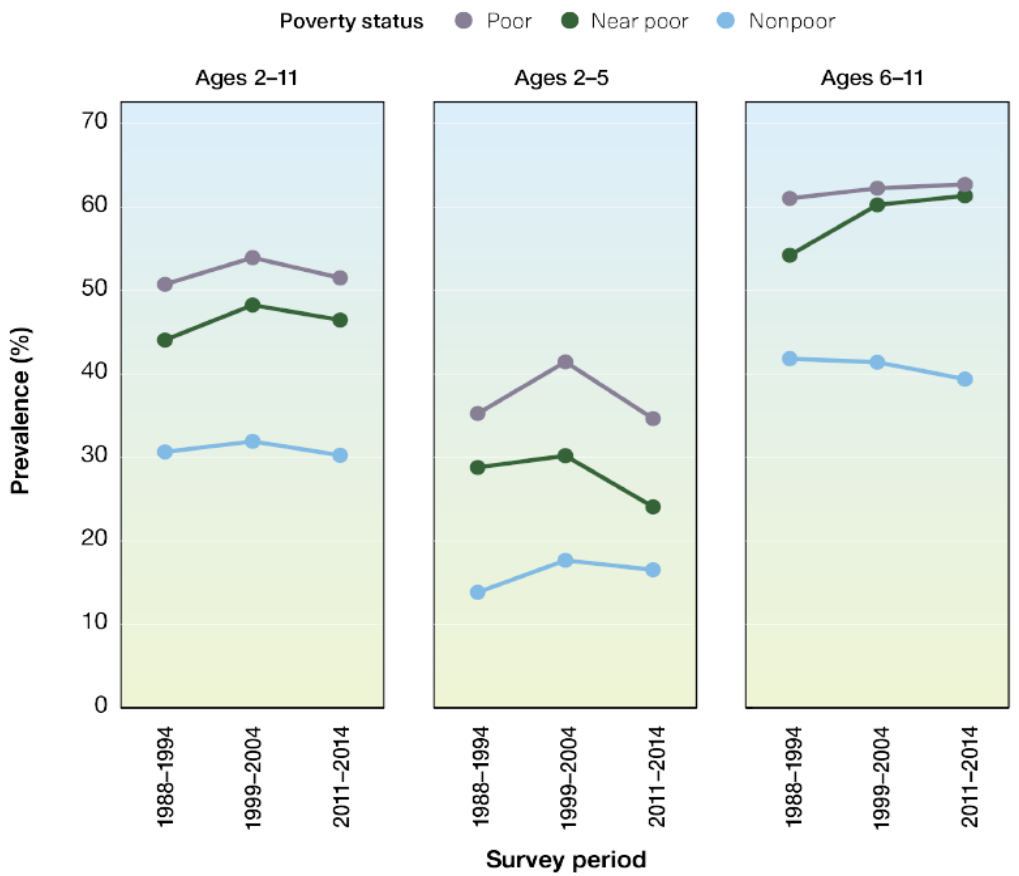
Oral Health in America

Figure 12. Percentage of children ages 2–11 with dental caries in primary teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of dental caries in primary teeth (dft > 0). **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

There has been no decline in dental caries prevalence for preschool-aged children – Unlike what has been seen for school-aged children

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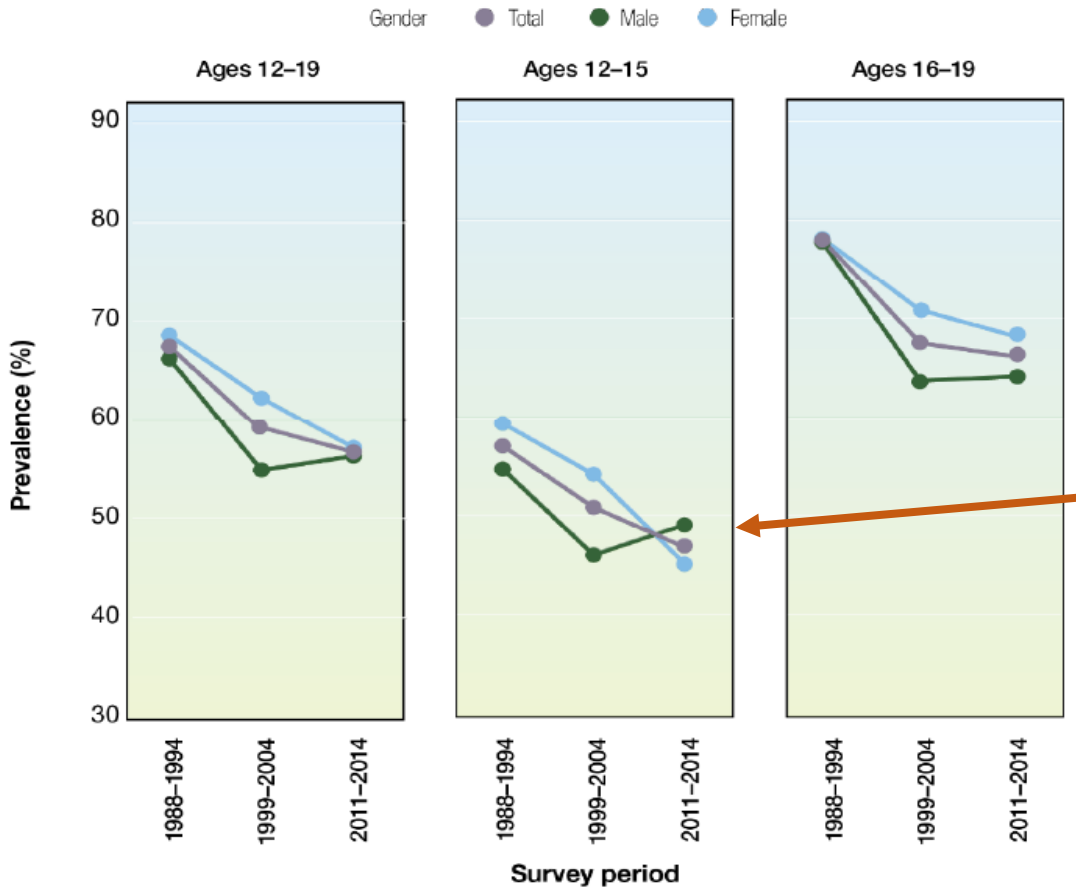
Oral Health in America

Figure 6. Percentage of adolescents ages 12–19 with dental caries in permanent teeth by age group and gender: United States, 1988–1994, 1999–2004, 2011–2014



Note: Prevalence of dental caries in permanent teeth (DMFT > 0).
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

The decline in dental caries prevalence for adolescents is not straightforward – something is happening that is negatively affecting boys

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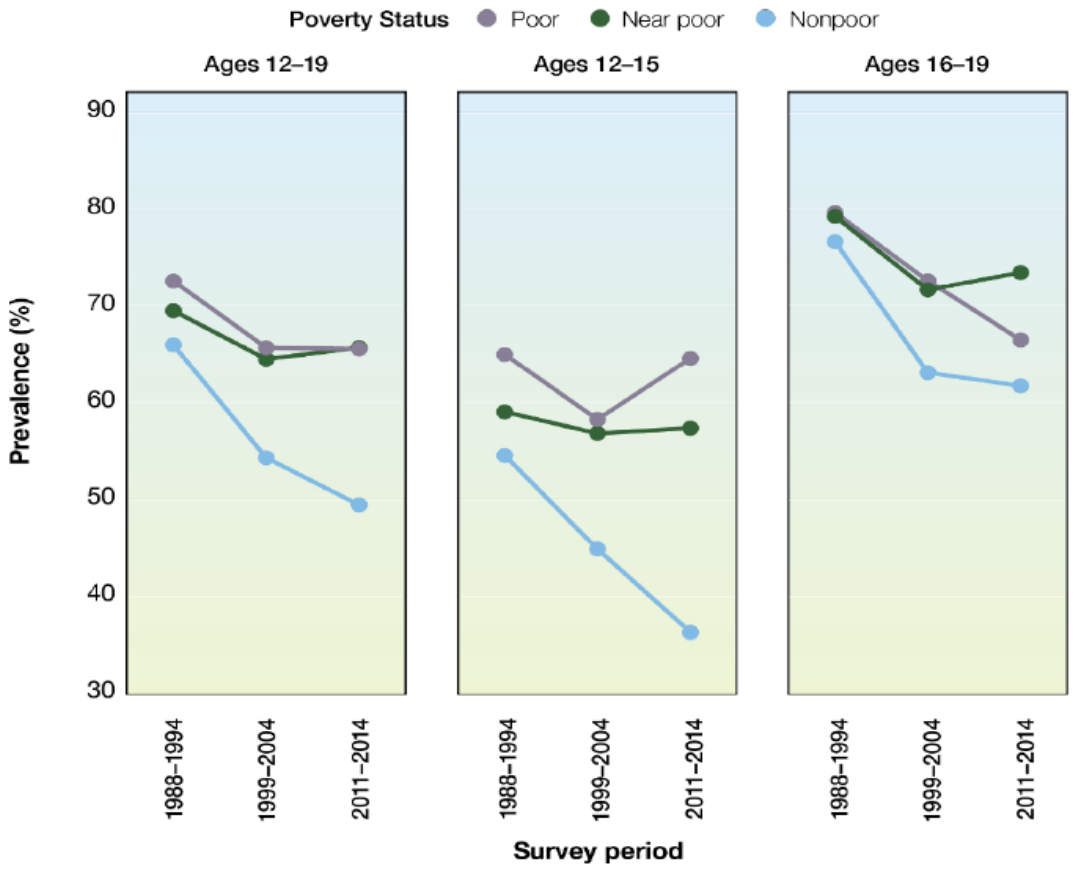
Figure 8. Percentage of adolescents ages 12–19 with dental caries in permanent teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of untreated dental caries in permanent teeth (DMFT > 0). **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

The most important driver of the decline in dental caries prevalence in adolescents is for those who live in non-poor households – More importantly disparities are increasing

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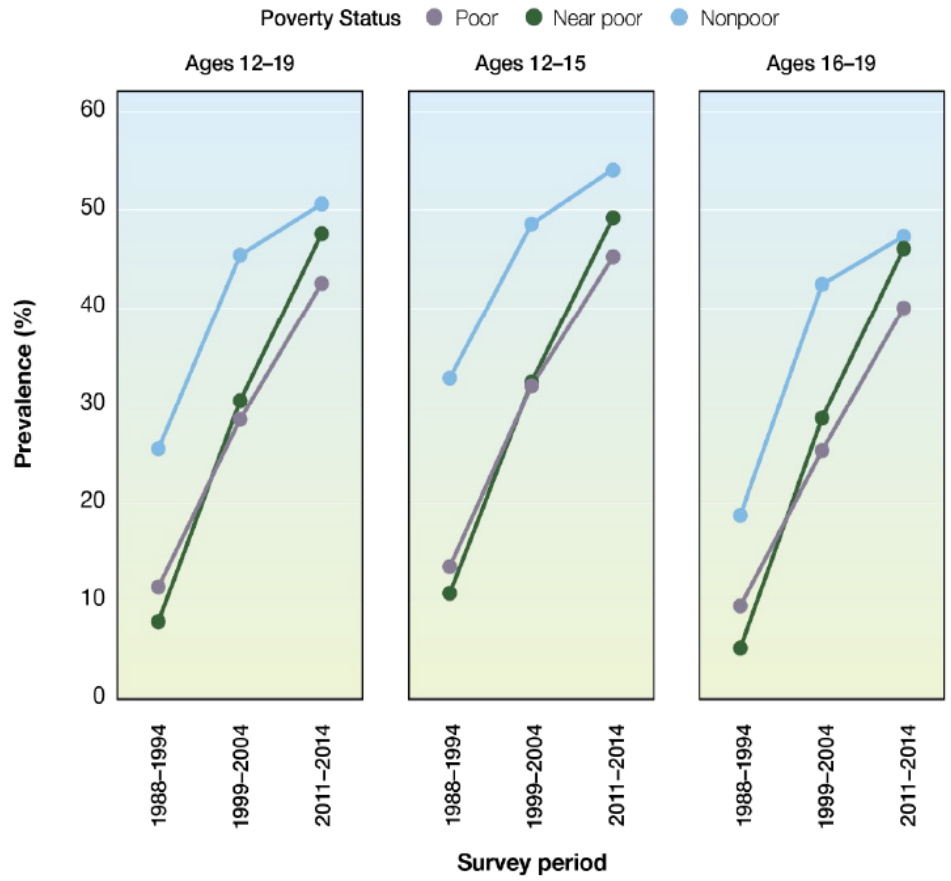
Figure 17. Percentage of adolescents ages 12–19 with dental sealants on permanent teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of dental sealants is having at least one permanent molar tooth sealed. **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

For dental sealant prevalence the picture is very similar – if not better – for adolescents compared to children – a dramatic increased affecting all adolescents regardless of poverty that has reduced sealant disparity.
Yet, the substantial increase in sealants is juxtaposed a significant increase in caries prevalence disparities by poverty status

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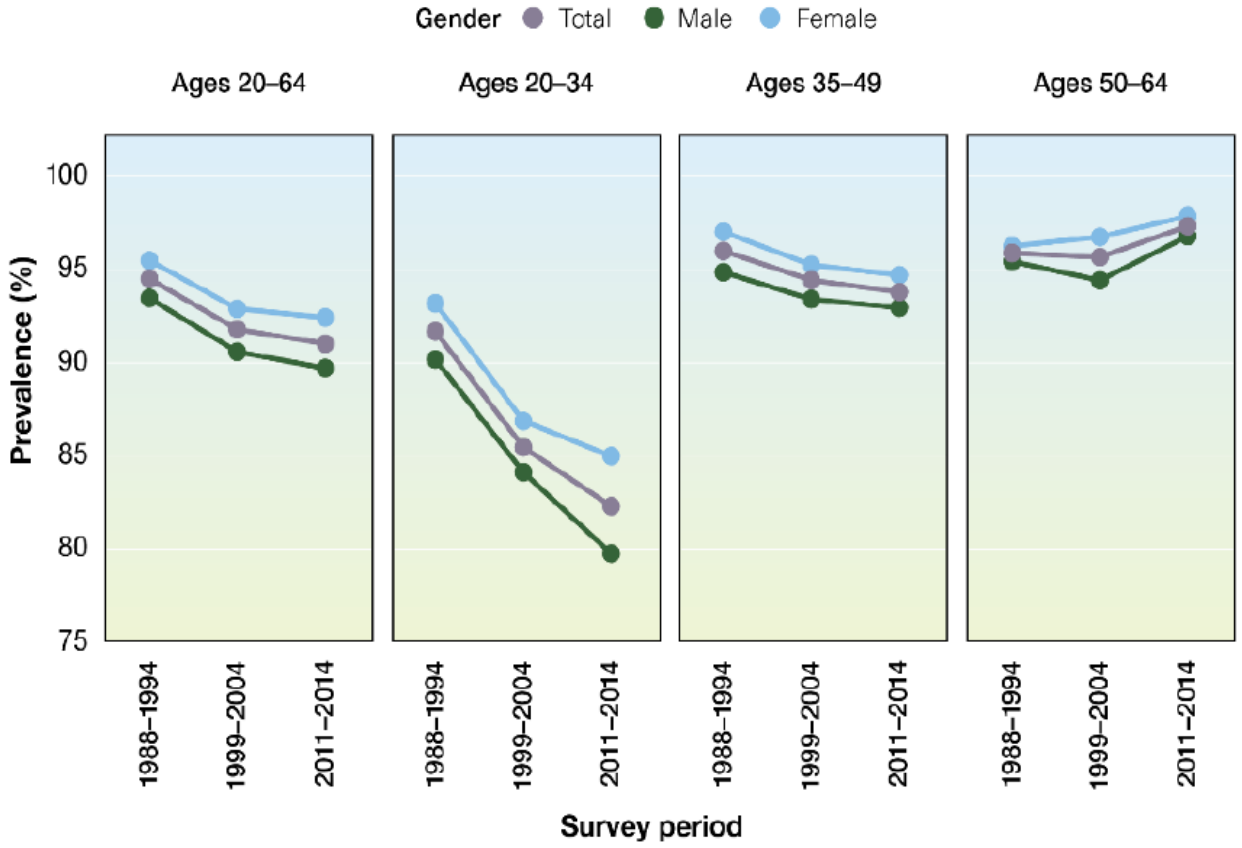
Figure 13. Percentage of adults ages 20–64 with dental caries in permanent teeth by age group and gender: United States, 1988–1994, 1999–2004, 2011–2014



Note: Prevalence of dental caries in permanent teeth (DMFT > 0).
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Point of hope – youngest cohort of adults are experiencing lower prevalence of dental caries

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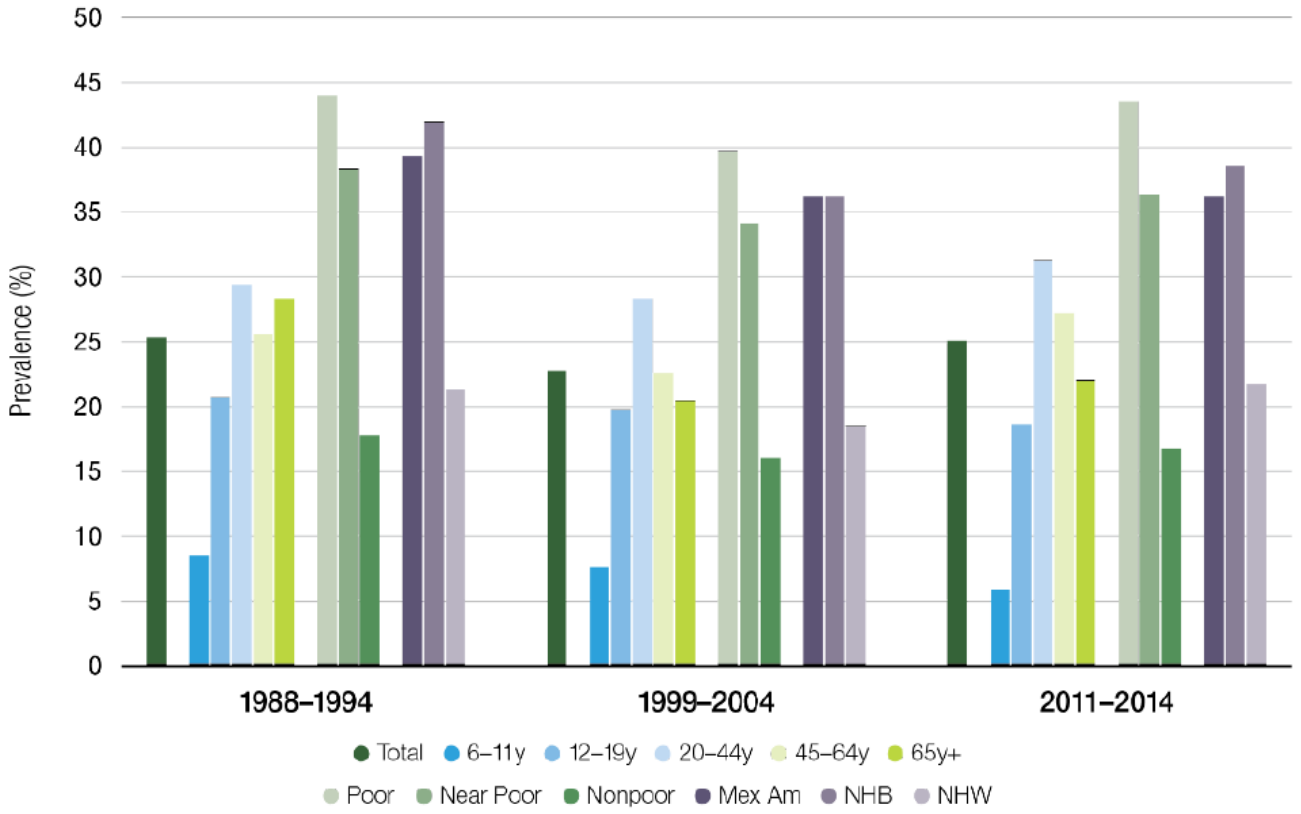
Figure 11. Percentage of individuals ages 6 and older with untreated dental caries in permanent teeth by age group, poverty status, and race/ethnicity: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of untreated dental caries (DT > 0). NHW = non-Hispanic White, NHB = non-Hispanic Black, Mex Am = Mexican American. FPG = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey, public use data, 1988-1994,1999-2004, 2011-2014.

Across the Lifespan – untreated dental caries remains essentially unchanged except for youth where we see some downward movement. It's important to remember that untreated dental caries is a marker of access to care

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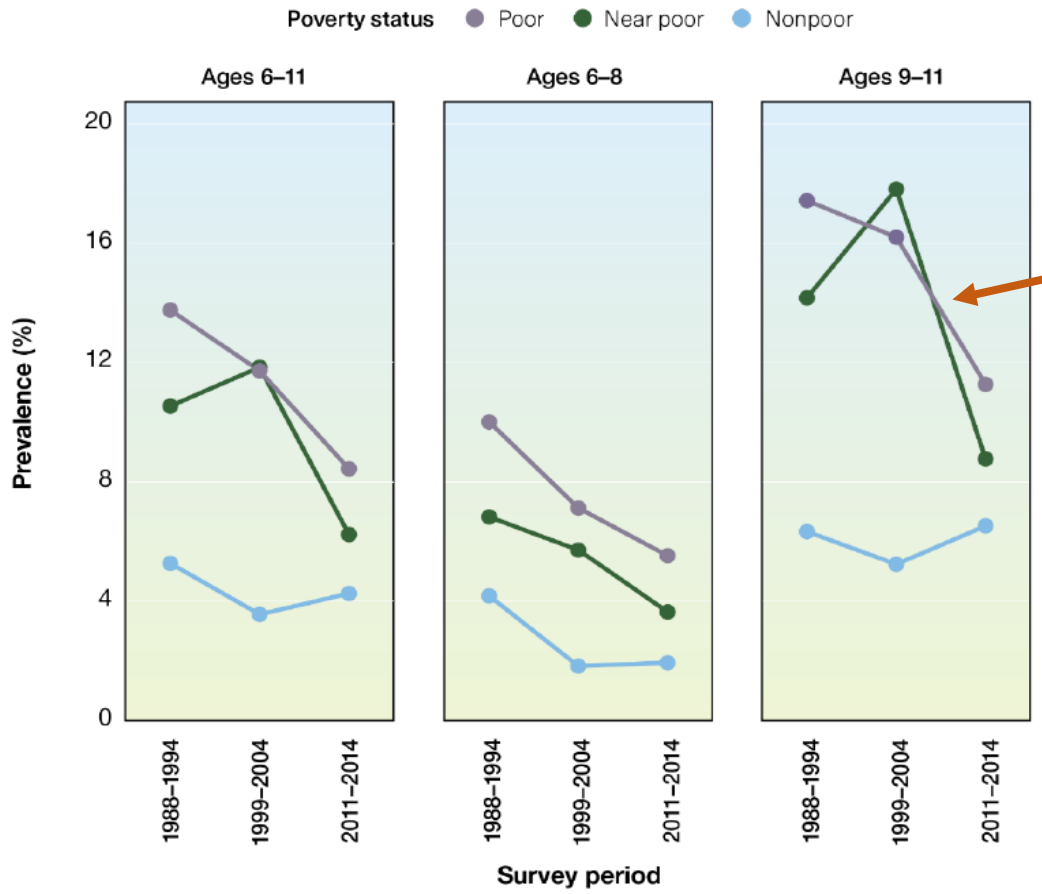
Figure 20. Percentage of children ages 6–11 with untreated dental caries in permanent teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of untreated dental caries in permanent teeth (DT > 0). **FPG** = Federal Poverty Guideline; < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Children living in lower income households are seeing a decline in untreated caries prevalence and this decrease has yielded reduction in disparities. Better access to care?

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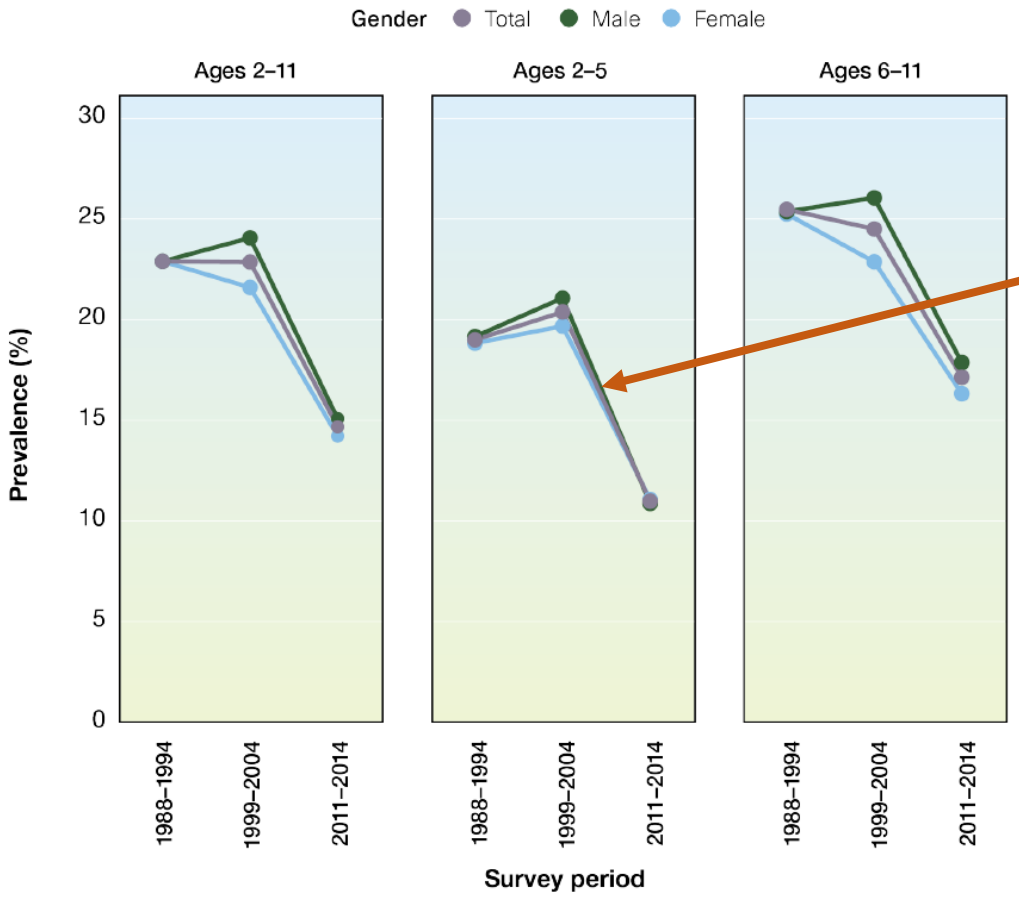
Figure 13. Percentage of children ages 2–11 with untreated dental caries in primary teeth by age group and gender: United States, 1988–1994, 1999–2004, 2011–2014



Note: Prevalence of dental caries in primary teeth (dt > 0).
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Reduction in untreated caries in preschool children represents one of the most important achievements in oral health in the last 20 years

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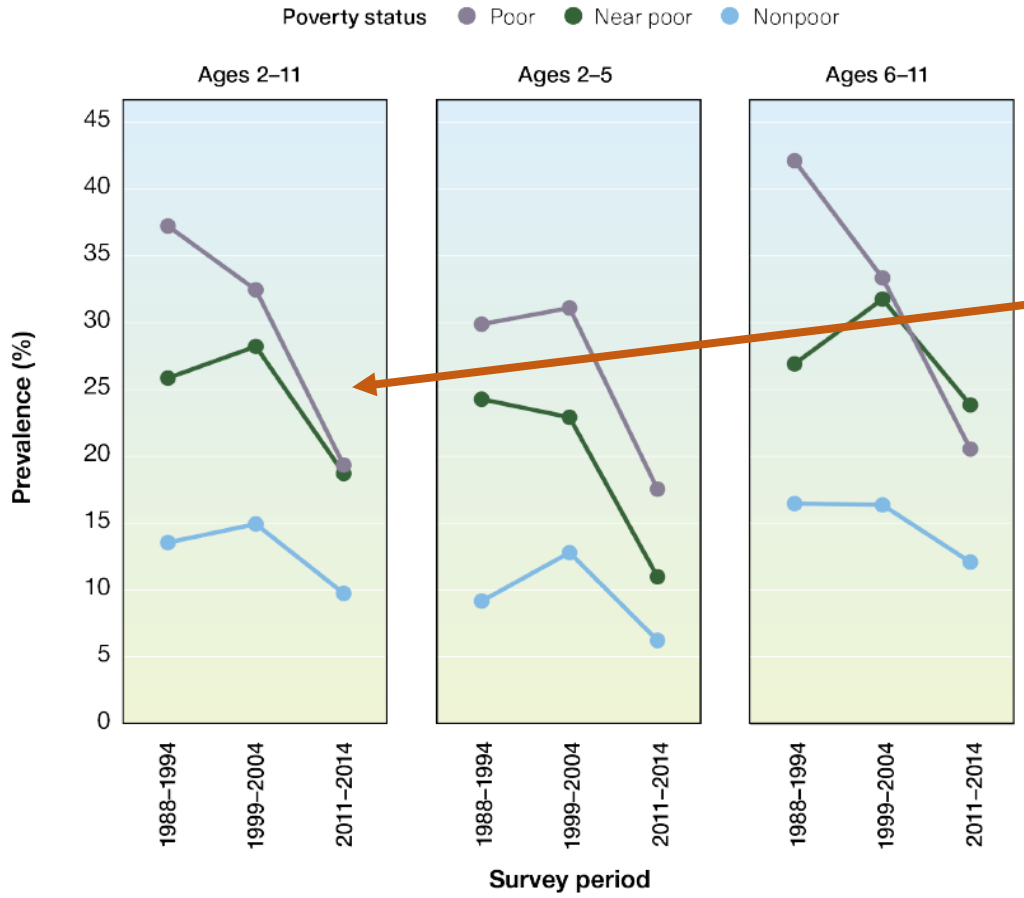
Figure 14. Percentage of children ages 2–11 with untreated dental caries in primary teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of dental caries in primary teeth (dt > 0). **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Reduction in untreated caries has significantly benefited lower income children - Better access to care resulting in reduction of disparities

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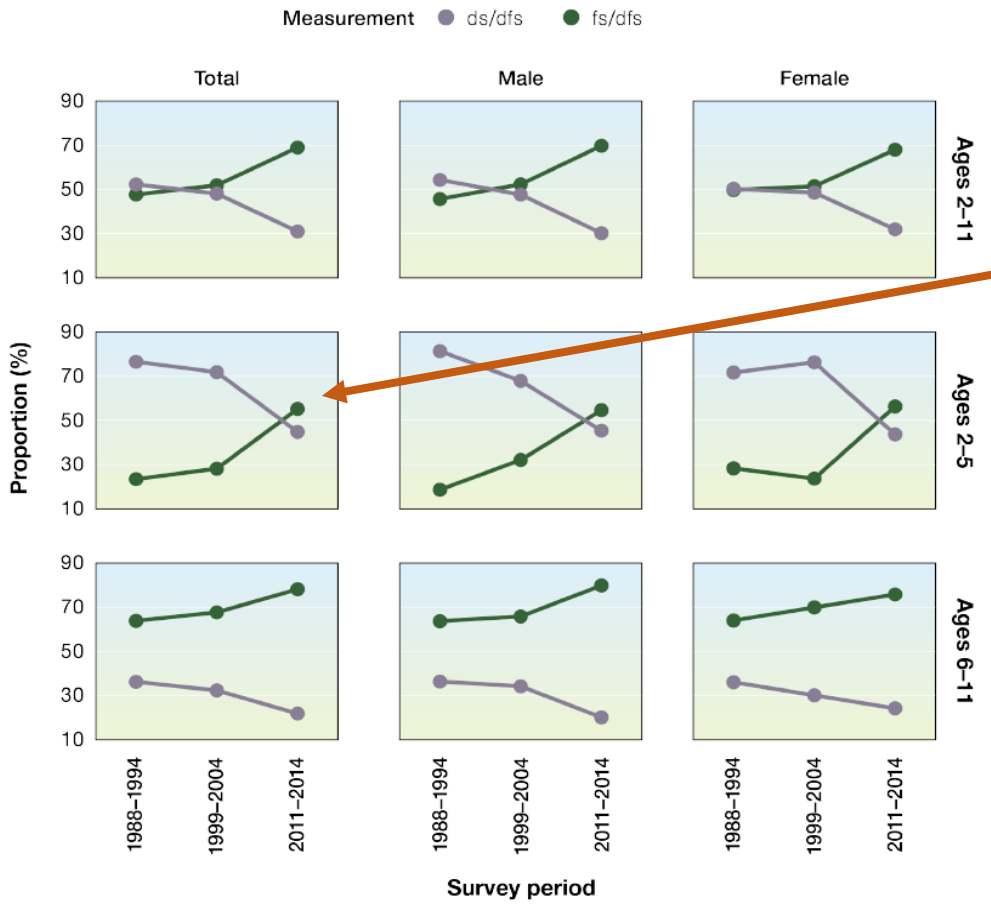
Figure 25. Contribution of decayed (ds) or filled surfaces (fs) to the number of decayed and filled surfaces (dfs) of primary teeth in children ages 2–11 by gender and age group: United States, 1988–1994, 1999–2004, 2011–2014



Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994, 1999–2004, and 2011–2014.

Better access to care resulting in more treatment

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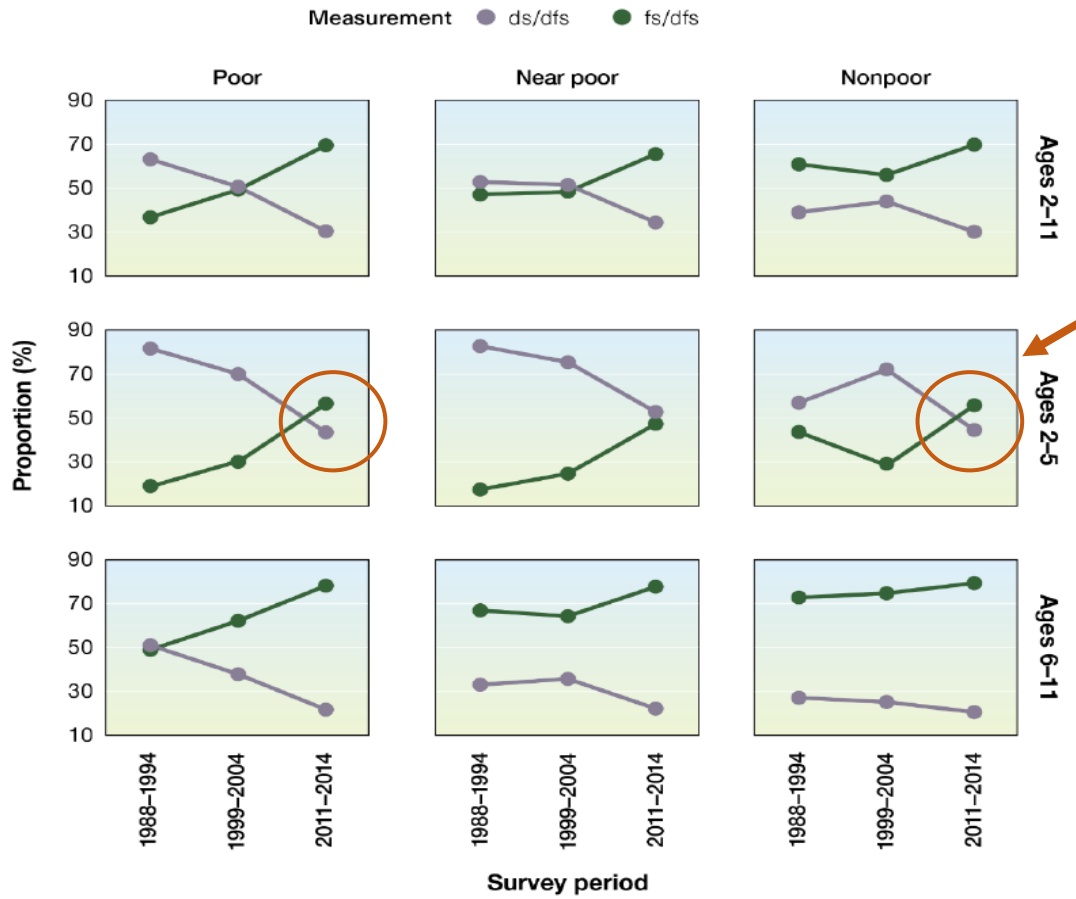
Figure 26. Contribution of decayed (ds) or filled surfaces (fs) to the number of decayed and filled surfaces (dfs) of primary teeth in children ages 2–11 by poverty status and age group: United States, 1988–1994, 1999–2004, 2011–2014



Note: FPG = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994, 1999–2004, and 2011–2014.

Better access to care resulting in <u>more treatment</u> and the <u>elimination of health disparities</u>

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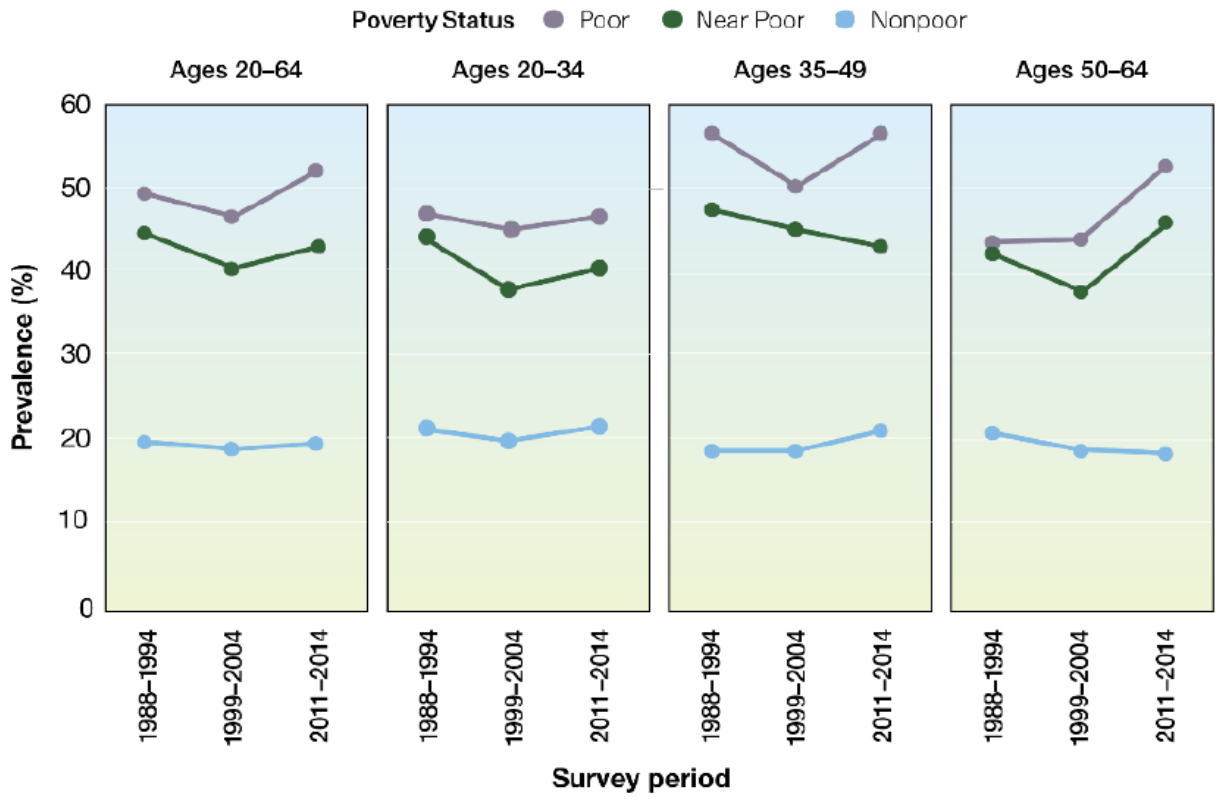
Figure 18. Percentage of adults ages 20–64 with untreated dental caries in permanent teeth by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Prevalence of untreated dental caries in permanent teeth (DT > 0); Federal Poverty Guideline (FPG): < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994, 1999–2004, and 2011–2014.

The pattern in untreated caries in working-age adults has remained consistent – indicating no significant intervening forces that have affected access to dental care. This is setting the stage for compounding problems as we age into and past retirement age.

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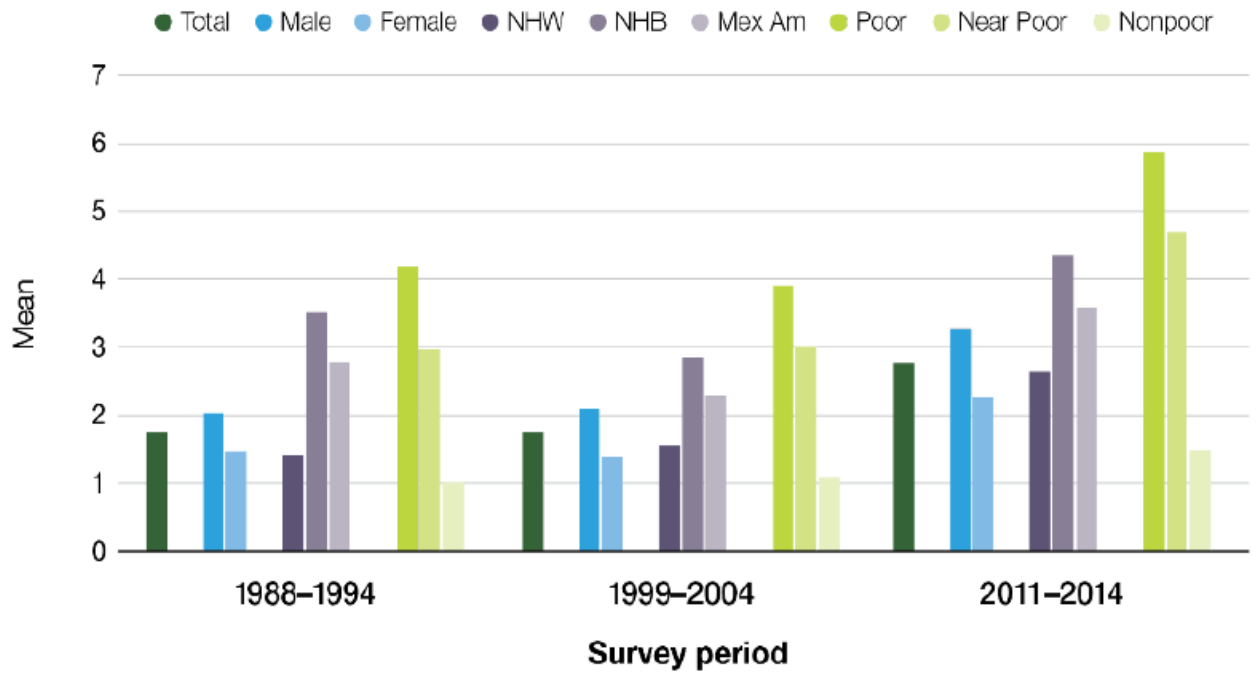
Figure 19. Mean number of dental surfaces affected by untreated dental caries in permanent teeth among adults ages 20–64 by gender, race/ethnicity, and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Federal Poverty Guideline (FPG): < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor. NHW = non-Hispanic White, NHB = non-Hispanic Black, Mex Am = Mexican American.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994, 1999–2004, and 2011–2014.

Bad news: although prevalence generally remains unchanged the mean DS is increasing – deferred care?

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Tooth loss

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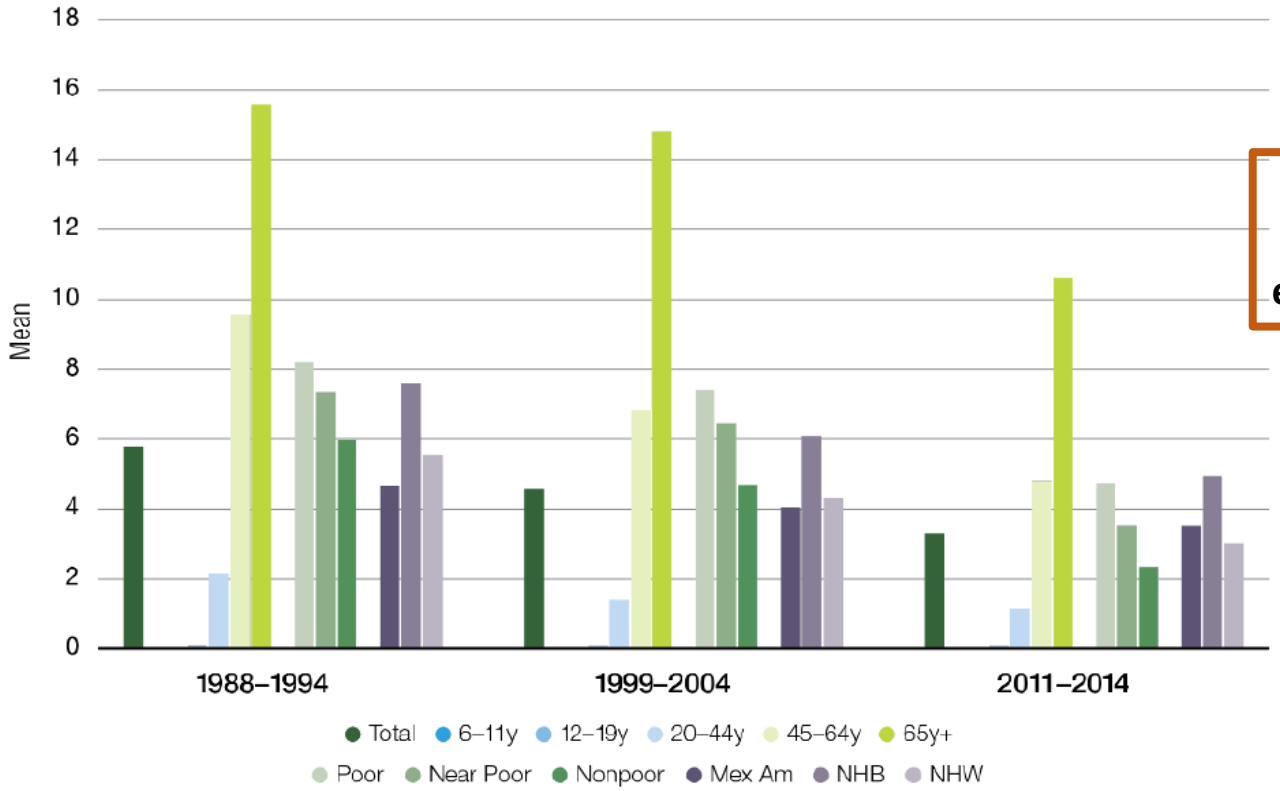
Figure 12. Mean number of missing permanent teeth due to dental disease among individuals ages 6 and older by age group, poverty status, and race/ethnicity: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Mex Am = Mexican American, NHB = Non-Hispanic Black, NHW = Non-Hispanic White; per the Federal Poverty Guidelines (FPG), Poor = income <100% FPG, Near-poor = income 100–199% FPG, and Nonpoor = income ≥200% FPG.

Source: CDC. National Health and Nutrition Examination Survey, public use data, 1988–1994,1999–2004, 2011–2014.

Good news – bad news: mean number of missing teeth continues to decline for everyone but there's little change in disparities

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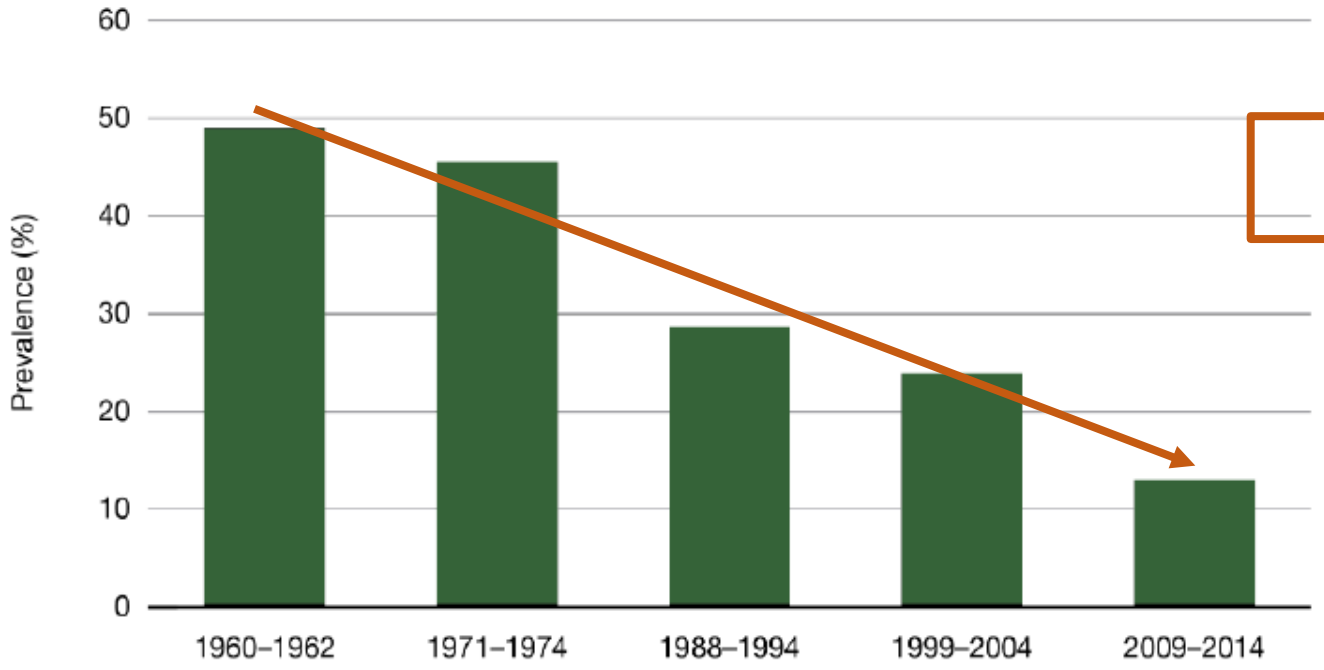
Figure 5. Trend in edentulism among adults ages 65–74: United States, 1960–1962 to 2009–2014



Note: Edentulism is complete loss of all natural permanent teeth.
Source: Adapted from Dye et al. (2019).

Another very <u>important achievement</u> – continuing decline in edentulism

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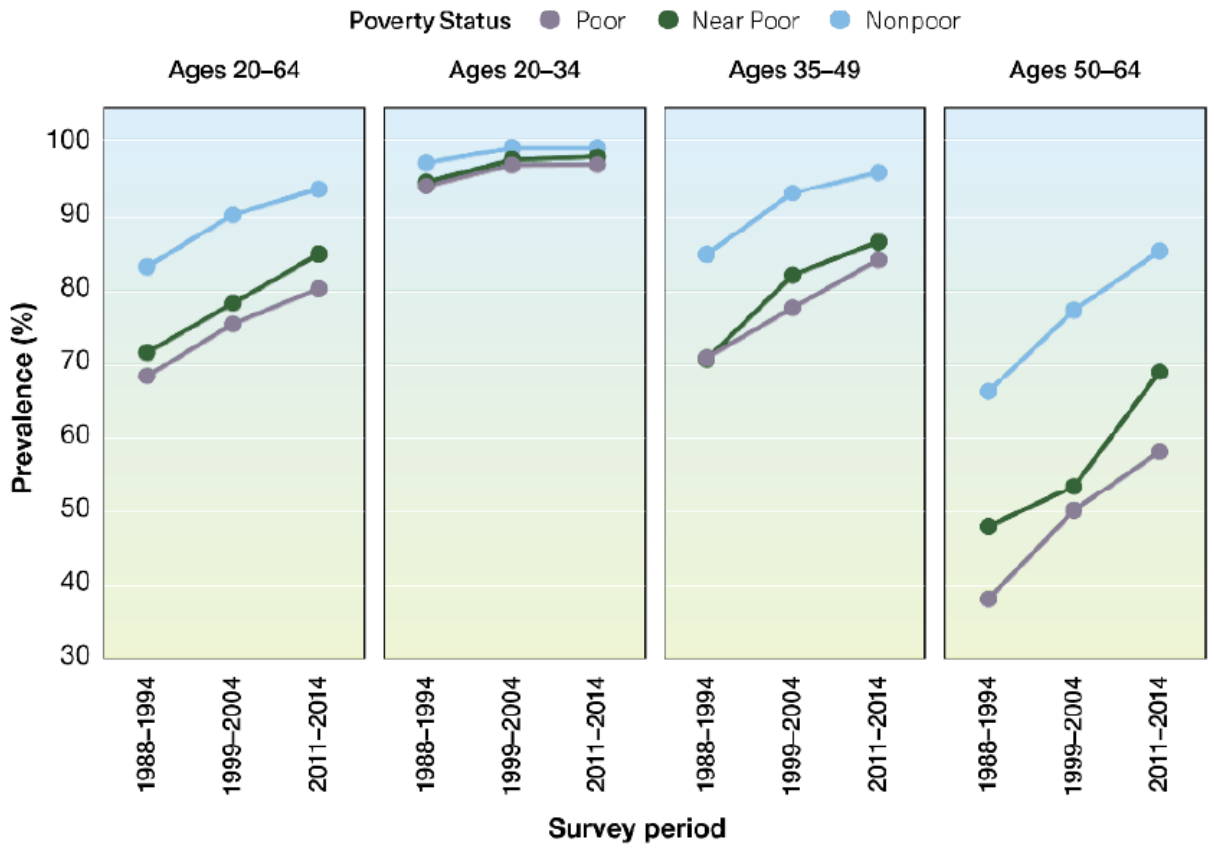
Figure 23. Percentage of adults ages 20–64 with a functional dentition by age group and poverty status: United States, 1988–1994, 1999–2004, 2011–2014



Notes: Functional dentition is having 21 or more permanent teeth remaining, excluding third molars (wisdom teeth); Federal Poverty Guideline (FPG): < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Also important – Functional dentition is increasing for working-age adults; however, there's been no change in disparities

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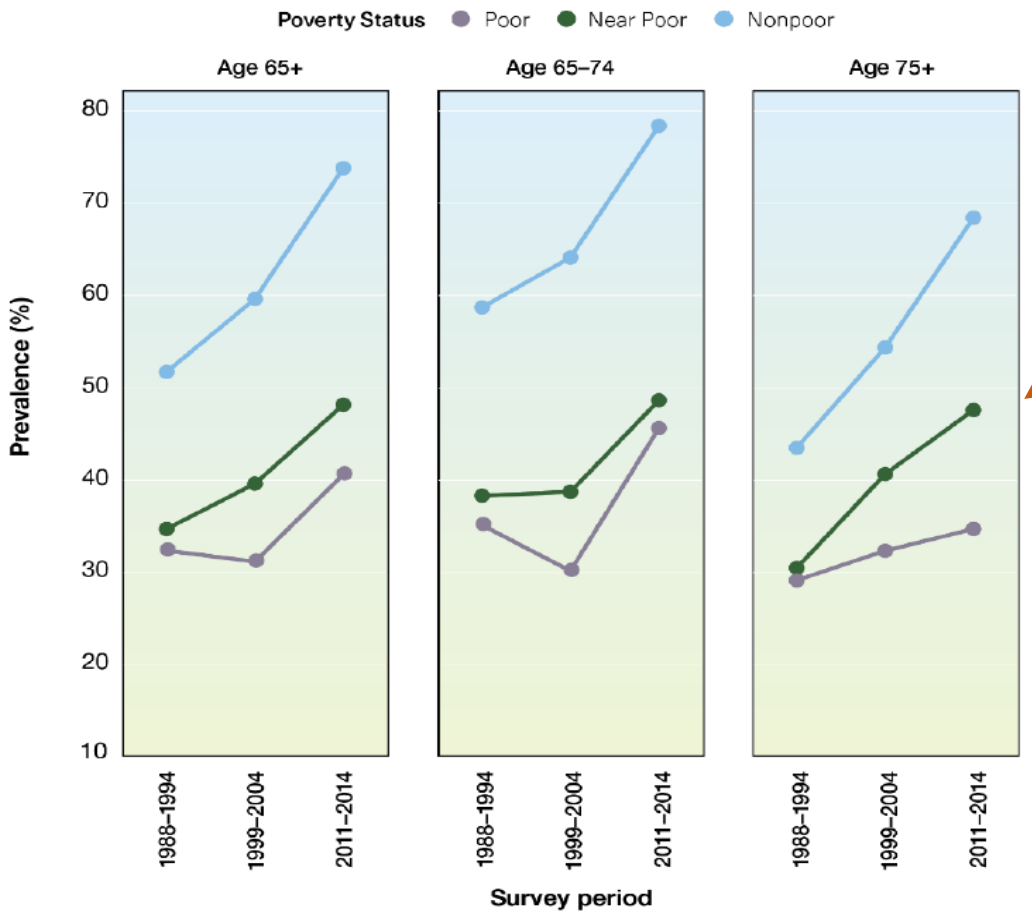

Notes: Functional dentition is having 21 or more permanent teeth remaining, excluding third molars (wisdom teeth). FPG = Federal Poverty Guideline; < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.
Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Very important – Functional dentition is increasing for older adults too – but disparities are also increasing especially by poverty status.

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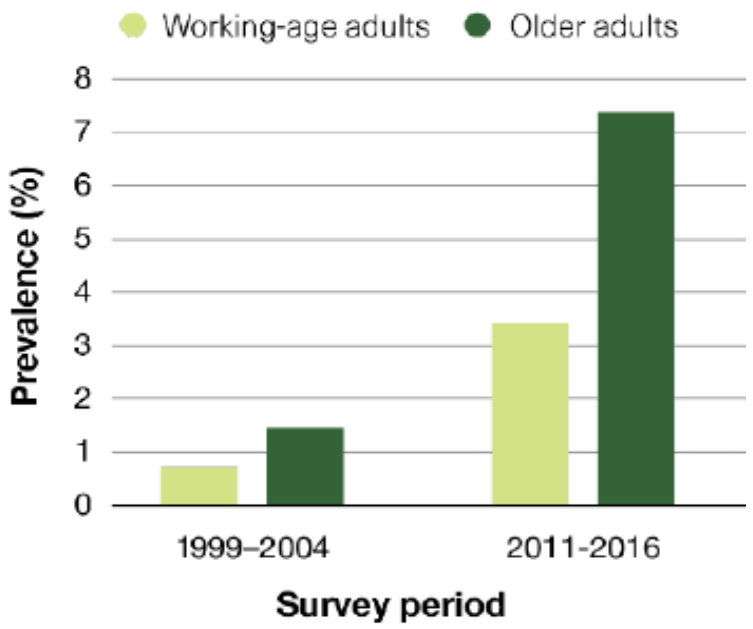
Figure 23. Percentage of adults age 20 and older with at least one dental implant: United States, 1999–2004 and 2011–2016.



Note: Working-age adults are ages 20–64 years; older adults are age 65 and older.

Source: CDC. National Health and Nutrition Examination Survey. Public use data, 1988–1994,1999–2004, and 2011–2014.

Implant demand is increasing especially among older adults

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Access to care

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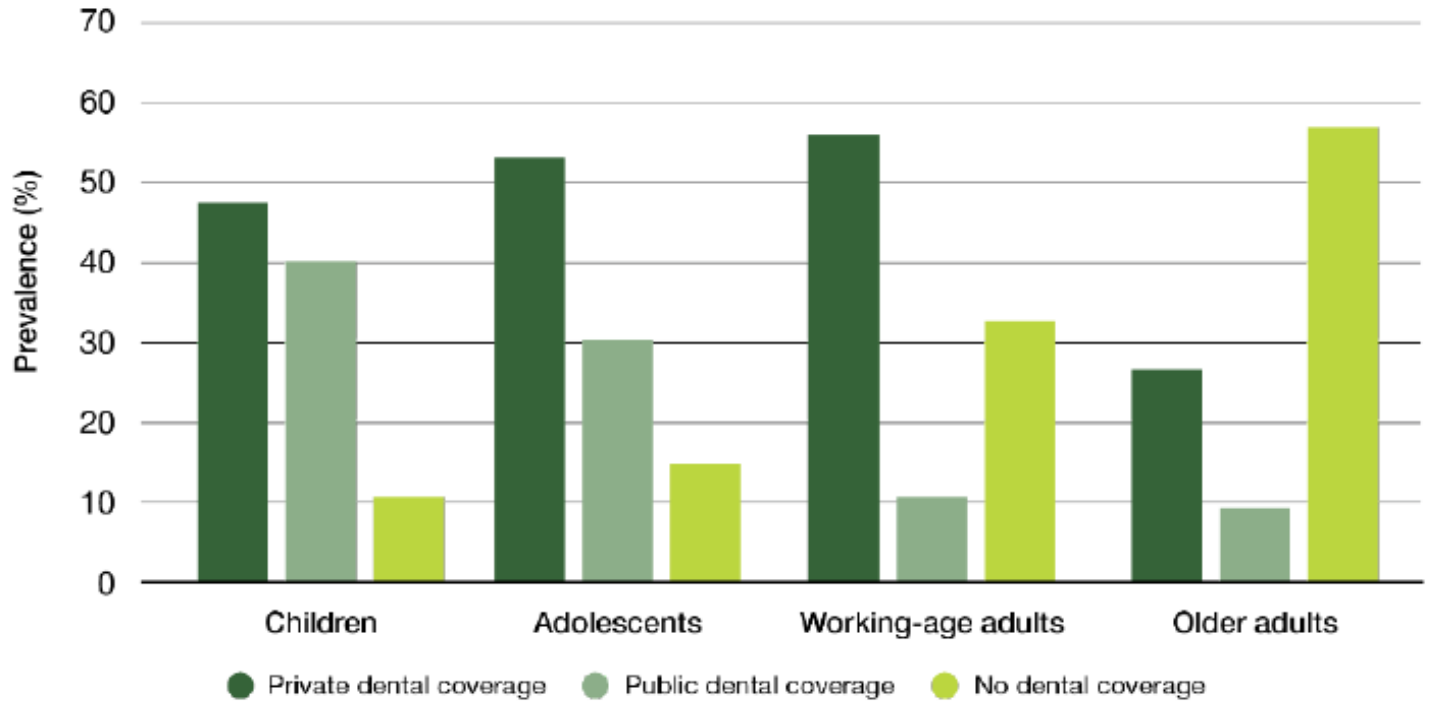
Figure 2. Percentage of individuals ages 2 and older by age group and dental insurance status: United States, 2011–2014



Notes: Children (ages 2–11), Adolescents (ages 12–19), Working-age adults (ages 20–64), Older adults (65 and older).
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Public use data, 2011–2014.

Lack of dental insurance coverage increases as we age

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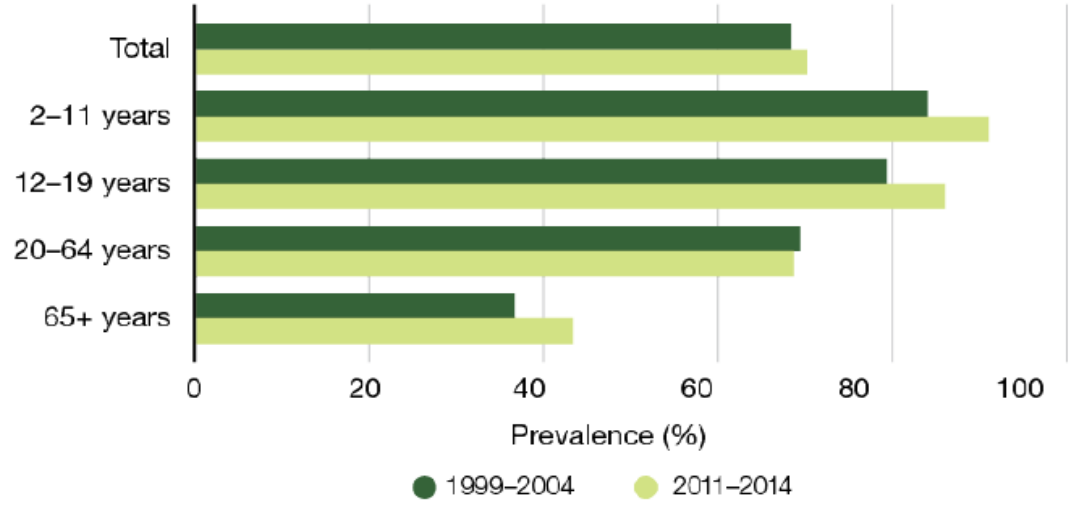
Figure 36. Percentage of the population with any dental insurance coverage by age group: United States, 1999–2004 and 2011–2014



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Research and Quality, public use data, 1999–2004 and 2011–2014.

We're approaching universal dental coverage for youth, but more than half of seniors continue to have no dental insurance coverage.

The increase in coverage for youth is most likely attributed to increase in public insurance coverage, whereas increase in coverage for older adults is most likely attributed to purchasing Medicare Advantage Plans

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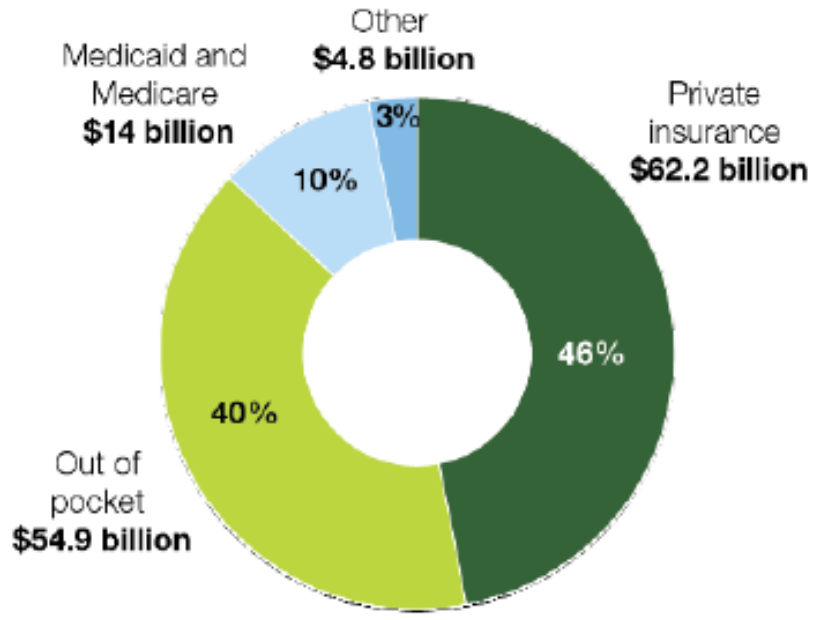
Figure 3. Dental expenditures by source of payment: United States, 2018



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Survey 2018 (2020).

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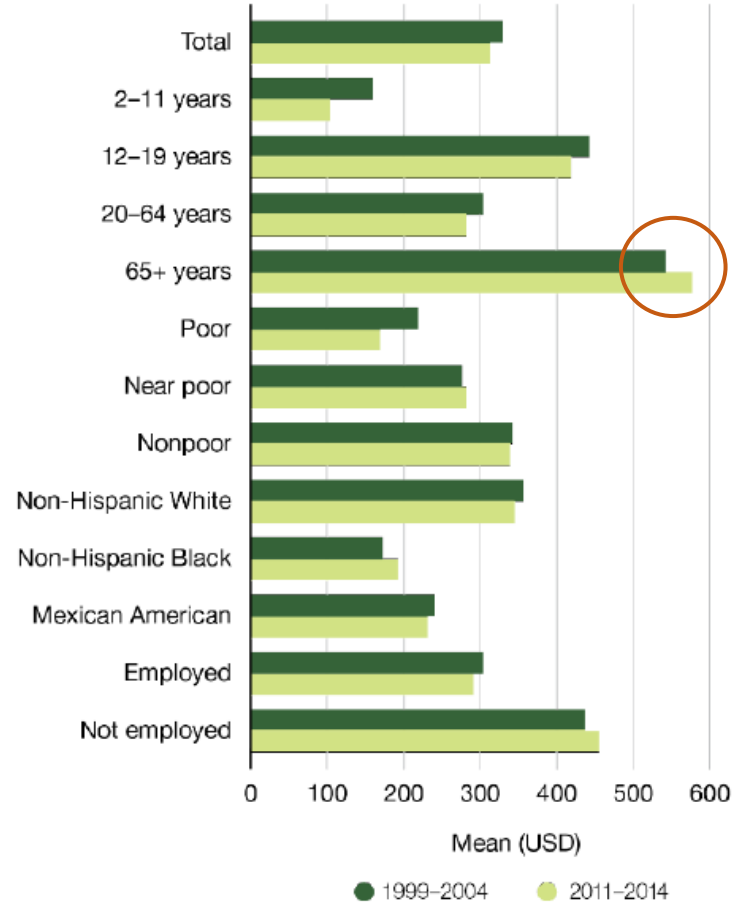
Figure 13. Mean out-of-pocket dental expenditures per person in dollars (adjusted): United States, 1999–2004 and 2011–2014



Notes: Expenses adjusted to 2015 US Dollars (USD). **FPG** = Federal Poverty Guidleline; < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor. Employment calculated for people ages 16 years and older.

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey (MEPS), public use data, 1999–2004 and 2011–2014.

Out of pocket dental expenditures have decreased for youth – yet has increased for older adults

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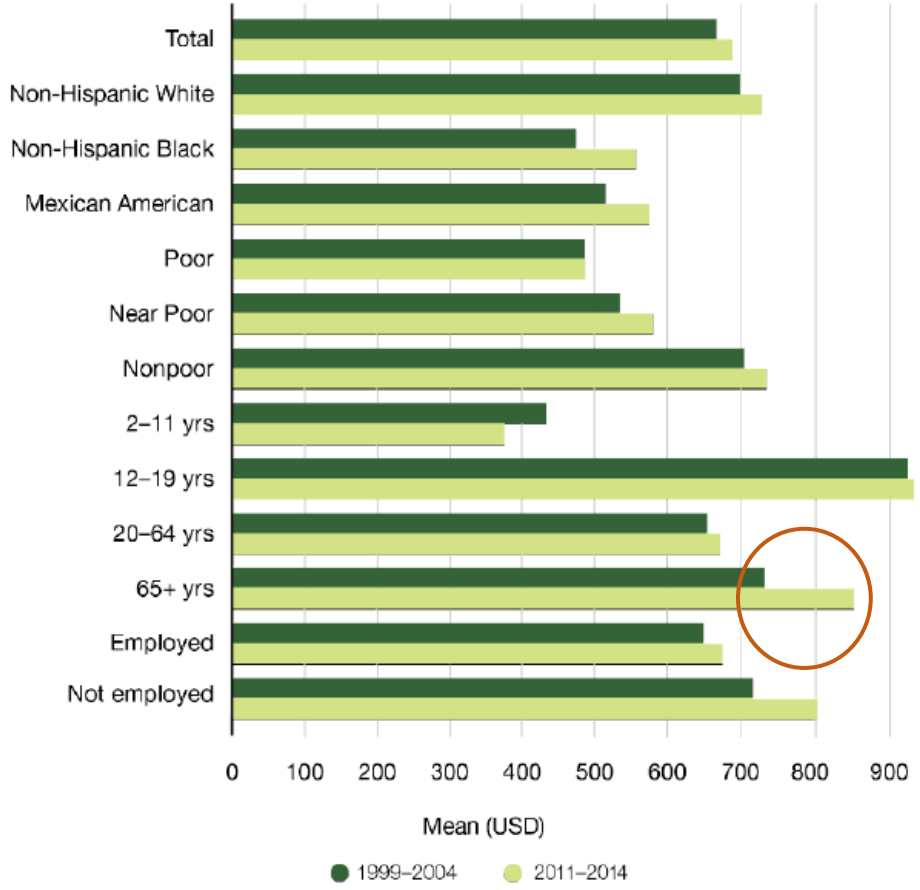
Figure 14. Mean total dental expenditures per person in dollars (adjusted): United States, 1999–2004 and 2011–2014



Notes: Expenses adjusted to 2015 US Dollars (USD). **FPG** = Federal Poverty Guideline: < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor. Employment calculated for people ages 16 years and older.

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey (MEPS), public use data, 1999–2004 and 2011–2014.

The largest increase in TOTAL dental expenditures have been for older adults

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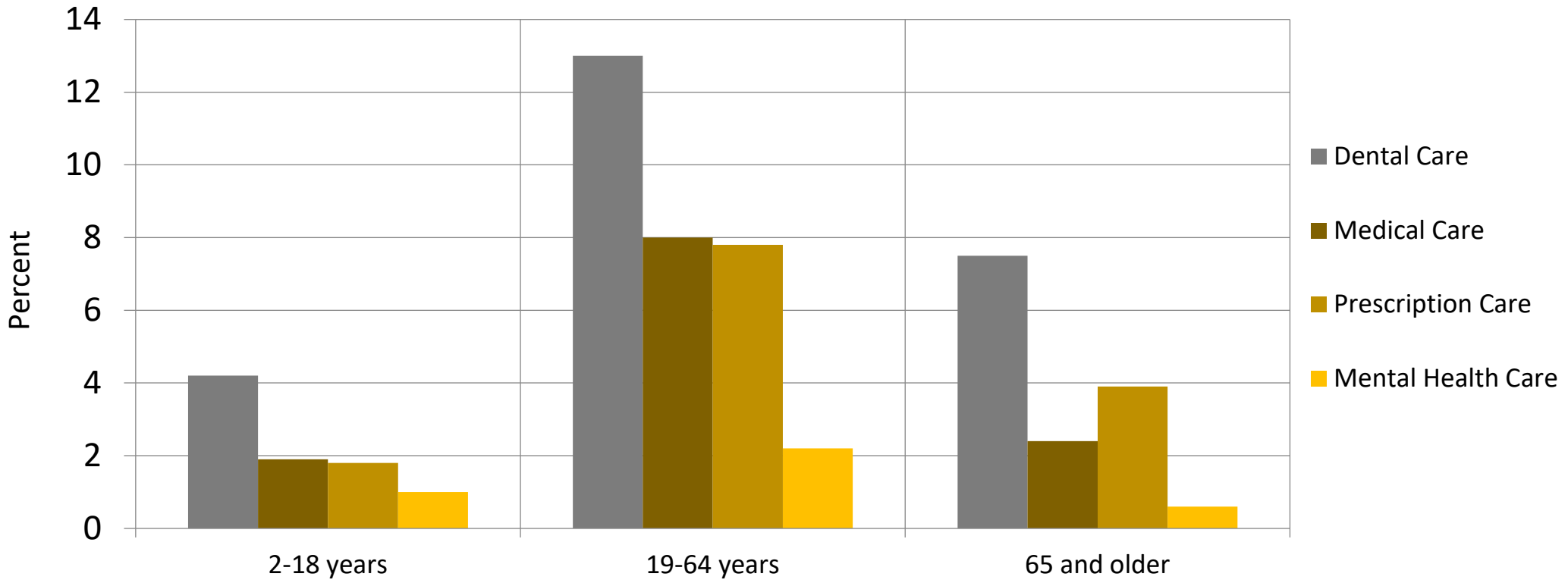
Percent of people who did not get selected health care services they needed in the past 12 months because of cost



Source: M Vujicic. Health Affairs 2016;35(12):2176–2182.

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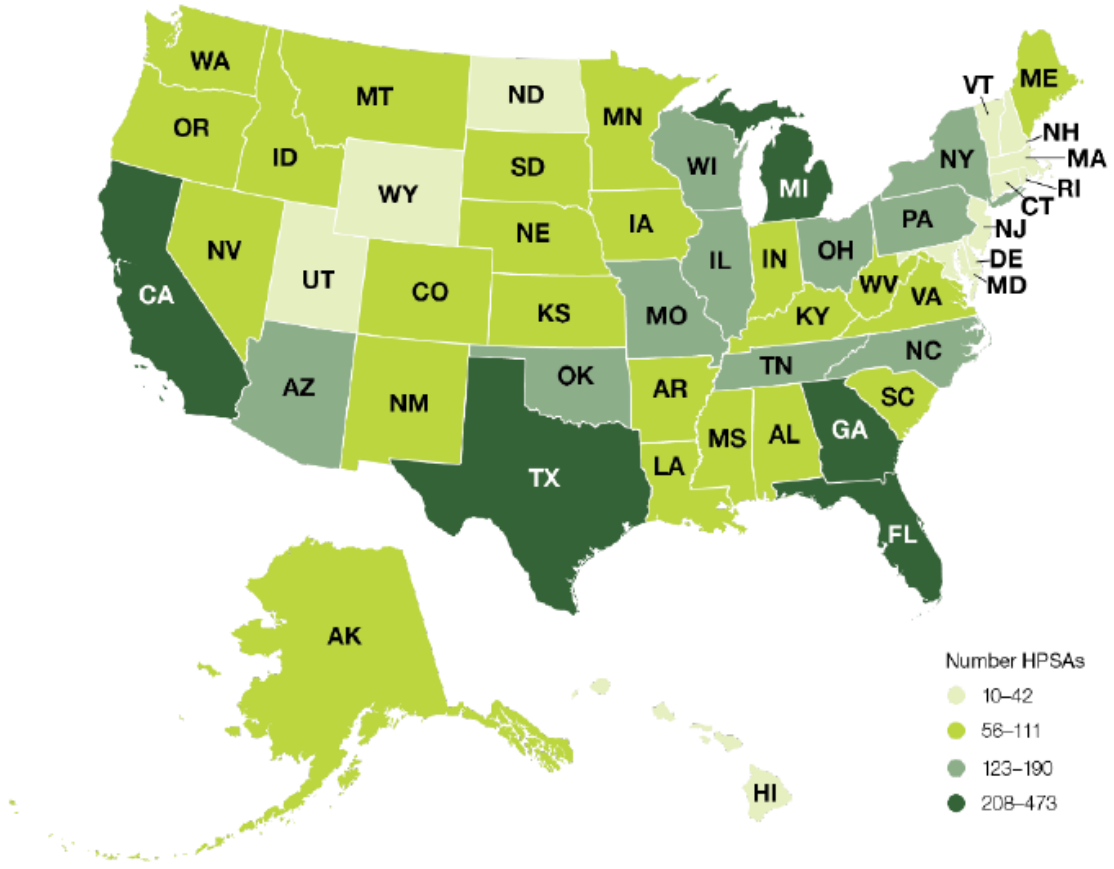
Figure 5. Dental health professional shortage areas (HPSAs): United States, 2018



Note: Number of HPSAs refers to the number of shortage areas within each state.
Source: Health Resources and Services Administration (HRSA), Bureau of Health Workforce (2018).

The number of Dental HPSAs remains high

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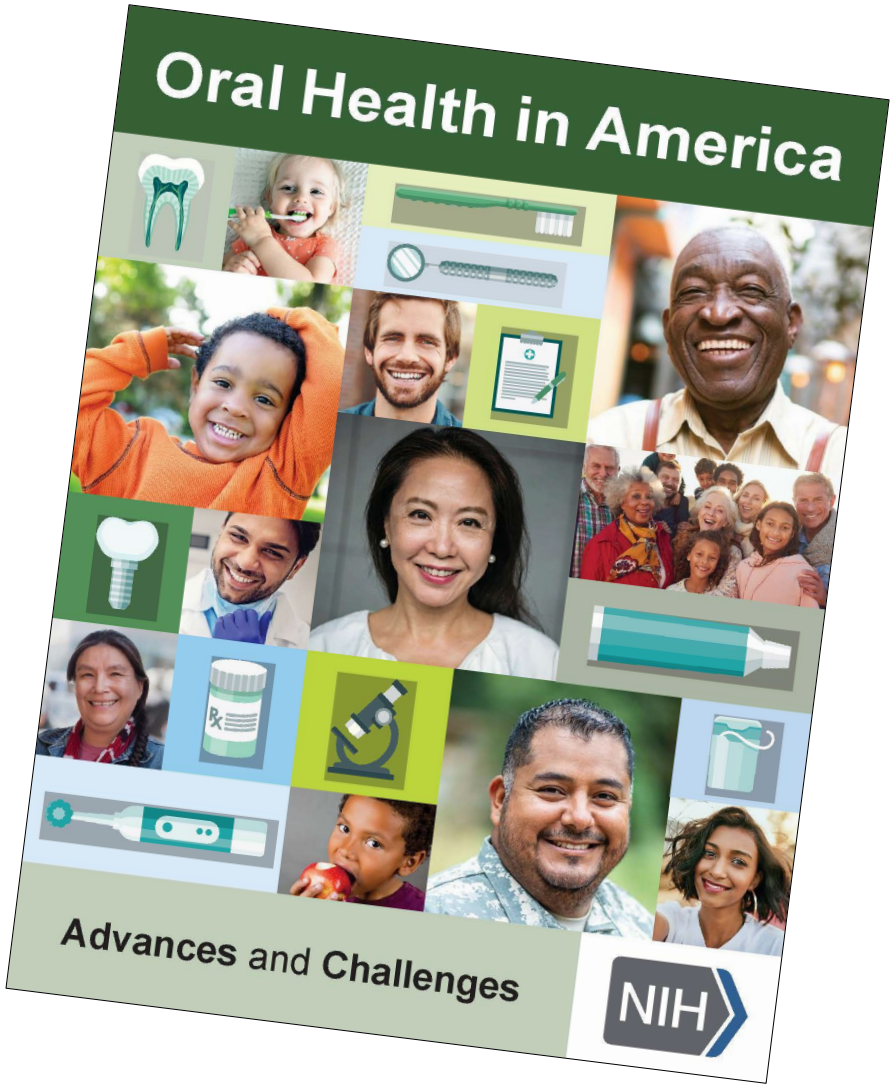
Oral Health in America 2021 – Some Takeaways



1. Preventing dental caries remains an ongoing challenge
2. Substantial progress has been made in reducing untreated dental caries in children, especially primary teeth
3. Untreated caries remains unchanged in adults and very high for those living in or near poverty
4. Edentulism is at historical lows
5. Adults are keeping more teeth but disparities in tooth retention is increasing for older adults

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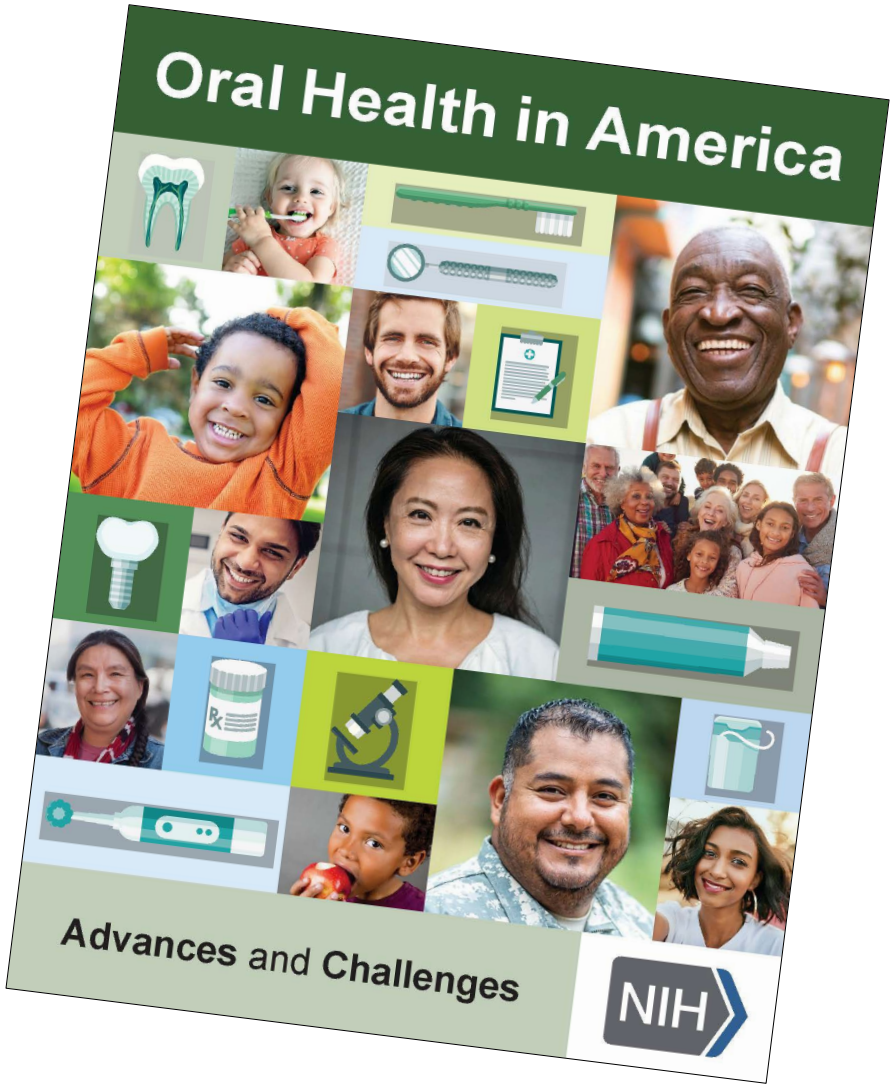
Oral Health in America 2021 – Some Takeaways



6. Dental coverage has expanded for children, more treatment has significantly changed the diseased/filled proportions
7. Out-of-pocket dental expenditures have increased for older adults as have total dental expenditures
8. Deferred dental care is higher than any other health care due to costs – especially among the working-age adults
9. High number of designated dental health professional shortage areas continues to be a challenge

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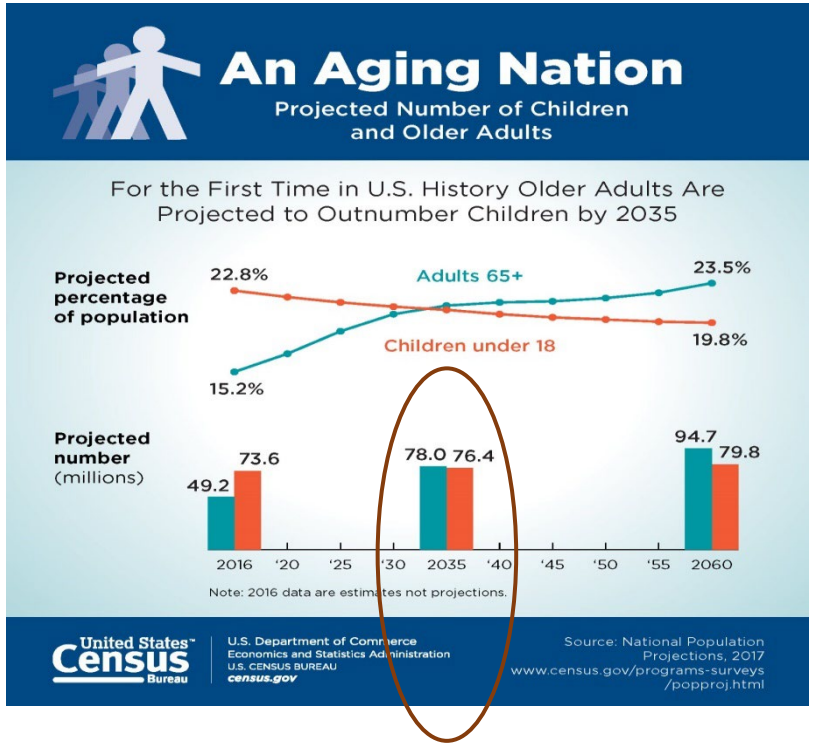
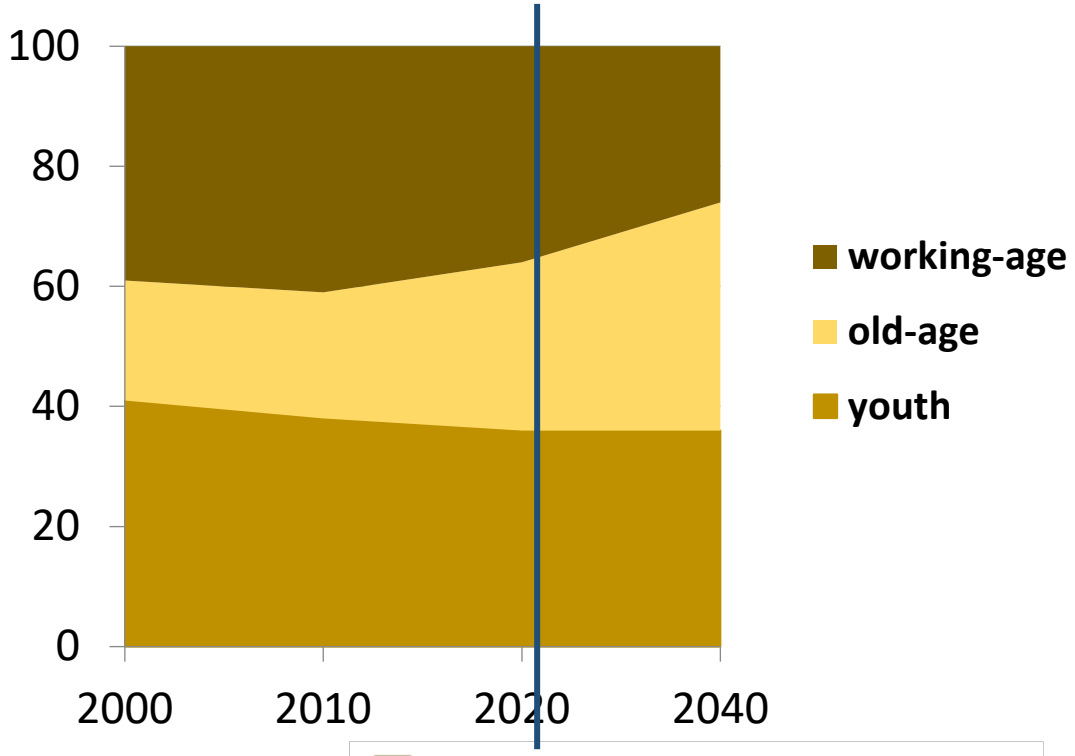
Aging of America will significantly impact Oral Health

By 2035, there will be more older adults than youth in the US



Changing Dependency Ratios can affect employment-based insurance coverage



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What does a Greying America mean for Oral Health?

1. Many working-age adults are deferring dental care, experiencing higher levels of untreated caries, and struggle with obtaining affordable dental care
2. As working-age adult cohorts age into retirement, although they may have benefited from having more teeth than previous cohorts, they will require more dental care
3. If the current dental care delivery systems remain unchanged for an America that is rapidly ageing – health disparities will increase, quality of life will be impacted, and oral health inequities will worsen for older adults

What does it mean for Ohio?

Ohio's demographics and other factors favor ongoing Oral Health challenges for seniors

- **Over 4M Ohio residents are >50 years of age.**
- **Ohio has one of the largest populations of older adults compared to other states.**
- **About 1 in 4 Ohioans are age 60 or older.**
- **Unlike Colorado, Ohio is not in the top 10 most rapidly aging states – however, the older adult population is expected to proportionally increase.**
- **Chronic conditions, including heart disease, dementia and related disorders, remain a concern for older Ohioans* (Hypertension and CVD are higher in Ohio).**
- **While most older Ohioans can cover their basic needs, many are not financially prepared for life after work***

(*): https://www.healthpolicyohio.org/wp-content/uploads/2020/06/SAPA_SummaryAssessmentofOlderOhioans_ExecutiveSummary_06022020.pdf

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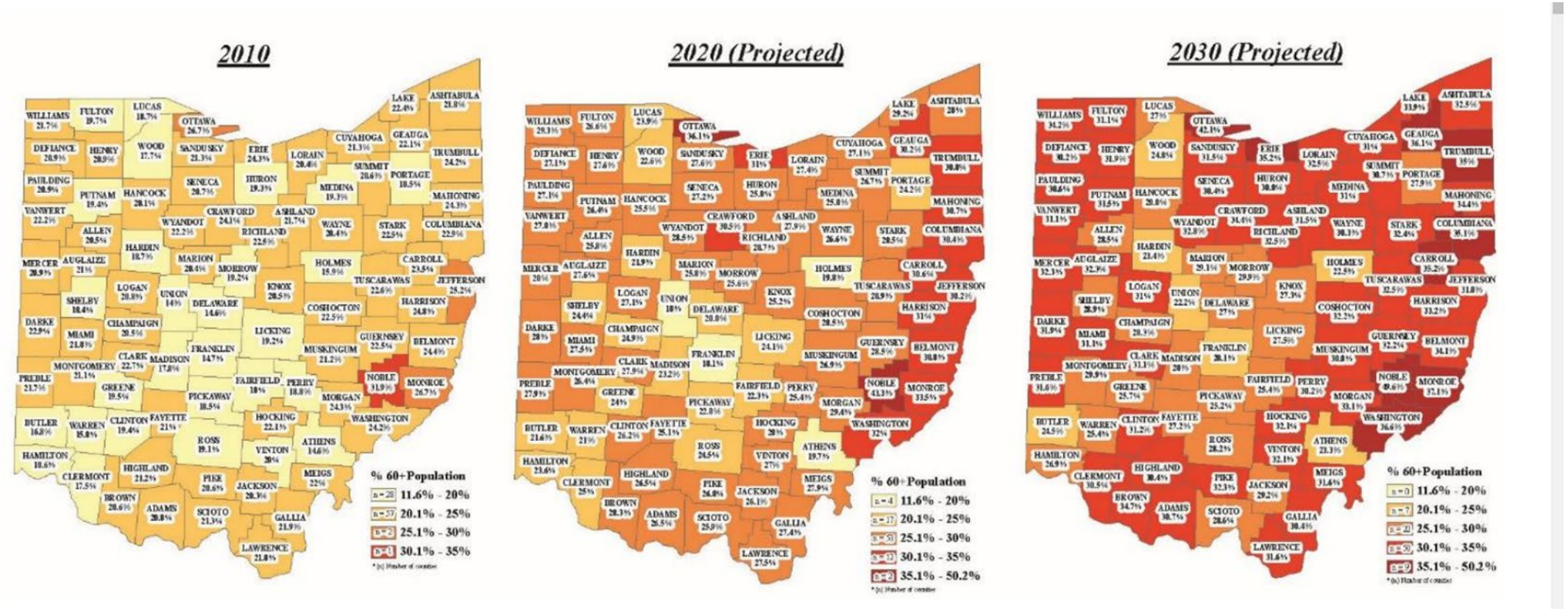
What does it mean for Ohio?



http://www.advancingstates.org/sites/default/files/Ohio_State_Plan_19-22.pdf

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What does it mean for Ohio?

- Ohio is going to need a greater focus towards creating opportunities and interventions that target older adults.
- The key is increasing access to care.
- Support pilot and community projects that can demonstrate success not only in improving oral health outcomes but also reducing disparities.
- The new report on Oral Health in America further strengthens the connection between health and oral health – oral health care must be recognized as essential health care.

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Thank you

Draft

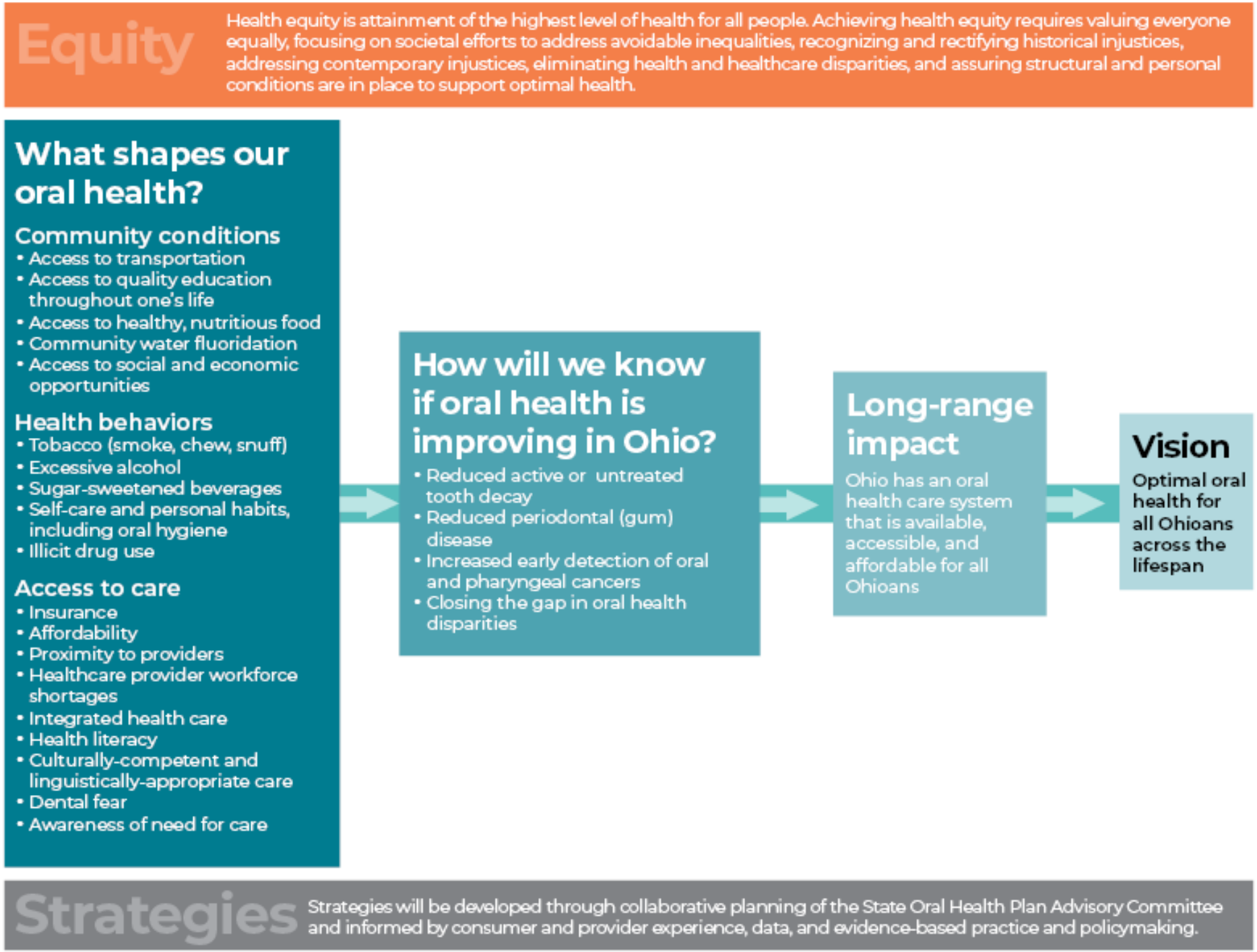
Core values

1. The health and well-being of all people and communities is essential to a thriving, equitable society.
2. Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.
3. Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.
4. Promoting and achieving health and well-being across Ohio is a shared responsibility that is distributed across the national, state, and community levels, including the public, private, and not-for-profit sectors.

Discussion question

What additions or modifications would you like to see to the core values?

Conceptual framework



Discussion question

What additions or modifications would you like to see to the conceptual framework?

Next

Advisory Committee meeting

Wednesday, July 13

1-4:30 p.m.

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