Building Upon the Past, Embracing the Present and Forging a Dynamic Future: Re-Envisioning State Oral Health Programs

National Oral Health Conference

April 18, 2016

astdd
Where oral health lives

Lessons Learned from the Past:

2008-2013 CDC Oral Health Program Cooperative Agreements Evaluation

Katherine Weno, DDS, JD
Senior Advisor
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control and Prevention

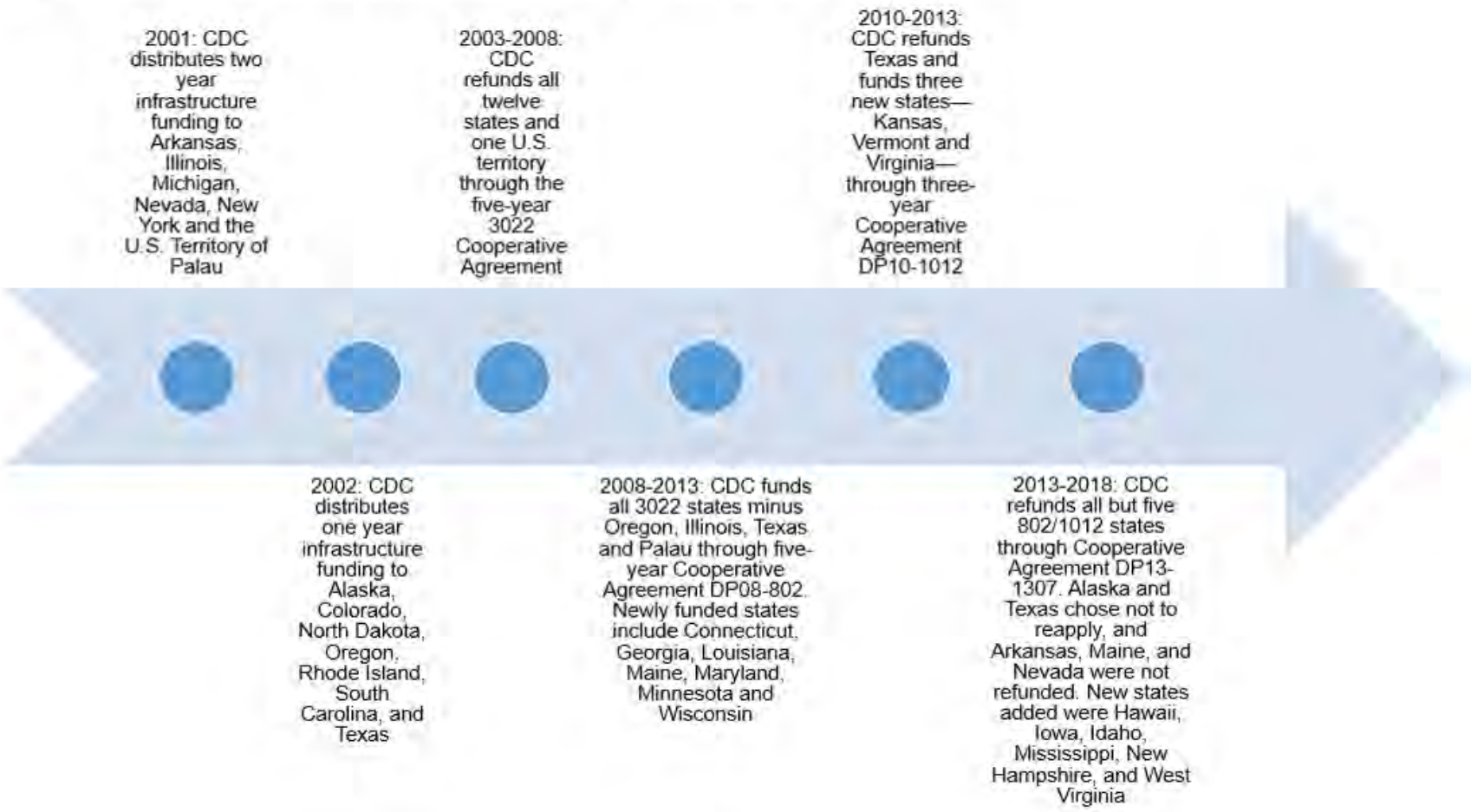
National Oral Health Conference
April 18, 2016

CDC Division of Oral Health

- Program Services Team
- Science Team
  - Surveillance
  - Evaluation
  - Fluoride Engineering
  - Health Economics
  - Infection Control
- Policy and Communications
- Administration
- Leadership

History of CDC Oral Health Cooperative Agreements

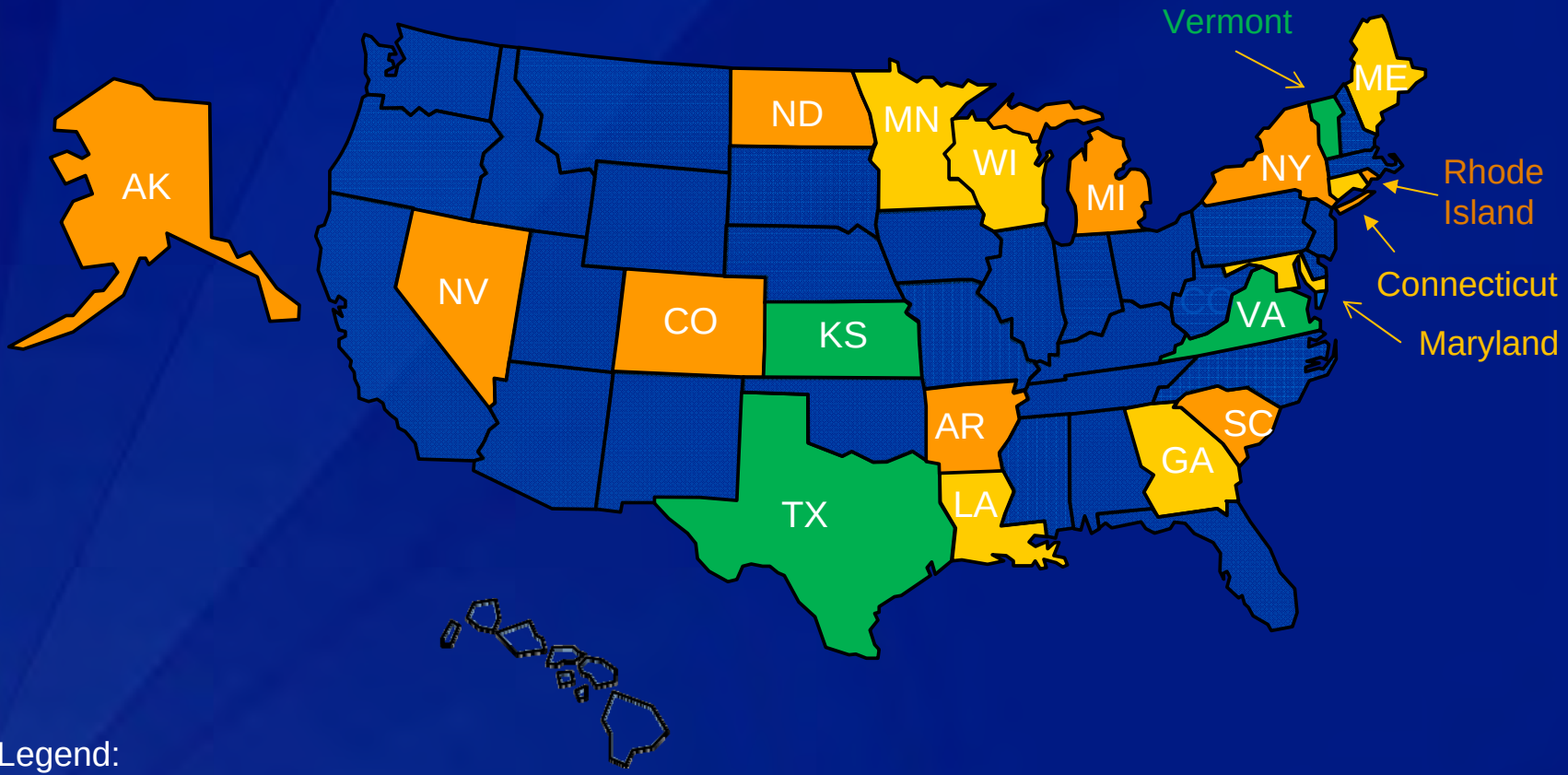
Figure 1. History of CDC Oral Health Infrastructure Cooperative Agreements, 2001-2018



Overarching Evaluation Questions

1. To what extent have grantees built a sustainable infrastructure for their state oral health program?
2. What factors influence capacity of state oral health programs?
3. In which cooperative agreement activities have grantees had the most success?

CDC Oral Health Grantees: 2008-2013



Legend:
Grantees of FOA 802 only (2008-2013)
Grantees of FOA 1012 only (2010-2013)
Grantees of FOAs 802 and 3022 (2008-2017)

2008-2013 CDC Cooperative Agreement Recipient Activities

1. Build and sustain staffing and management functions

2. Develop an oral health surveillance system

3. Create a statewide oral health plan

4. Establish partnerships and coalitions

5A. Increase access to and utilization of oral health preventive interventions – school-based dental sealant programs

5B. Increase access to and utilization of oral health preventive interventions – community water fluoridation

6. Assess and monitor existing oral health policy in the state

7. Develop processes and activities for consistent program evaluation

8. Collaborate with other bureaus or agencies within the state health department to maximize talents and resources

Staffing and Management

FOA 802/1012 Expectations:

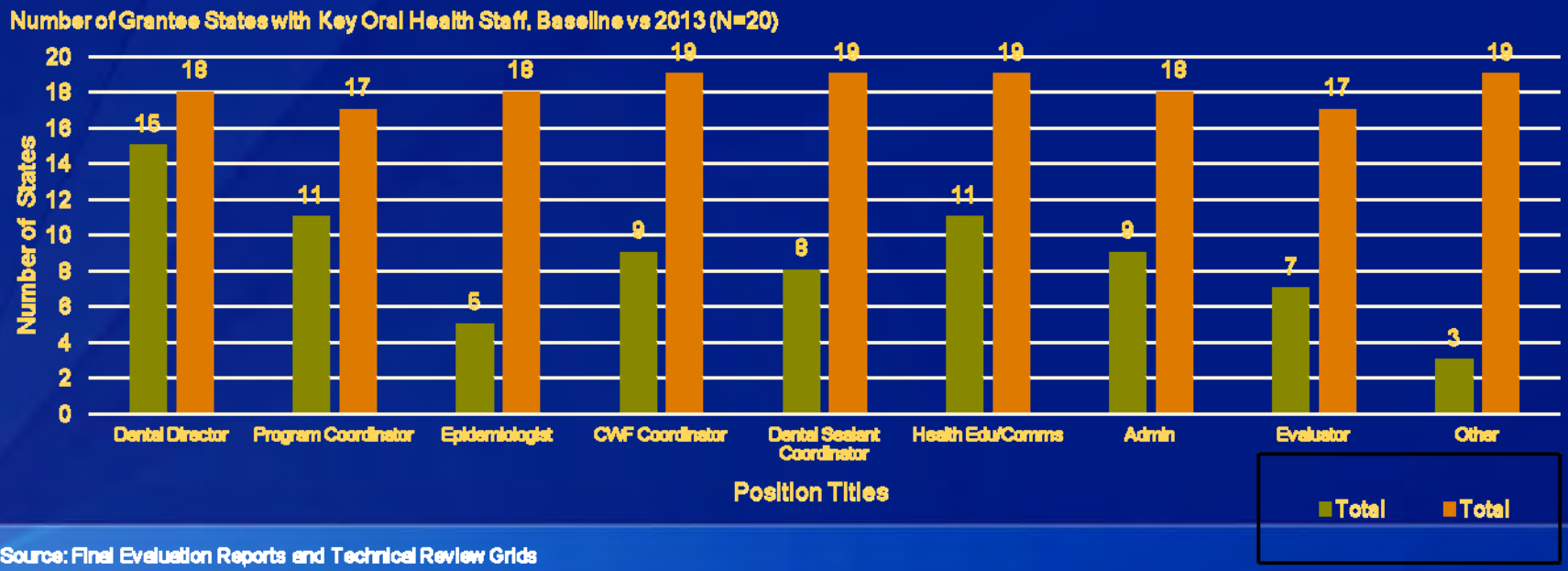
Hire and maintain a total staff capacity of no less than 4.0 full time equivalent (FTE) staff, including:

- 1 full-time dental director
- .5 FTE program coordinator.
- .5 FTE Epidemiologist
- .5 FTE dental sealant coordinator.
- .5 FTE community water fluoridation (CWF) specialist
- .25 FTE program evaluation
- .25 FTE health education/communication specialist
- Administrative support (as needed)
- "Other" staff positions, such as financial coordinator and grant writer

Staffing and Management

Key Accomplishments of FOA 802/1012:

- Average SOHP size increased from 4.5 FTE (2008) to 8.2 FTE (2013)
- CDC supported positions that would not normally be supported – e.g. Epidemiologist, Evaluator, CWF Engineer, Dental Sealant Coordinator
- Largest growth between baseline and end of CoAg for the Epidemiologist position and other positions such as fiscal coordinator or grant writer



Source: Final Evaluation Reports and Technical Review Grids

Staffing and Management

Facilitators:

- Sharing staff within the health department
  - Partnerships with academic institutions
  - Funding outside of CDC cooperative agreement for staff salaries

Challenges:

- Staff turnover inhibited progress – 12 SOHPs had delays due to vacancies
- Lack of qualified staff
- Hiring freezes

"Other than the program epidemiologist, none of the staff who created the 2009 evaluation plan currently work in the program."

–Colorado

Surveillance

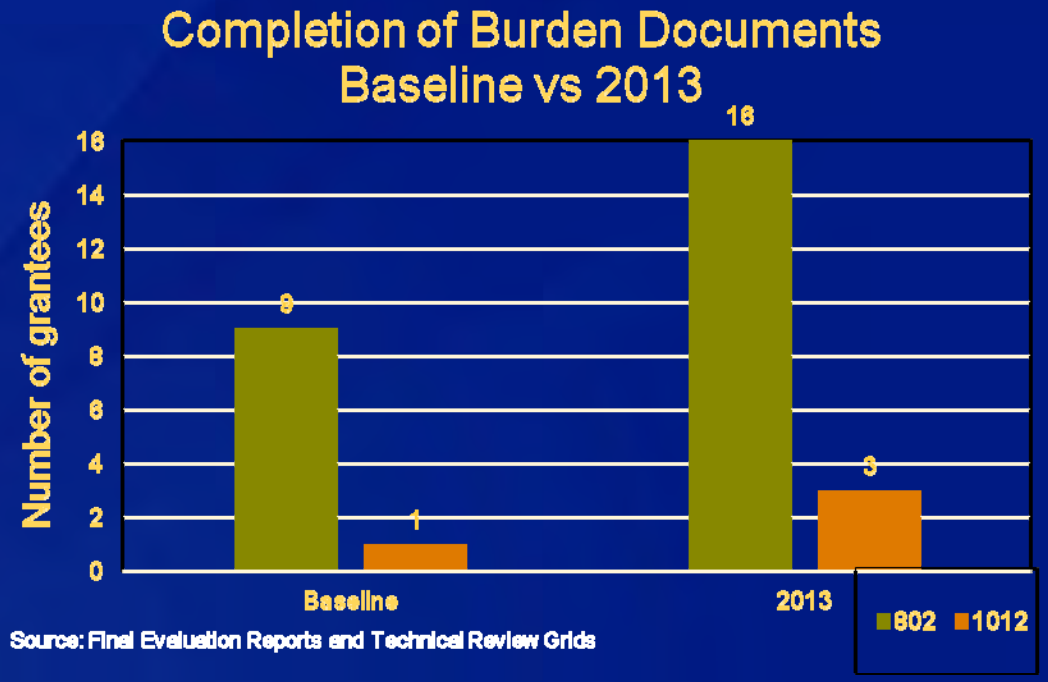
FOA 802/1012 Expectations:

- Burden of oral disease document
- State oral health surveillance plan
- Annual submission of data to State Synopsis and National Oral Health Surveillance System (NOHSS)
- Basic Screening Survey (BSS) for 3rd graders
- School-based dental sealant program need assessment
- Reporting of data to Water Fluoridation Reporting System (WFRS)

Surveillance

Key Accomplishments:

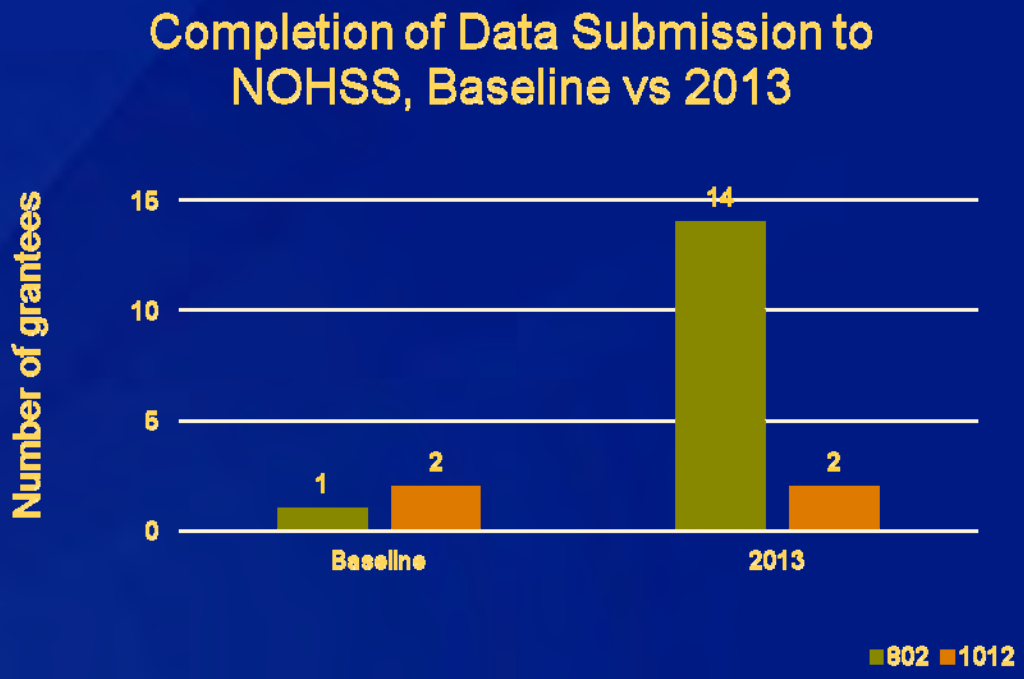
- All 20 states completed the State Surveillance Plan and 19 states completed the Burden Document



Surveillance

Key Accomplishments:

- Sixteen (65%) additional states were submitting annual standardized data to NOHSS for the first time or after a long hiatus of non-reporting



Source: Final Evaluation Reports and Technical Review Grids

Surveillance

Key Accomplishments:

- Thirteen (65%) grantees were able to add oral health related questions to existing state surveys like PRAMS and BRFSS
- Most states were able to:
  - create state-wide recognized surveillance systems
  - increase the frequency of data collection, and
  - broaden the set of oral health indicators collected

"The OOH's first statewide population- specific Basic Screening Survey for Older Adults (BSSOA) was conducted in 2011 with funding provided by the National Association of Chronic Disease Directors through an opportunity grant for Healthy Aging."

Connecticut

Surveillance

Facilitators:

- Staffing an Epidemiologist position
- Staff sharing with other health division and academic institutions
- External partnerships – data sharing with partners outside of the Health Department facilitated collection of secondary data to inform surveillance efforts

Challenges:

- Lack of qualified personnel
- Securing additional funding for data collection and management
- Dependence on external partners for data
- Filling gaps in population data – particularly for specific populations

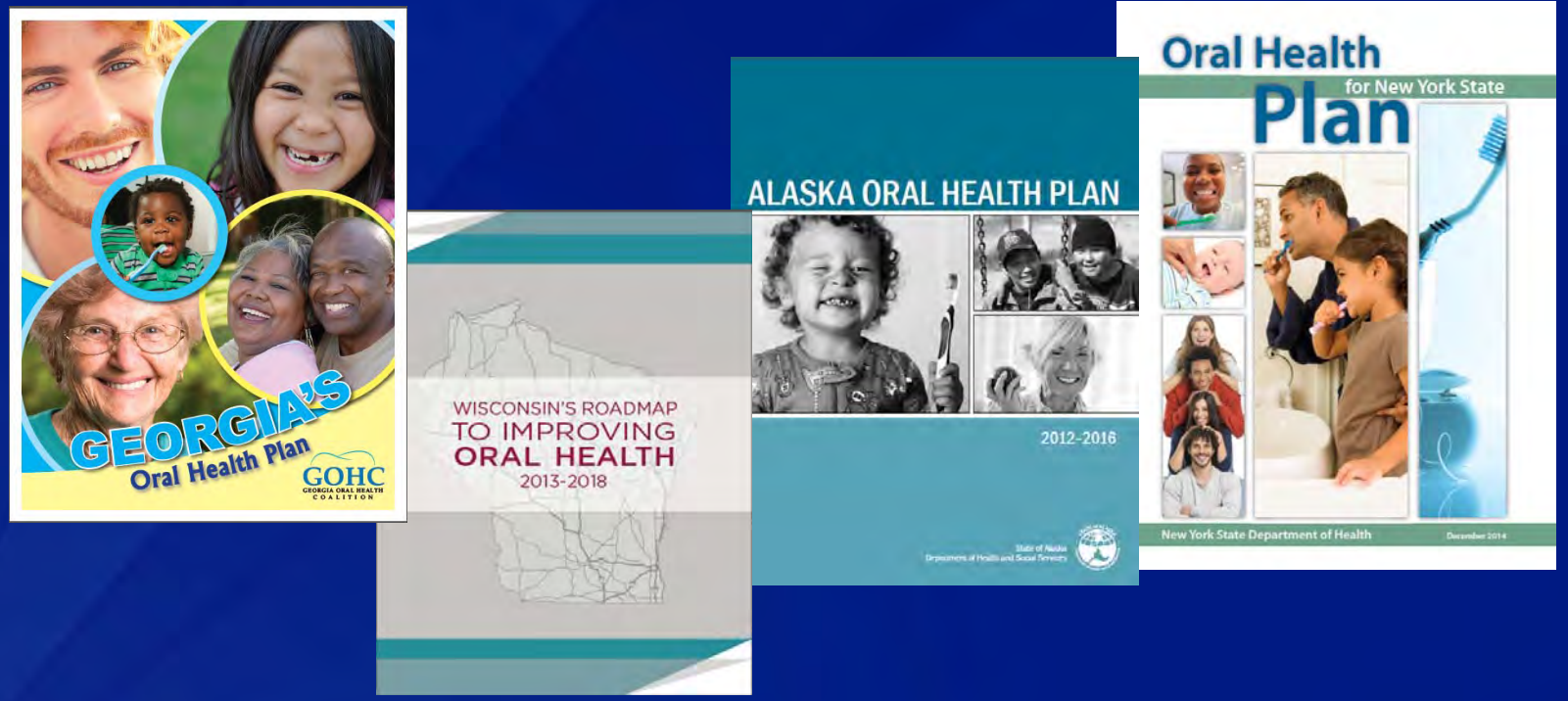
"The barriers experienced while developing and implementing [surveillance] were the lack of resources and funding to develop a sophisticated data bank or repository system for oral health data and collect primary data"

-

Maryland

Strategic Planning: State Oral Health Plan

- 17 (85%) grantees completed a State Oral Health Plan



Partnerships and Coalitions

Facilitators/Challenges:

- All grantees created a state oral health coalition and developed partnerships
- Nine state coalitions (45%) achieved non-profit status or independence
- Coalitions played a key role in developing the State Oral Health Plan and/or the Evaluation Plan in eighteen (90%) states

> "The Wisconsin Oral Health Coalition (WOHC) has minimal funding and would be ineffective without funding from the CDC CoAg. Additionally, the State Oral Health Plan would never have been completed without the use of the WOHC"
>
> *- Wisconsin*

Facilitators/Challenges:

- Dedicated FTE to manage coalition
- Competing agendas – Partners sometimes had different agendas than SOHPs
- Role definition – Poor definition of the relationship between the SOHP and partners/Coalition led to frustration

School-Based Dental Sealant Programs

FOA Expectations:

The FOA required that the School-Based Sealant Program (SBSP) be implemented in tw phases:

Phase 1 –

- School sealant program plan
- Implementation of a pilot project
- Evaluation of the pilot project

Phase 2 –

- Tracking and reporting SBSP outcomes
- Conduct a cost-analysis of SBSP programs using SEALS software
- Submit the cost-analysis report to the ASTDD Best Practices Project

School-Based Dental Sealant Programs

Facilitators:

- Additional financial support for program implementation
- Favorable Policy
  - Changing supervisory requirements for dental hygienists
  - Increasing Medicaid reimbursement for dental providers performing dental assessments and preventive care

"The awareness of dental decay in young Native children and Tribal program shift to more prevention led to the support to get Medicaid reimbursement coverage for fluoride varnish and oral evaluation for children under age 3 for non-dental health providers."

- Alaska

School-Based Dental Sealant Programs

Challenges:

- Adverse state policy – Fourteen (70%) states reported a barrier with Medicaid reimbursement policies at some point during the funding period
- Obtaining parental consent
- Access to care – States with large rural regions (AK, KS, ND, NV, WI) continue to struggle to provide SBSP to rural communities
- Standardized data collection – Schools do not uniformly collect data on dental sealant services. States did not uniformly provide CDC with sealant data
- SEALS software was not uniformly accepted or used

Community Water Fluoridation

FOA Expectations:

The FOA required that the Community Water Fluoridation (CWF) program be implemented in two phases:

Phase 1 –

- Fluoridation plan and submit annual status reports
- WFRS submission
- Report on new or replacement fluoridation equipment
- Measure and report progress toward Healthy People goals

Phase 2 –

- CWF quality control program, CDC Lab Proficiency Testing Program
- Education and promotion of CWF
- Work with communities to promote optimal fluoridation

Community Water Fluoridation

"With support from the CDC grant, the fluoridation coordinator has reached and trained more than 450 water systems operators from 2009 to 2013."

– *Georgia*

Key Accomplishments:

- All grantees regularly submitted data to the Water Fluoridation Reporting System (WFRS)
- Sixteen (80%) grantees coordinated or conducted fluoridation trainings for community water operators and engineers
- Eight states (Alaska, Louisiana, Michigan, Maine, Colorado, New York, North Dakota, and South Carolina) were able to maintain and/or expand water fluoridation systems and meet both Phases of Recipient Activity 5b requirements
- Eleven (55%) grantees used additional non-CDC funding to support a portion of CWF programs and staffing positions

Community Water Fluoridation

Facilitators:

- Staffing a Fluoridation Specialist position
- Political support prevented anti-fluoridation laws and legislations from passing in state government
- National recognition through WFRS fluoridation awards encouraged communities to keep fluoridating

Challenges:

- Underqualified water engineers
- Insufficient funding to replace equipment and upgrade systems
- Anti-fluoridation campaigns were common
- Data quality

"It is most difficult to monitor and identify communities that may be facing a challenge to fluoridation. Because of relationships developed by the CWF program coordinator, some communities are beginning to call to ask for assistance if they know a challenge will be mounted at a community meeting."

- Michigan

Policy

Key Successes:

- Thirteen grantees held policy workshops
- Fifteen states documented positive local or state policy changes that impacted activities

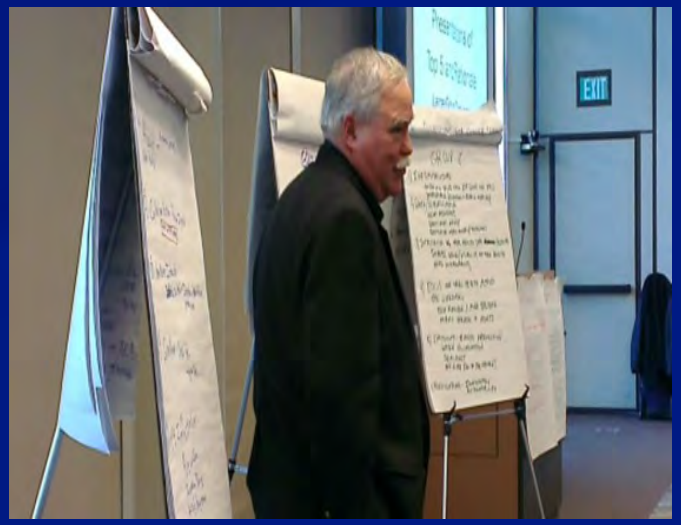
> "Feedback on policy development was gathered during targeted workshops and programs. An Oral Care Workshop was held that brought Native American tribal community members together to discuss oral health issues."
>
> --
>
> *North Dakota*

Key Challenges:

- Least defined, most confusing part of the cooperative agreement
- Most SOHPs have no policy staff, although all agree it is critically important

Evaluation

- Grantees developed evaluation plans but CDC Project Officers and Evaluators felt states lacked capacity to fully implement them. Also it was felt that states didn't really take ownership and accountability for the plan



- State Evaluators often underqualified:
  - Position is often filled by epidemiologists or others with limited evaluation expertise
  - 40% of grantees hired external evaluation consultants
- Grantees requested more TA from CDC and ASTDD evaluators

Program Collaboration

- 18 (90%) grantees shared staff with other programs within the Health Department, most commonly the Epidemiologist
- Most common activity collaborations were with:
  - Maternal and Child Health
  - Chronic Disease
  - Tobacco
  - Obesity Prevention
- Challenges:
  - lack of interest or energy for collaboration
  - availability of funding
  - unclear or unequal distribution of work and resources
  - departmental re-organization and staff turnover

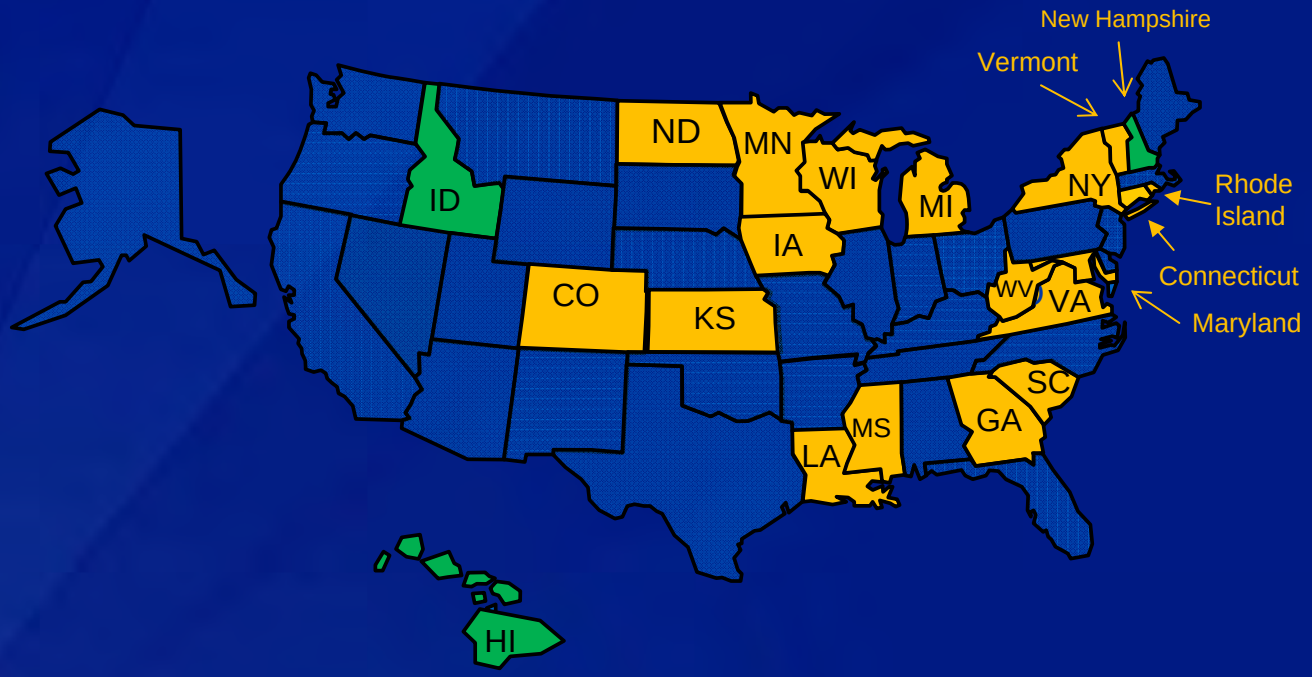
Key Successes – 802/1012

- Increase in staffing and infrastructure
  - Epidemiologists and Fluoride Staff
- Development of State Oral Health Surveillance Systems
  - Basic Screening Surveys
  - Dissemination Products – Burden documents, fact sheets
  - Participation in Water Fluoridation Reporting System (WFRS)
- Development and Implementation of School-Based Sealant Programs
- Oral health coalitions created and developed
  - Many became independent and 501(c)(3)
- Development and implementation of “Policy Tool”
  - Convening stakeholders to discuss policy priorities

Continued Grantee Challenges

- How to attract and maintain qualified staff
- Diversifying funding sources – CDC funding alone can't pay for infrastructure and activities
  - School sealant programs
  - Surveillance
- Assessing the mutual benefit of an oral health coalition
  - Define roles of coalition vs. SOHP to not compete for resources
  - Be aware of competing agendas of members
- Ensuring that evaluation is integrated into all activities
- Funding for communication activities
- More technical support needed from CDC especially in evaluation and policy

Current Cooperative Agreement 1307 – State Oral Disease Prevention 2013-2018



Legend:
"Component 1" Grantees
"Component 2" Grantees

Planning for Future Funding Opportunities

Process has started…

Step One: Evaluate Prior Cooperative Agreements

Step Two: Environmental Scan – What has Changed?

- Are there new players impacting oral health?
- New science or policies?
- What are CDC's current priorities?

Step Three: Stakeholder Input

Step Four: Development of a New Funding Opportunity

- Current Cooperative Agreement ends August, 2018
- Planning for another FOA is always contingent on Congressional appropriations

CDC Division of Oral Health

www.cdc.gov/oralhealth

(770) 488-6054

oralhealth@cdc.gov

For more information please contact Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

Dental Public Health: Current Challenges and Opportunities

STATE ORAL HEALTH PROGRAMS IN THE CROSSROADS

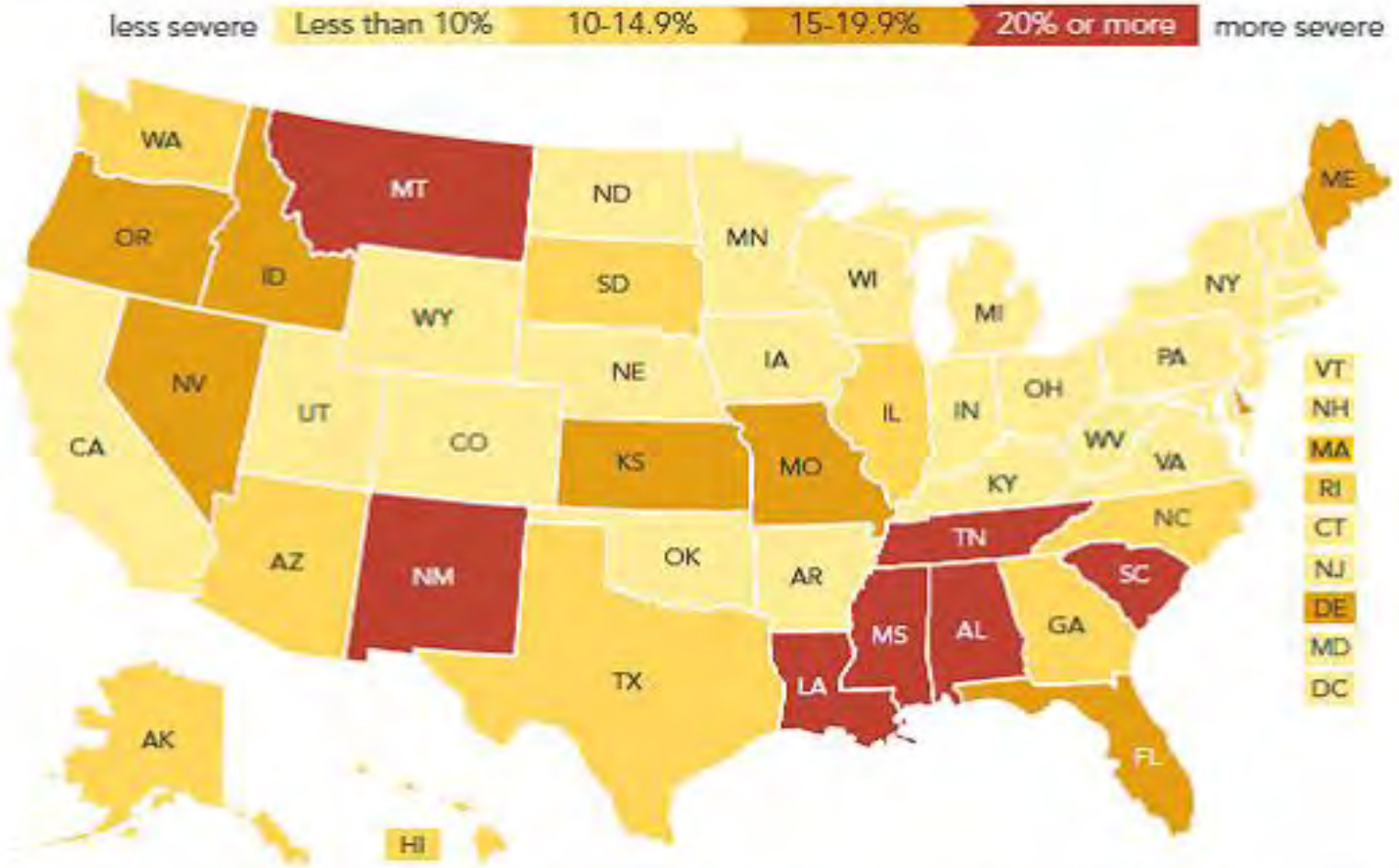
BOB RUSSELL, DDS, MPH

Prevailing Barriers in Oral Health Access Common Among the States

- Dental provider inadequacy to meet or investment in low income population needs
- Dental provider's focus on small business interests rather than health care delivery
- Current dental training model not aligned with the needs of the safety net and public health
- Low utility in the use of allied dental workforce
- Separation of oral health and dental from health care transformation activities
- Access trends for adults decreasing
- Access for children increasing; but not significant for racial minorities and low income populations

Severe Dentist Shortages Persist

More than 31 million Americans are unserved due to a shortage of dentists. The percentage of unserved Americans varies by state.



SOURCE: Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, "State Population and Health Professional Shortage Area Population Statistics as of 12/8/10," http://datawarehouse.hrsa.gov/quickaccessreports.aspx (Accessed December 9, 2010)

RK1

Dental Access Trends Decreasing

- Adults' access to dental care has fallen steadily since the early 2000s

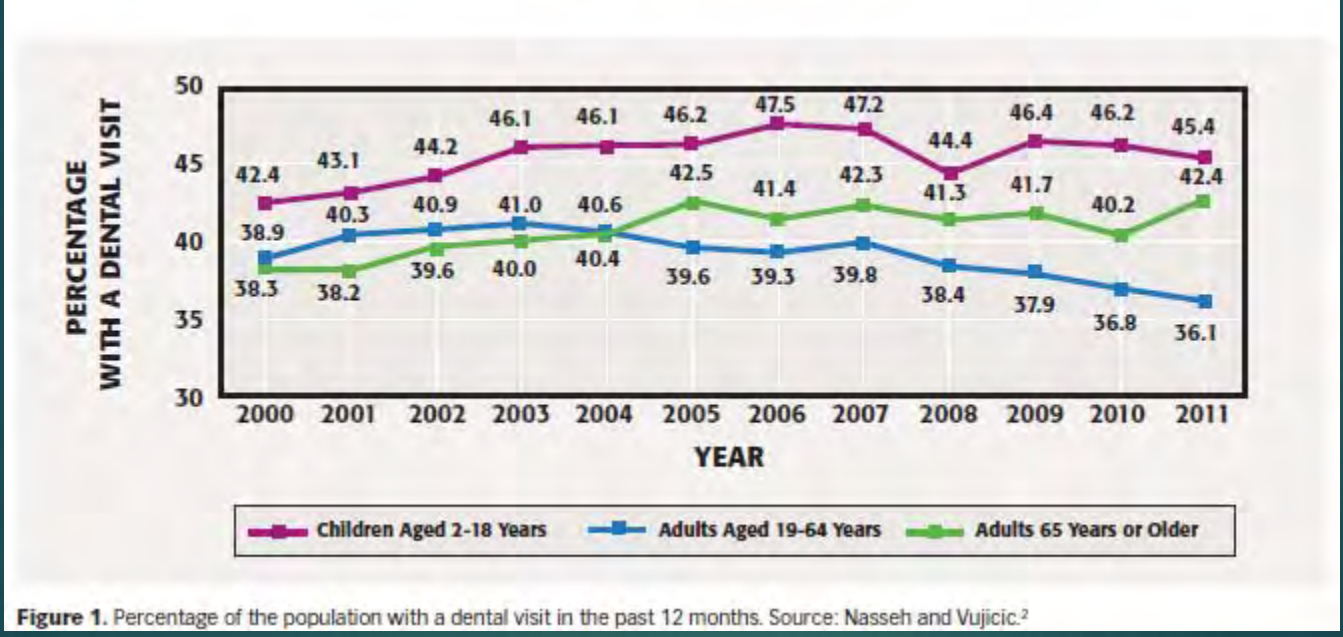


Figure 1. Percentage of the population with a dental visit in the past 12 months. Source: Nasseh and Vujicic.[2]

Vujicic M et al. A profession in transition. J am dent assoc 2014;145:118-121

Slide 35

RK1 After the first bullet, paste the table and citation from the last slide (#39). This clearly demonstrates the point that you are trying to make with this first bullet. Then, place the remaining bullets from this slide onto a new slide

Kuthy, Raymond A, 9/14/2014

Barriers to Seeking Oral Health in Rural America

- Fewer Dentists work in rural areas
- Fewer numbers of rural residents have dental insurance coverage
- Rural water systems less likely to be fluoridated

Improving Access to Oral Health Care for Vulnerable and Underserved Populations. Institute of Medicine 2011

Other Factors

- Uneven distribution of dentists and oral health prevention access points in rural communities
- A relatively small number of dentists that take Medicaid clients or limit their numbers when and where dentists are available
- Distance factors and lack of adequate transportation
- Lower health literacy in certain rural and geographically restricted areas
- Dentistry is simply becoming too costly

Methods to Improve Prevention

- Population Based Services
  - School-Linked Dental Clinic System
  - School- Based Sealant Program
  - Community Water Fluoridation
  - Oral Health Literacy

Common Ingredients for Population Preventive Programs

- A sufficient and sustainable workforce
- Lower overhead costs
- Multiple sites and locations
- A targeted approach in using resources effectively
- Less educational burden and costs for workforce development and deployment
- Flexibility
- Effective messaging to engage the public

Emerging New threats?

Kaiser Health News: Selling The Health Benefits Of Tap Water, In An Age Of Flint

Colorado Public Radio's John Daley, in partnership with Kaiser Health News and NPR, reports: The water crisis in Flint, Michigan, is making some public health messages harder to get across — namely, in most communities, the tap water is perfectly safe and it is so much healthier than sugary drinks.

It's a message Dr. Patty Braun, a pediatrician and oral health specialist at Denver Health, spends a lot of time on in Denver, even before lead was found in the water system of Flint. (Daley, 2/18)

Emerging New Dental Quality Measures Stress Prevention

- The Dental Quality Alliance (DQA) announce in September, 2014 that the National Quality Forum (NQF) has endorsed **five** DQA measures:
  - Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
  - Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk
  - Utilization of Services: Dental Services
  - Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services
  - Oral Evaluation: Dental Services

Affordable Care Act (ACA): MEDICAID EXPANSION -2016

- **Adopted the Medicaid Expansion: 32 states (including DC);**
- **Adoption of the Medicaid Expansion under Discussion: 3 states;**
- **Not Adopting the Medicaid Expansion at this Time: 16 states**

ADA Health Policy Institute: A Slow level of Progress

- 2000 AND 2013, THE PERCENTAGE OF MEDICAID CHILDREN WITH A DENTAL VISIT INCREASED FROM 29% TO 48%

- THE GAP IN DENTAL CARE USE BETWEEN MEDICAID AND PRIVATELY INSURED ADULTS IS MUCH WIDER THAN IT IS FOR CHILDREN

MEDICAID COVERAGE DOESN'T SOLVE MANYACCESS PROBLEMS; *especially for adults !*

Even in states where Medicaid has been expanded to include dental care, people are still struggling to find a dentist. "Translating Medicaid coverage into care is a significant problem

" Dental Access Project Director David Jordan says in *USA TODAY*, "The number of adults on Medicaid who are able to see a dentist is woefully short of where it needs to be."

Challenges Remain

- Dentists and professional dominated licensing boards are highly resistant to new workforce models
- State and federal public program spending is decreasing
- State and local public health infrastructure decreasing
- Loopholes in the ACA leave gaps in dental coverage
- Federal payment systems (Medicaid, Medicare) have less than a 9% impact on the private dental practice market
- Little leverage for governmental incentive or enforcement
- Many states resist expanding Medicaid and participating in the ACA
- *The Safety Net health system is already stretched!*

Challenges for the Safety Net in Rural Settings under the ACA

- Many state scope of practice laws limit the reach of the existing or potential expanded workforce
- Reimbursement policies restrict who can provide care
- Telehealth regulations hamper wider adoption of this technology
- The financial stream for workforce training are misaligned with need
- The ramifications of the change of insurance mix on the safety net is unclear

Issues and Policy Options in Sustaining a Safety Net Infrastructure to Meet the Health Care Needs of Vulnerable Populations
National Academy for State Health Policy

Desperate States Seek Solutions

- Problems in the dental workforce issue have been long standing and resistant to change
- States and local communities are seeking new solutions or abandoning addressing dental care completely
- Market pressures are forcing changes, some good, some not so good……
- Use of “Disruptive Innovations” are rising

Plasticity- an emerging health trend?

- FutureDocs Workforce model factors in "plasticity"
- "Plasticity lets you think about who can deliver a set of services and allow different configurations in different communities for those services."
- "Using this model (FutureDocs) to look at demand and what the workforce looks like, and using plasticity to see if I can use a *less-expensive workforce*."

HealthLeaders Media

http://www.healthleadersmedia.com/page-1/COM-308229/FutureDocs-Workforce-Model-Factors-in-Plasticity (accessed February 18, 2016)

Building Momentum

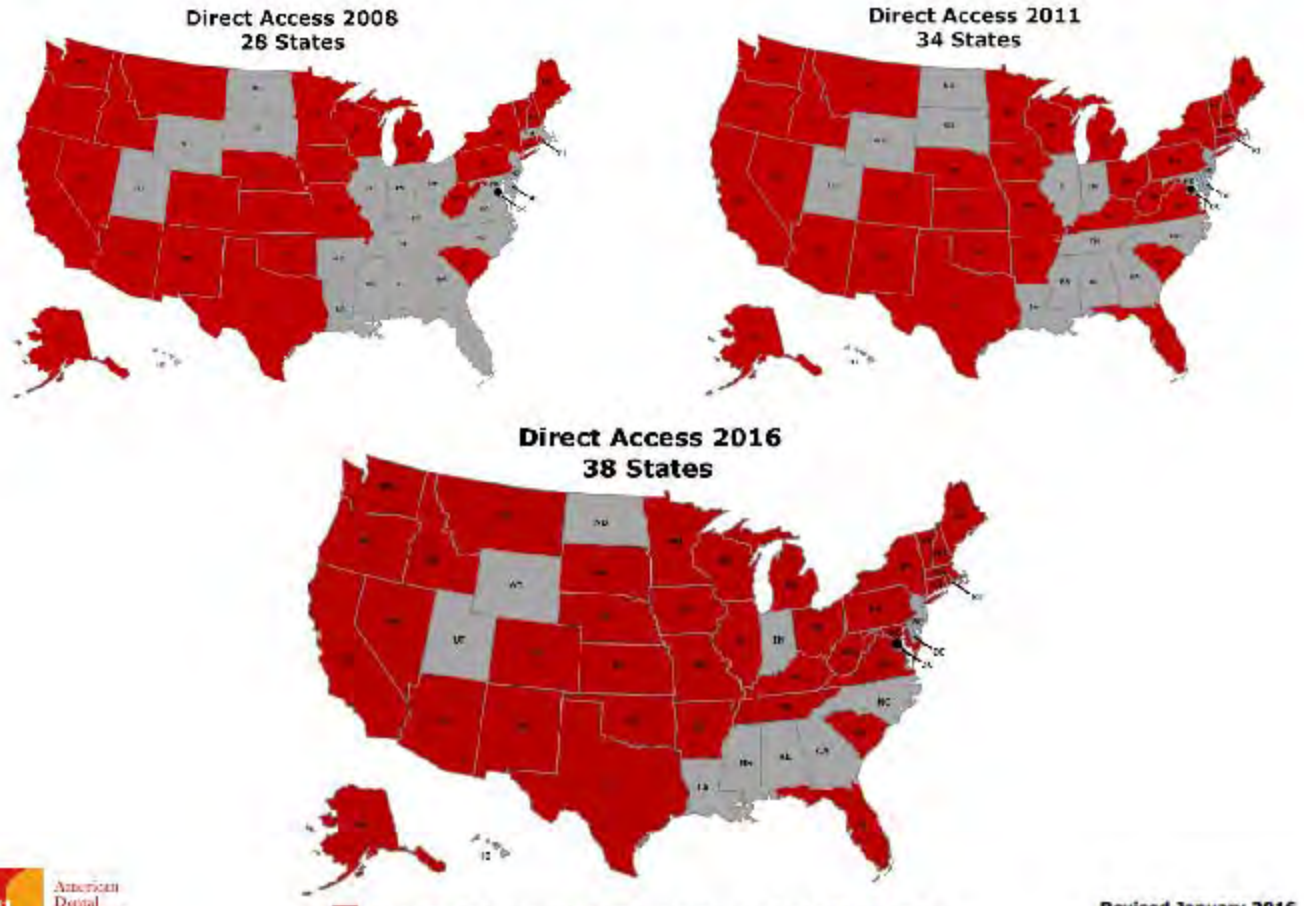
- On February 6, 2015 the Commission on Dental Accreditation (CODA), voted to adopt national dental therapy training standards
- *Standards approved by CODA - August 2015*

Challenging Old Traditions

National Policy Notes

- **SUPREME COURT RULES ON NORTH CAROLINA DENTAL BOARD**
  - On February 21, the U.S. Supreme Court made a decision that has implications for dental board oversight across the country. As one reporter in *USA TODAY* sums it up, *"Dentists can make your teeth sparkling white, but they can't decide who else can."*

The Progression of Direct Access



NATIONAL AND STATE-LEVEL PROJECTIONS OF DENTISTS AND DENTAL HYGIENISTS:

HRSA brief and Community Catalyst's summary, "National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025," provides information on national and state projections on the supply and estimated demand for dentists and dental hygienists from 2012 to 2025.

Dentists

a) Nationally, increases in supply ***will not meet the increases in demand*** for dentists, which will exacerbate the existing shortage.

i) The supply of dentists is expected to grow by 11,800 full-time equivalents (FTEs) – from 190,800 in 2012 to 202,600 in 2025 – a 6 percent increase nationally.

ii) The national demand for dentists is projected to grow by 20,400 FTEs – from 197,800 in 2012 to 218,200 in 2025 - a 10 percent increase.

"IT IS AN EXCITING TIME AS COMMUNITIES BEGIN TO EXPLORE AND IMPLEMENT THEIR OWN SOLUTIONS IN THE ABSENCE OF ADEQUATE PROFESSIONALLY DRIVEN SOLUTIONS." -ROBERT "SKIP" COLLINS DMD, MPH

Planning and Oral Health Future Medscape Jan.9, 2013

The Emerging Oral Health Emphasis Needed by the States

- Prevention, early detection, and behavioral modification
- Interdisciplinary case management
- More flexibility in deployment and better use of allied dental providers
- Less post-disease repair
- No one size fits all – individualized care
- Risk based treatment protocols
- Dental providers trained with a mission and appreciation of public health values

"Change is Coming!"

- Primary Drivers:
  - Costs of health care delivery
  - Increasing poverty and population demand
  - Marketplace adjustments
  - Expanding use of Safety Net delivery systems
  - Need for more efficiencies at lower costs
  - Changing practice models
  - Emerging cooperate practice, MCO and ACO models: emphasis on integrated managed care

More Steps……

- Case management and care coordination must be enhanced to increase health delivery network in rural settings
- Regulations on the use of telehealth and payment systems must allow remote case management between a provider and extended dental workforce deployed in the rural communities
- Flexible interdisciplinary care teams inclusive of dental services must be developed and expanded in non-traditional locations and methods to engage the public
- Dentists trained as health managers within an interdisciplinary system of primary health care

Bob Russell, DDS, MPH
State of Iowa Public Health Dental Director
515-281-4916
e-mail: bob.russell@idph.iowa.gov

Forging a Dynamic Future from a Frustrating Present: Re-Envisioning State Oral Health Program Leadership

Jack Dillenberg, DDS, MPH
Dean, Arizona School of Dentistry & Oral Health
A.T. Still University
Mesa, Arizona

The Present Health Care System: Where are we?

- Oral Health a critical component of overall health: True or False?
- Prevention of oral diseases
  - Available
  - Inexpensive
  - Under utilized – poor success with oral cancer
- Providers – Who? What? Where? When?
- Innovation and Technology – beyond esthetics and clinical advances

Some Oral Health Facts

- 60-90% of school children and nearly 100% of adults have dental cavities
- About 30% of people aged 65-74 have no natural teeth
- Severe periodontal disease is found in 15-20% of adults 35-44 years

Signs of a Broken Oral Health System

- Emergency room visits have increased for oral health
- Reimbursement systems allow patients to see a physician –very little/none to see a dentist
- Few collaborative approaches link medical and dental health

Current Dentist Workforce

- Current dentist workforce is aging – almost 40% over 55 years of age
- Many U.S. states report that fewer that one half of dentists treated any Medicaid patients

- Sixty percent of dentists ages 44 or below are women
- Dental school debt influencing career choices

Change is good.

You go first.

A.T. STILL UNIVERSITY ATSU

The Three Aims for Better Health

- Better Care
  - Patient Safety
  - Quality
  - Patient Experience

- Reduce Per Capita Cost
  - Reduce unnecessary and unjustified medical cost
  - Reduce administrative cost thru process simplification
- Improve Population Health
  - Decrease health disparities
  - Improve chronic care management and outcome
  - Improve community health status

Current Health Delivery Models

- Medical Home
- Dental Home
- Behavioral Home

Future = Health Home = New Oral Health Provider

1%

Only 1% of professionally active dentists in the U.S. dedicate their career to serve Health Center patients

Source: Numbers based on 2006 data; report by the National Association of Community Health Centers (NACHC)

2014 Health Center Oral Health Data

- 4.78 million dental patients served
- 15.6 million dental visits
- 71% of patients are below the poverty line

Source: http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014

ER Seeing Increase of People Visiting With Dental Problems

ADA News July 15, 2013

Authors: Thomas Wall, M.A., M.B.A.; Kamyar Nasseh, Ph.D.

Emergency department (ED) visits for dental conditions are increasing, driven primarily by a larger share of dental visits taking place in EDs rather than dental offices.

Decreases in private dental insurance coverage among young adults combined with significant reductions in adult dental Medicaid programs have created a financial barrier that could have led to a substitution of dental ED visits for dental office visits.

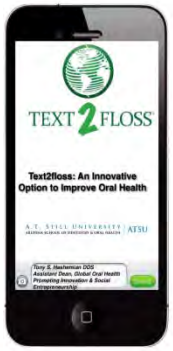
Needs of Special Care Patients

- Intellectually Disabled
- Medically Complex
- Elderly
- Physically Disabled – Homebound
- Poverty - Homeless


off the mark.com
by Mark Parisi
YOU SHOULD TAKE BETTER CARE OF YOUR TEETH. YOU CAN'T GET BY ON BRUSHING ALONE.
OK, DOC.
MARK PARISI
ATLANTIC FEATURE © 2010 MARK PARISI
offthemark.com

Text2floss: An Innovative Option to Improve Oral Health

In 2011, A.T. Still University (ATSU) devised a series of text message programs designed to reach, educate, and remind current patients about preventive and ongoing initiatives of health and wellness.



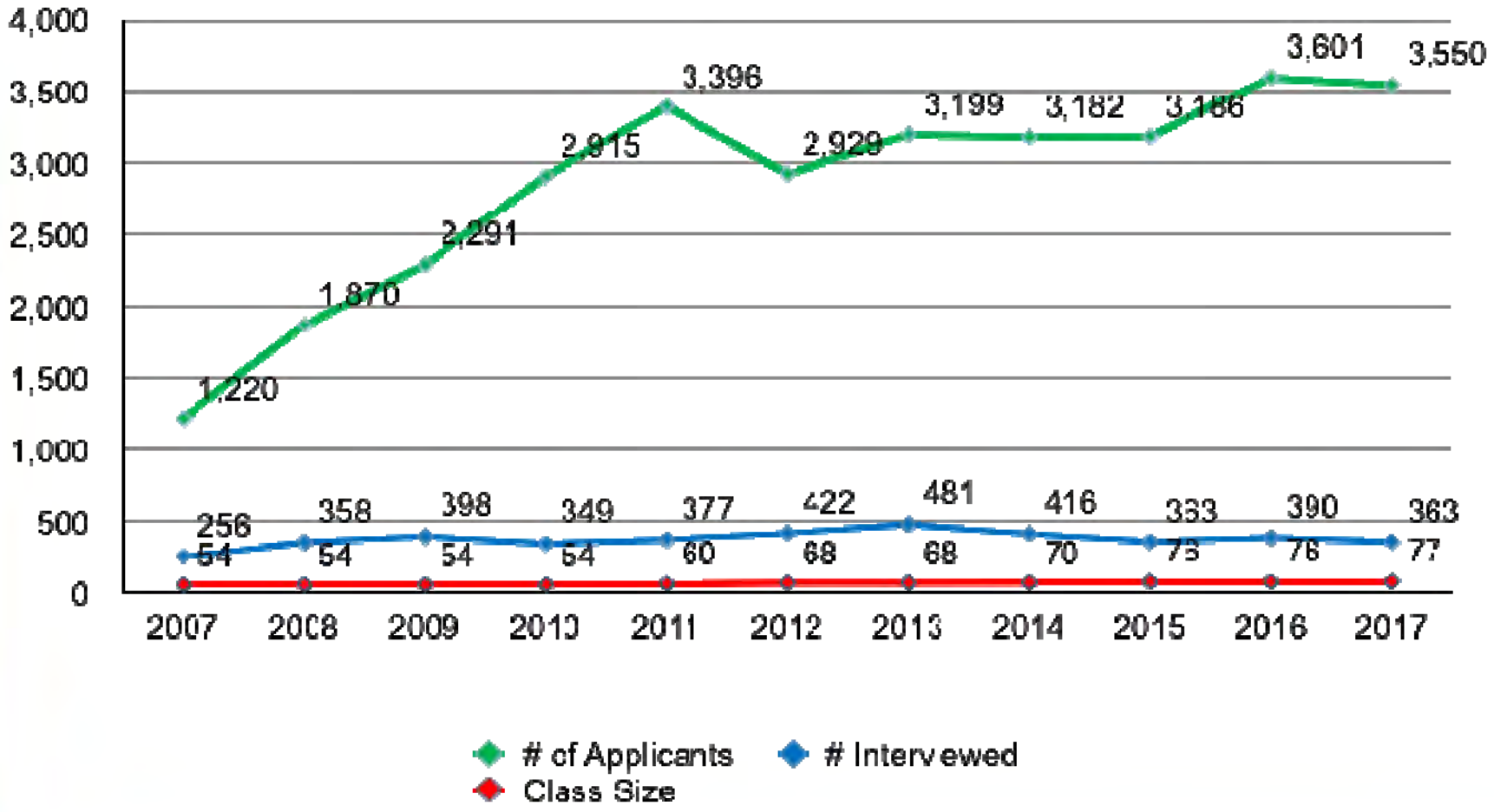
Leadership Requires Courage and Discipline

A.T. STILL UNIVERSITY ATSU

The Future of Our Profession

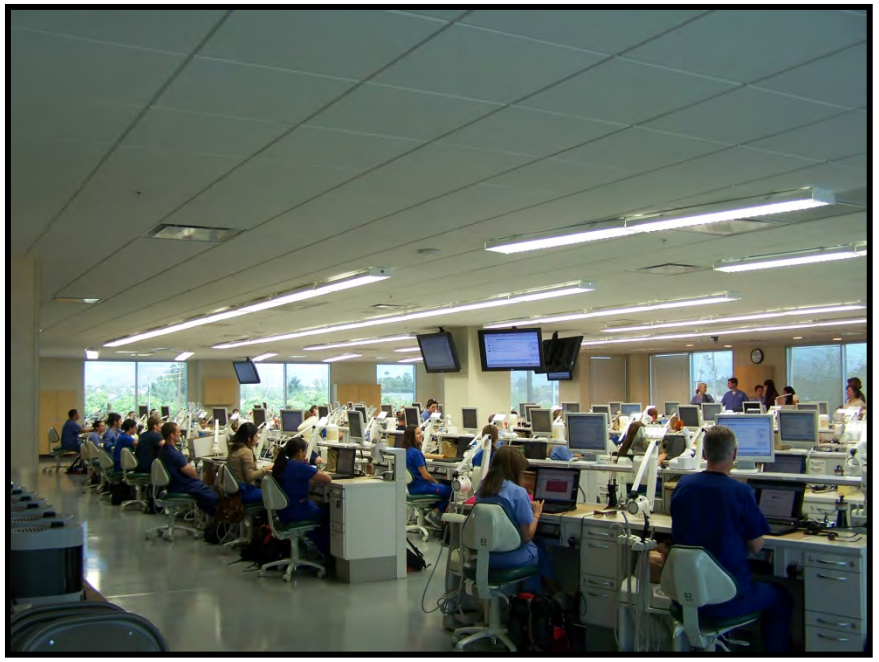
A.T. STILL UNIVERSITY ATSU

ASDOH Admissions (by class)



Innovative Curriculum

- Nurture students and provide Community service
- Condense/Modularize Basic Sciences
  - save time and money
- Initiate Simulation early
- Integrate technology
  - I Pads, etc.
- Interprofessional Collaboration



iconnect

A PUBLICATION OF COMMUNICATIONS & MARKETING

your online connection to all things ATSU

news students faculty/staff alumni

ASDOH and ASHS' PA students participate in IPE program

March 22 2013 | events, student headlines, university headlines

No Comments

Students from A.T. Still University's Arizona School of Dentistry & Oral Health (ATSU-ASDOH) and ATSU's Arizona School of Health Sciences physician assistant (PA) program came together on Feb. 14 to participate in an interprofessional education (IPE) program. With a growing oral health disparity in the United States, ATSU-ASDOH students recognized that PAs could be very beneficial in improving the oral health of children in underserved communities.

During the IPE, ATSU-ASDOH students taught the Smiles for Life curriculum to PA students. The Smiles for Life program is endorsed by the American Dental Association and is a national oral health curriculum that comprises basic oral anatomy and oral pathology. Additionally, PAs were taught how xylitol is used in deterring caries, how to screen for oral cancer, and the importance of fluoride through the application of fluoride varnish.

Interprofessional Education

Fri 14 Dec 2012

ATSU holds Interprofessional Education Competition

Posted by grubenstein under Events, Students

No Comments

The inaugural A.T. Still University (ATSU) Interprofessional Education Collaborative Case Competition (IPE-CCC) was held Saturday, Dec. 1. Seven teams of students representing nine programs from ATSU's Arizona and Missouri campuses and Arizona's Grand Canyon University (GCU) nursing program participated. Each team presented an analysis of a hypothetical case to judges on both ATSU campuses via interactive technology.

Prizes of $2,500, $1,500, and $1,000 were awarded to the top three teams. First place was awarded to Stephen Leonard, PT, '14; Caroline Lindsey, AuD, '16; Rebecca Tansey, D2; and Mariam Ter-Stepanian, OMS II.

- Collaborative Case Competition
  - provides students the ability to demonstrate an understanding of other health professions
  - promotes a team approach to patient care and health care management

Student 4th Year Rotations

- "Real World Community Dental Experience"
  - Partnerships with Community Health Centers
  - 68 sites throughout United States
  - Serve underserved in Whole Person Health Environment
  - Inter Professional Experience

Bethel, Alaska

ASDOH Graduates

- 72% reported that before entering dental school, one of their professional objectives was to treat underserved populations (or in an underserved area)
- 57% graduated with more than $250,000 in debt
- 58% reported that debt influenced their practice choice with most of those responses pointing to the ability to get loan repayment as a reason for working in a community based setting

Source: Zoomerang survey of ASDOH Graduates (Class of 2007-2010), Jan. 2011; 45% response rate.

ASDOH Graduates

- 78% of graduates serve Underserved patients
- 94% of graduates strongly agree that ASDOH prepared them to treat patients from socio-economically disadvantaged backgrounds
- 83% of graduates strongly agree that ASDOH prepared them to treat patients with disabilities

Source: Zoomerang survey of ASDOH Graduates (Class of 2007-2010), Jan. 2011; 45% response rate.

Jack's Suggestions for Good Leadership

1. Work at something you enjoy and that's worthy of your time and talent

2. Give people more than they expect and do it cheerfully

3. Become the most positive and enthusiastic person you know

Jack's Suggestions for Good Leadership

4. Be forgiving of yourself and others

5. Be generous

6. 

Have a grateful heart

Jack's Suggestions for Good Leadership

7. Persistence, persistence, persistence

Image from: http://showmeyourindies.com/indieflix/indieflix-blog/the-tortoise-and-the-hare-being-a-filmmaker-in-an-ever-changing-world/

Jack's Suggestions for Good Leadership

8. **Be loyal**

9. Be honest

10. **Be bold and courageous**

When you look back on your life, you'll regret the things you didn't do more than the ones you did.

A.T. Still University
ATSU

- Each year over 5 million people visit the Grand Canyon
  - 95% of those visitors arrive in a bus, a train or a car, go to the rim, are appropriately impressed, buy a souvenir and leave within 2 ½ hours

- 5% of those visitors actually make a trip below the rim

A.T. STILL UNIVERSITY ATSU

- Only 1% ever make the effort to go to the river and discover that it is a pretty spectacular place to be

A.T. STILL UNIVERSITY ATSU

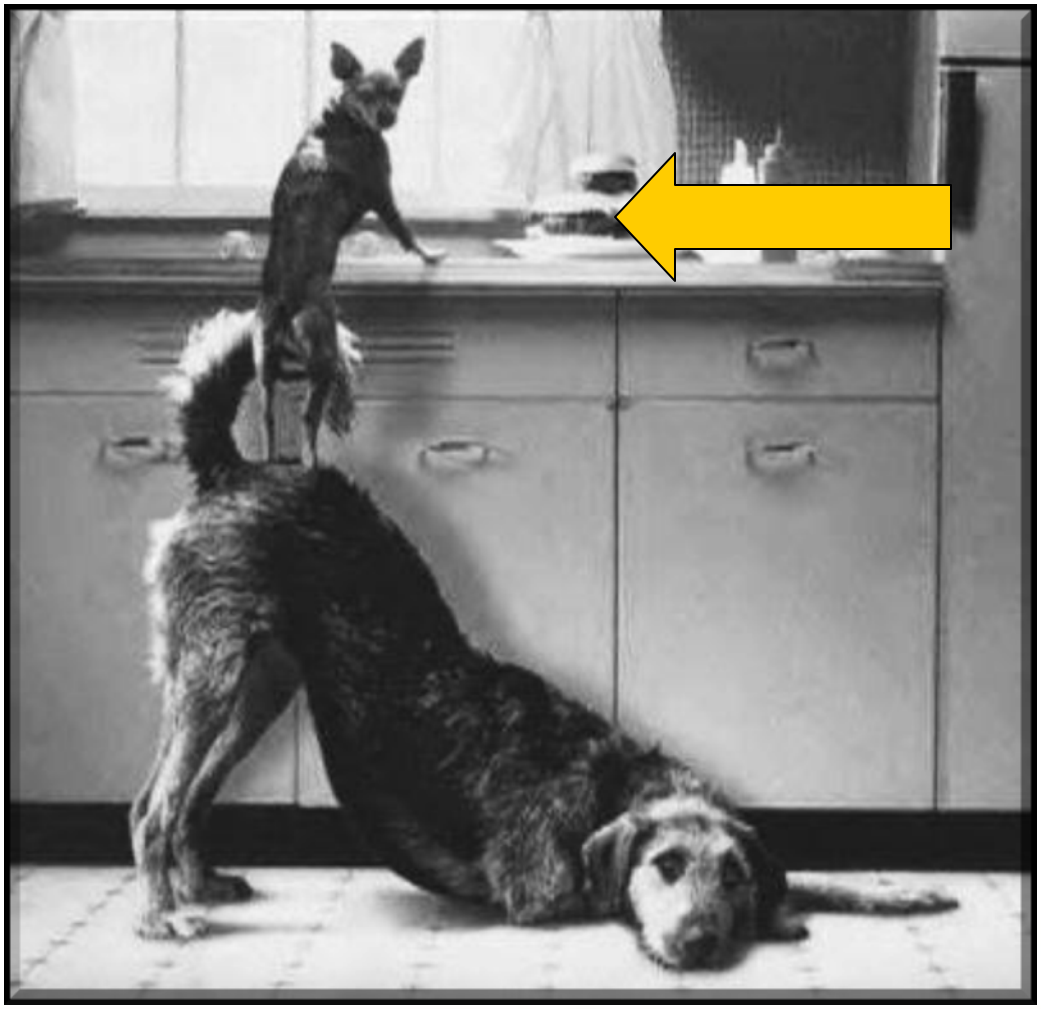
The Access to care problem will not be helped simply by graduating more dentists who go places that 99% of dentists have always gone

We need to graduate more 1%ers

Those who are willing to go where 99% of the dentists don't want to go, and find out that it is a pretty spectacular place to be

A.T. STILL UNIVERSITY | ATSU

Team Work



A.T. STILL UNIVERSITY ATSU

ADHA White Paper

September 2015: ADHA released a white paper "Transforming Dental Hygiene Education and the Profession for the 21st Century."

•Key topics of the paper

- Current state of dental hygiene education
- Access to care crisis
- Direct access (38 states)
- Dental therapy education standards
- Utilization of dental hygienists in underserved populations, specific examples from CA, KS, & OR
- ADHA's national research agenda
- The role of dental hygiene educators including pilot projects at Eastern Washington University and Vermont Technical College

Transformational Outcomes

Added Bioethics as a required course. This was originally an elective.
Expanded Community Oral Health (COH) course to be two semesters instead of one (COH I and COH II). COH I focuses on classroom instruction. COH II requires students to complete a community–based outreach project.
Added two semesters of weekly 90-minute clinical seminar lectures. This provides for increased lecture time for ethics, personal responsibility, leadership, advocacy, advanced instrumentation skills, motivational interviewing, cultural competence**, interdisciplinary work models,** alternative practice settings, and evidence-based decision making/critical thinking.
Implemented an Interprofessional Education format which includes: Business/Practice Management, Affordable Care Act, Health Informatics, Electronic Health Records, Interprofessional Education and Interprofessional Practice, Advocacy**, Leadership** .
Expanded practice management content to include tracking, analyzing, and implementing steps to improve productivity in the clinic.
Deleted a dental anatomy lab course and replaced it with a new course entitled: Oral Health Literacy.
Decreased the number of credits for Nutritional Counseling and added a course entitled: Interprofessional Education.
Added Leadership/Health/Policy/Advocacy/Ethics/Law.
Added Practice/Business Management/Risk Management.
Removed topics that are only tested on the national boards, but not clinically relevant. Plan to provide handouts to the students on those topics.

A.T. STILL UNIVERSITY ATSU