Amy Rohling McGee
President, Health Policy Institute of Ohio
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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.
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
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
Advisory Committee

Introductions
Discussion question

What encourages you most about this work?
Process, timeline and role of the Advisory Committee
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
• 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
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

**Equity**
Health equity is achieved when all people in a community have access to affordable, inclusive, and high-quality infrastructure and services that, despite historical and contemporary injustices, allow them to reach their full health potential.

**Priorities**
The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages.

**What shapes our health and well-being?**
Many factors, including these 3 SHIP priority factors:
- Community conditions
  - Housing affordability and quality
  - Poverty
  - K-12 student success
  - Adverse childhood experiences
- Health behaviors
  - Tobacco/nicotine use
  - Nutrition
  - Physical activity
- Access to care
  - Health insurance coverage
  - Local access to healthcare providers
  - Unmet need for mental health care

**How will we know if health is improving in Ohio?**
The SHIP is designed to track and improve these 3 SHIP priority health outcomes:
- Mental health and addiction
  - Depression
  - Suicide
  - Youth drug use
  - Drug overdose deaths
- Chronic disease
  - Heart disease
  - Diabetes
  - Childhood conditions (asthma, lead)
- Maternal and infant health
  - Premature births
  - Infant mortality
  - Maternal morbidity

**All Ohioans achieve their full health potential**
- Improved health status
- Reduced premature death

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

**Strategies**
The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio’s performance on these priorities.

*These factors are sometimes referred to as the social determinants of health or the social drivers of health*

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

- Specific
- Measurable
- Achievable*
- Realistic*
- Time-bound

Source: 2020-2022 State Health Improvement Plan, Ohio Department of Health
SMART objective and target example

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Indicator (source)</th>
<th>Most recent actual data</th>
<th>Short-term target (2022)</th>
<th>Intermediate target (2025)</th>
<th>Long-term target (2028)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce infant mortality</td>
<td>MIH2 Infant mortality. Number of deaths for infants under age 1, per 1,000 live births (ODH Vital Statistics/ODH)</td>
<td>6.9</td>
<td>6.5</td>
<td>6.3</td>
<td>6</td>
</tr>
<tr>
<td>Priority populations</td>
<td>Black (non-Hispanic)</td>
<td>14</td>
<td>10.8</td>
<td>8.4</td>
<td>6</td>
</tr>
</tbody>
</table>

**Source:** 2020-2022 State Health Improvement Plan, Ohio Department of Health
Strategies and Policy

Recommendations
Project timeline

May
- 5/25 Advisory Committee meeting
- 6/7-6/11 Virtual healthcare provider focus groups
- 6/21-7/1 Regional consumer focus groups

June
- 7/13 Advisory Committee meeting (in person)

July
- 9/14 Advisory Committee meeting (in person)

August

September
- Develop objectives and select strategies and policy recommendations

October
- Review State Oral Health Plan draft
- HPIO draft due to OHO

November
- HPIO final draft due to OHO
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
Connections between oral health and overall health

Mental health conditions such as addiction, anxiety and depression can negatively impact oral health.

Painful oral health conditions can exacerbate management of substance use disorders.

Poor oral health can exacerbate physical health conditions such as diabetes, and is connected with heart disease, stroke and birth complications.

Physical health conditions such as HIV/AIDS, osteoporosis and multiple sclerosis can have detrimental effects on oral health.

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

[Graph: Visited the dentist or dental clinic within the past year for any reason, 2020]

Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System, via America’s Health Rankings
Visited the dentist or dental clinic within the past year for any reason, ages 18 and older, 2020

Ohio worse than U.S.

Ohio: 65.3%
U.S.: 66.7%

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.

Ohio 12.8%  U.S. 14.3%

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.

74.1% 77.5%

Ohio U.S.

Source: National Survey of Children's Health, 2019-2020
Ohio worse than U.S.
Water fluoridation
Percent of population served by community water source receiving fluoridated water, 2018

Ohio better than U.S.

Ohio: 92.5%
U.S.: 73%

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
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
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
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
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
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
The 2021 Follow-up – Oral Health in America

“…people in the United States experience oral health differently.”
The 2021 Follow-up – Oral Health in America

Oral Health in America: A Report of the Surgeon General

Oral Health is integral to Overall Health
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
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
What’s in the new Report on Oral Health in America?

Section 1: Professional Education
- Provider Diversity
- Workforce Distribution
- Integrated Health Care
- Access to Care
- Quality and Safety

Section 2: Prevention and Early Intervention
- Families and Caregivers
- Risk Assessment
- High-risk Behaviors
- Peer Influences
- HPV Vaccination

Section 3: Oral and General Health
- Health Literacy
- Employment and Insurance
- Complex Medical History
- Quality of Life
- Aging and Care Support

Section 4: Inequities and Disparities
- Diverse Communities
- Social Determinants
- Public Health
- Health Systems

Section 5: Pain Management
- Opioid Misuse
- Tobacco
- Substance Use Disorders
- Mental Illness

Section 6: Novel Technologies
- Genomics and Microbiome
- Diverse Scientific Workforce
- Telehealth
- Electronic Health Records

School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

DENTAL. INTEGRATED FOR HEALTH.
The 2021 Follow-up – Oral Health in America

What are some key epidemiologic data informing the report:

*Oral Health in America: Advances and Challenges?*
Oral Health in America

Dental caries
Oral Health in America


Notes: Prevalence of dental caries (DMFT ≥ 1). NHW = non-Hispanic White, NHB = non-Hispanic Black, Mex Am = Mexican American. FPG = Federal Poverty Guidelines: < 100% FPG = poor; 100–199% FPG = near poor; ≥ 200% FPG = nonpoor.


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

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.
Oral Health in America


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.

Note: Prevalence of dental sealants is having at least one permanent molar tooth sealed.
Oral Health in America

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

Notes: Prevalence of dental caries in primary teeth (DMFT ≥ 6). FPG = Federal Poverty Guideline; < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.

Oral Health in America

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

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.


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.
Oral Health in America


- Ages 20–64
- Ages 20–34
- Ages 35–49
- Ages 50–64

Gender: Total, Male, Female

Prevalence (%): 100, 95, 90, 85, 80, 75


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

Note: Prevalence of dental caries in permanent teeth (DMFT > 0).
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.
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?
Reduction in untreated caries in preschool children represents one of the most important achievements in oral health in the last 20 years.
Oral Health in America

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


Better access to care resulting in more treatment.
Oral Health in America

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

Better access to care resulting in more treatment and the elimination of health disparities

Note: FPG = Federal Poverty Guideline; < 100% FPG = poor; 100–199% FPG = near poor; and ≥ 200% FPG = nonpoor.
Oral Health in America


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.

Oral Health in America


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

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.

Oral Health in America

Tooth loss
Oral Health in America

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


Oral Health in America

Another very important achievement – continuing decline in edentulism

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. (2010).
Oral Health in America

Figure 23. Percentage of adults ages 20–64 with a functional dentition by age group and poverty status:

Poverty Status
- Poor
- Near Poor
- Nonpoor

Ages 20–34
Ages 35–49
Ages 50–64

Prevalence (%)

Survey period

1988–1994
1999–2004
2011–2014

Also important – Functional dentition is increasing for working-age adults; however, there’s been no change in disparities.
Oral Health in America

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

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

- Working-age adults
- Older adults

Survey period:
- 1999–2004
- 2011–2016

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

Implant demand is increasing especially among older adults.
Oral Health in America

Access to care
Oral Health in America

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

Lack of dental insurance coverage increases as we age

Notes: Children (ages 2–11), Adolescents (ages 12–19), Working-age adults (ages 20–64), Older adults (65 and older).

Oral Health in America

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.

Oral Health in America

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

- Private insurance: $82.2 billion (46%)
- Out of pocket: $54.9 billion (40%)
- Medicaid and Medicare: $14 billion (10%)
- Other: $4.8 billion (3%)

Oral Health in America

Out of pocket dental expenditures have decreased for youth – yet has increased for older adults.
Oral Health in America

The largest increase in TOTAL dental expenditures have been for older adults.
Oral Health in America

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

Oral Health in America

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

The number of Dental HPSAs remains high

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

An Aging Nation
Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2035

Note: 2016 data are estimates not projections.


Working-age: [Working-age graph]
Old-age: [Old-age graph]
Youth: [Youth graph]
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*

What does it mean for Ohio?

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.
Thank you
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

Equity

Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, focusing on societal efforts to address avoidable inequalities, recognizing and rectifying historical injustices, addressing contemporary injustices, eliminating health and healthcare disparities, and assuring structural and personal conditions are in place to support optimal health.

What shapes our oral health?

Community conditions
- Access to transportation
- Access to quality education throughout one’s life
- Access to healthy, nutritious food
- Community water fluoridation
- Access to social and economic opportunities

Health behaviors
- Tobacco (smoke, chew, snuff)
- Excessive alcohol
- Sugar-sweetened beverages
- Self-care and personal habits, including oral hygiene
- Illicit drug use

Access to care
- Insurance
- Affordability
- Proximity to providers
- Healthcare provider workforce shortages
- Integrated health care
- Health literacy
- Culturally-competent and linguistically-appropriate care
- Dental fear
- Awareness of need for care

How will we know if oral health is improving in Ohio?
- Reduced active or untreated tooth decay
- Reduced periodontal (gum) disease
- Increased early detection of oral and pharyngeal cancers
- Closing the gap in oral health disparities

Long-range impact
Ohio has an oral health care system that is available, accessible, and affordable for all Ohioans

Vision
Optimal oral health for all Ohioans across the lifespan

Strategies
Strategies will be developed through collaborative planning of the State Oral Health Plan Advisory Committee and informed by consumer and provider experience, data, and evidence-based practice and policymaking.
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.
Columbus Main Library
96 S. Grant Ave. Columbus, OH 43215