NATIONAL ACADEMIES Sciences Engineering Medicine

Breakout Groups: Exploring Value Propositions

Group 2. Value Proposition through the lens of Interprofessional providers/educators (Room LL19B)

Leads: Jeffery Stewart & Cynthia Lord

Staff Support: Julie Pavlin

List **3 pains** that are most significant for interprofessional educators and providers. Explain why

PAIN	RATIONALE FOR INCLUDING
1. Inability to change federal/state policies. No valid research data that a different model of providing oral health care in a medical setting would have an impact on patient care.	Schools aren't incentivized to teach oral health since there is no evidence it improves patient outcomes.
2.Siloed care: medical care and dental care gap – need to be geographically in the same place, working together, to understand the benefits and patient needs.	Need integrated medical/dental care for the best patient outcomes.
3. Systems issue – documentation, billing, coding, etc. is separate for dental and medical and increases the gap.	Need integrated EHR for the best patient outcomes.

In case there are 2 more pains

PAIN	RATIONALE FOR INCLUDING
4. Interprofessional education – some advances, but a long way to go to work together. Even though health professions accreditation standards require IPE, it does not say how or how much. No standardization of what and how much IPE is being "taught" among institutions.	Schools are not integrated; very siloed– separate medical/dental/nursing/veterinary. Need to start early in a student's educational process. IPE has to be as valued as basic science and clinical medicine. Cannot be considered "optional" or an "add-on"
5. Lack of even basic education across professions, let alone working together. Medical students don't learn about oral health (or very little). Specialists exist for a reason, of course, but still need that interprofessional collaboration.	Need to understand how dental impacts the rest of the body, despite your specialty.

List **3 gains** that are most significant for interprofessional educators and providers. Explain why

GAIN	RATIONALE FOR INCLUDING
1.EHR that integrates with the medical side.	Couldn't communicate without it. (But need to integrate education modules into it – being done at Case Western Reserve now).
2. Students desire to learn from each other.	Facilitates interprofessional collaboration
3. Dental office can serve as a portal into the medical system – blood pressure, blood testing, etc.	Can facilitate entrance into the medical system when problems are identified.
4. Accreditation standards – IPE, caring for patients with special needs, etc. Can align with needs of institution.	Improves overall capabilities.

The Value Proposition is solving pains and enhancing gains for each of the stakeholder segments

What will it take for educators and providers to achieve their top three gains while minimizing the pains?

- Dental professionals should interact with undergrads, etc. (do it EARLY) to help promote the field and relationships between them.
- Provider reimbursements – without this, there is no incentive. Even if health professions students were taught the importance of working interprofessionally, it will depend on the environment/culture they are working in whether it happens in clinical practice.
- Need collaborative spirit and not competition between related specialties (ie, competition between OMF, ENT)
- Scope of practice – need to change and expand (e.g., vaccine delivery). Need policy changes. Expand scope of ability AND scope of attitude!

Will it involve other stakeholder groups? YES

- Professional associations that recommend what it takes to be a specialist.
- Policymakers in each state – dictates what you can test for, etc.
- Patients – if they are convinced oral health is better for their health, they will push for it.
- Recenter on the patient/person.

What is your number one pain for…

- Educators and Students?

- For Providers?

NATIONAL ACADEMIES Sciences Engineering Medicine

Breakout Groups: Exploring Value Propositions

Group 3. Value Proposition through the lens of the payers/policymakers (Room LL20A)

Leads: Marko Vujicic & Donna M. Hallas

Staff Support: Patricia Cuff

List **3 pains** that are most significant for payers and policymakers. Explain why

PAIN	RATIONALE FOR INCLUDING
1. PMT MODELS: Incentive structures are simply reinforcing treating disease rather than rewarding health. Both in pvt and public insurance.	Major driver of provider behavior
2. DATA: lack of usable, actionable and integrated data. Incl. med w/ dental in same record, patient reported outcomes, identifying patients with disabilities.	No data = no info
3. CLINICAL GUIDELINES: Guidelines are needed to change policy. But how to get guidelines for diabetes mgnt to include dental screening?	As much as “doing the right thing” is touted, you need prescriptive directives

List **3 gains** that are most significant for payers and policymakers. Explain why

GAIN	RATIONALE FOR INCLUDING
1. Cost savings	Fiscal impacts rule. Important to provide a financial ROI to enhanced oral health. Not just health care cost savings, but better employment, better life
2. Better care	With the system slowly going toward more of a focus on outcomes, better health is a key value
3. Equity	Finally being recognized as a priority within health care policy in the US. And especially within public insurance programs

The Value Proposition is solving pains and enhancing gains for each of the stakeholder segments

What will it take for payers & policy makers to achieve their top three gains while minimizing the pains?

- Private Insurance – market/sales driven; It needs to sell. Unless dental benefits all of a sudden become much more regulated, this action will only come through $.
- Public Insurance - regulate comprehensive coverage in public programs.
- Regulators – regulate interoperability, incentivize harmonization of records

Will it involve other stakeholder groups?

Yes

What is your number one pain for…

- Payers?
- Policymakers?

NATIONAL ACADEMIES Sciences Engineering Medicine

Breakout Groups: Exploring Value Propositions

Group 1. Value Proposition through the lens of persons with disabilities (Room LL19A)

Leads: Teresa A. Marshall & Daniel W. McNeil

Staff Support: Sarah Flynn

List **3 pains** that are most significant for persons with disabilities and caregivers. Explain why

PAIN	RATIONALE FOR INCLUDING
1. Access / Ability to find care	Ability to find adequate care; transportation/office accessibility; “hidden co-pays”/added costs
2. Demands on caregivers	Burnout; buy-in and prioritization (ex: nutrition)
3. Value of Oral Health Care	Prioritization; understanding importance

List **3 gains** that are most significant for persons with disabilities and caregivers. Explain why

GAIN	RATIONALE FOR INCLUDING
1. Improved quality of life	Acknowledgement impact of oral health on physical/systemic health
2. Advances in materials and technology	Easier delivery of and access to care; teledentistry
3. Progress towards inclusion	Improvements in awareness, acknowledgement, acceptance; change in NIH policies

The Value Proposition is solving pains and enhancing gains for each of the stakeholder segments

What will it take for educators and providers to achieve their top three gains while minimizing the pains?

- Educators to truly train students to be competent providers (time; comfort of educators). Didactic and experiential training. Payment element for providers and education of all providers (medical/dental/etc).
- Educators need to catch-up to students. Persons with disabilities and caregivers involved in education

Will it involve other stakeholder groups?

- Collaboration of all professional groups as well as persons with disabilities and caregivers.

What is your number one pain for…

- Persons with Disabilities and their caretakers?

Achieving Oral Health Equity

National Academies Global Forum on Innovation in Health Professional Education

February 16th, 2024

Minnesota's northern lights

Thank You!

Mike

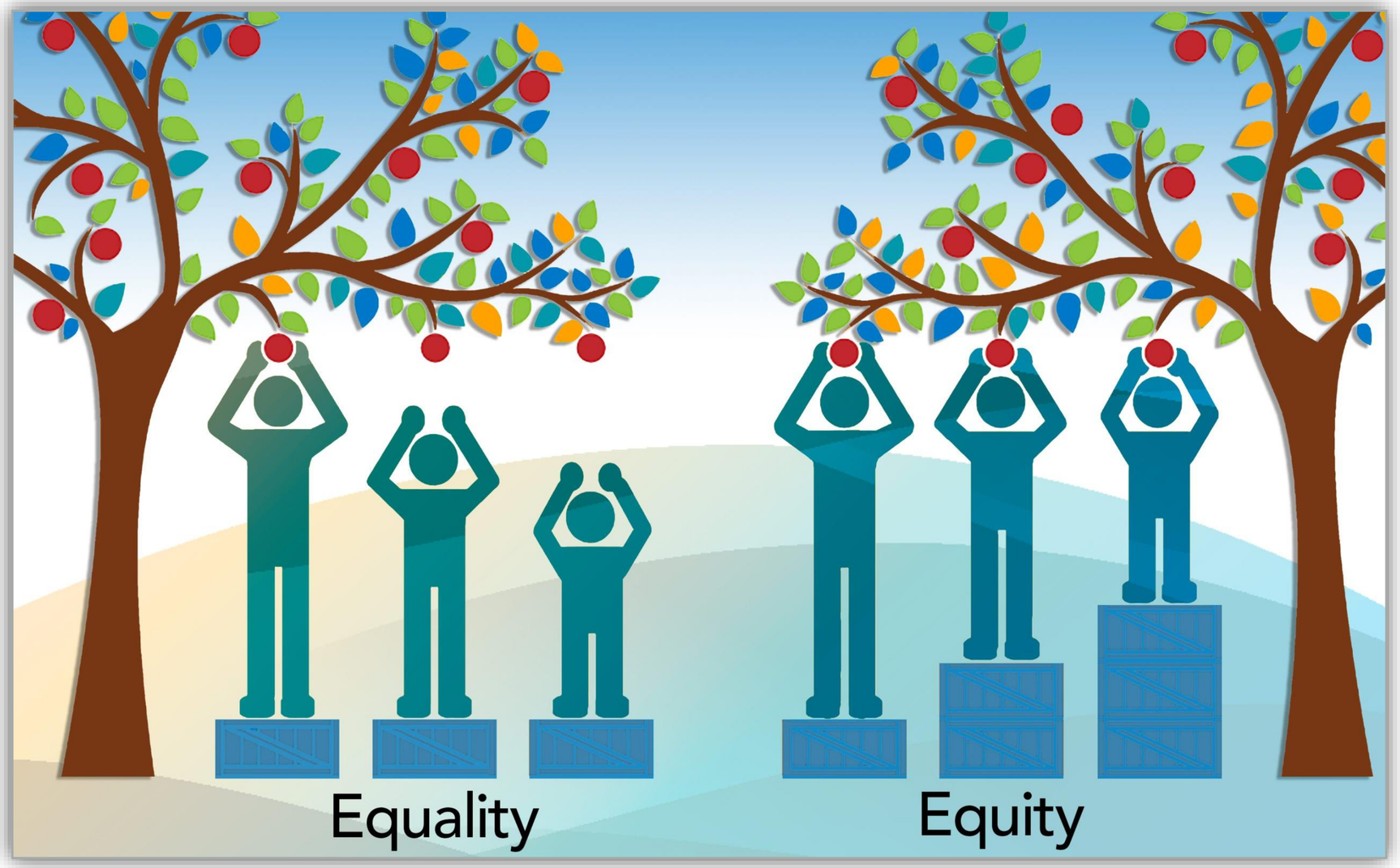
Dr. Michael Helgeson
Chief Executive Officer

APPLE TREE DENTAL
Access • Compassion • Excellence

Agenda

1. **What is Oral Health Equity?**
   - And why is it essential?
2. **How is Apple Tree helping create equitable health care systems?**
   - With our “community collaborative practice” model
3. **How can policy makers help?**
   - By piloting new value-based care models

1. What is Oral Health Equity?



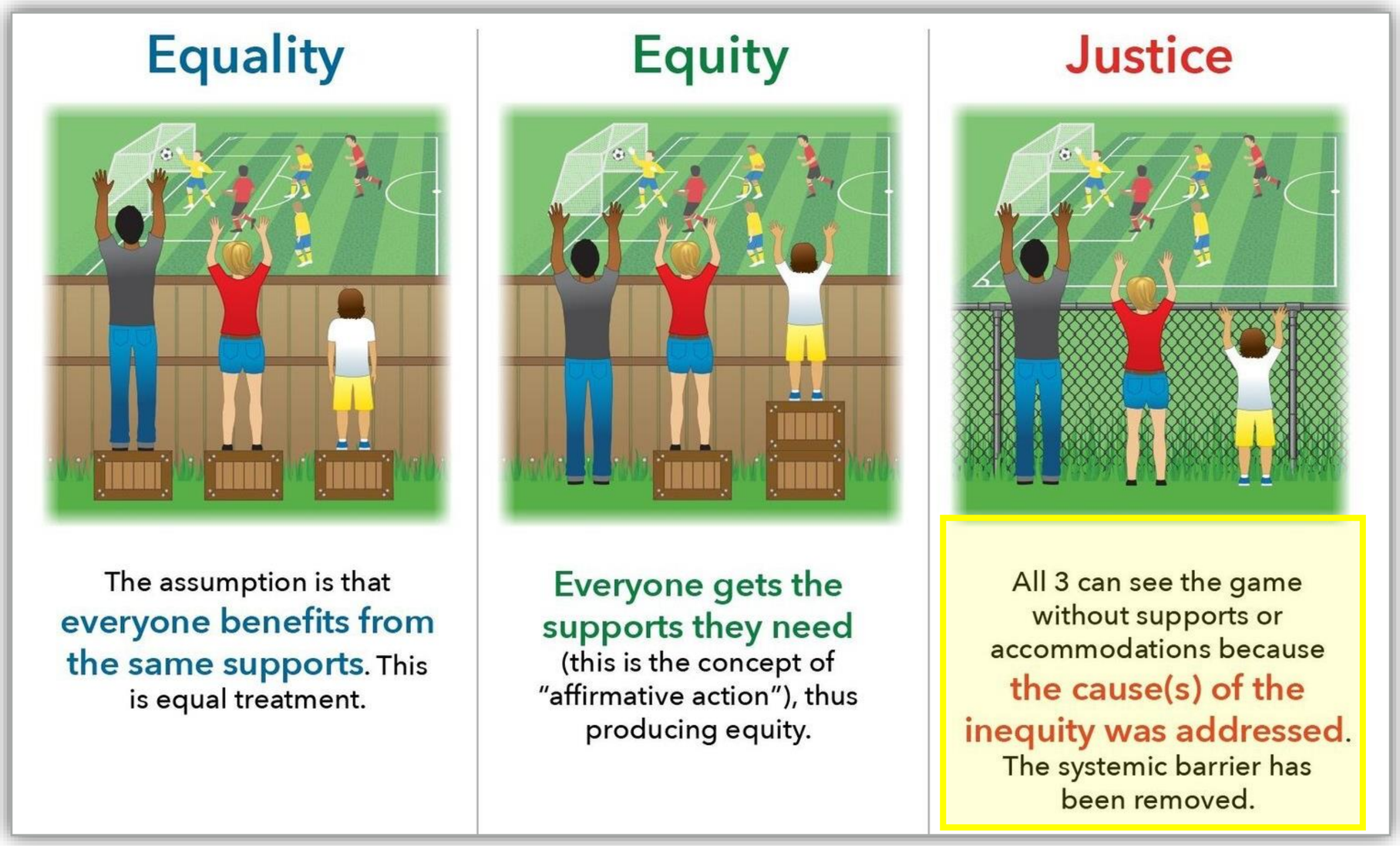
Apple Tree’s definition of “oral health equity"

1. people of all ages and abilities receive equitable oral health services

Oral Health Equity

Isn’t just about equal access, it’s about ***fairness***!

- Equity requires *recognition of the diverse oral health needs* of individual patients and their communities
- *Providers must learn* from patients, their advocates, and each other to provide equitable care
- *Interprofessional teams need to collaborate* in a variety of settings



Apple Tree's goal is oral health justice

1. Removing ***systemic barriers*** to create ***just and equitable*** oral health delivery systems

Oral Health Justice

Is achieved by removing ***systemic barriers …***

- Communities must collaborate to remove barriers to oral health
- Medicaid, Medicare and other public programs must provide *equitable oral health benefits,* tailored for people with special needs
- Increased interprofessional education in real-life clinical care settings is needed to achieve oral health justice

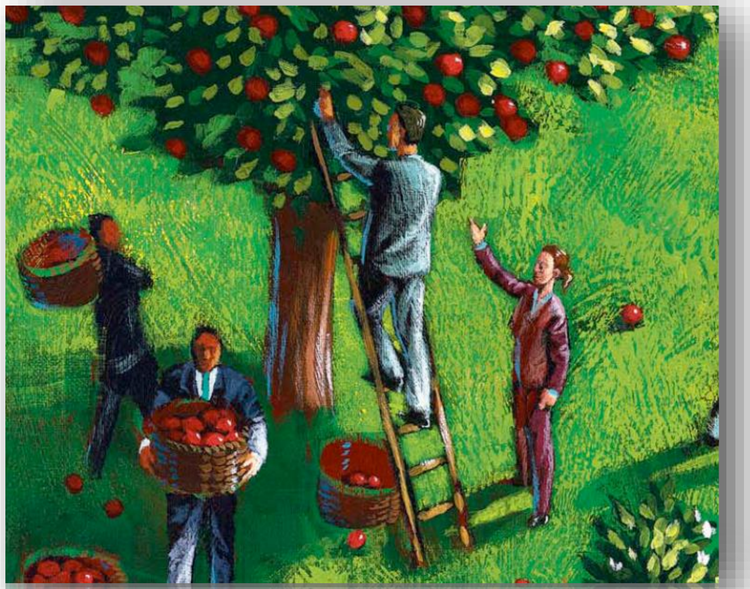
2. How is Apple Tree helping create equitable health care systems?

Apple Tree Dental

Access • Compassion • Excellence

Apple Tree Dental

Access • Compassion • Excellence



Celebrating our 39th year!

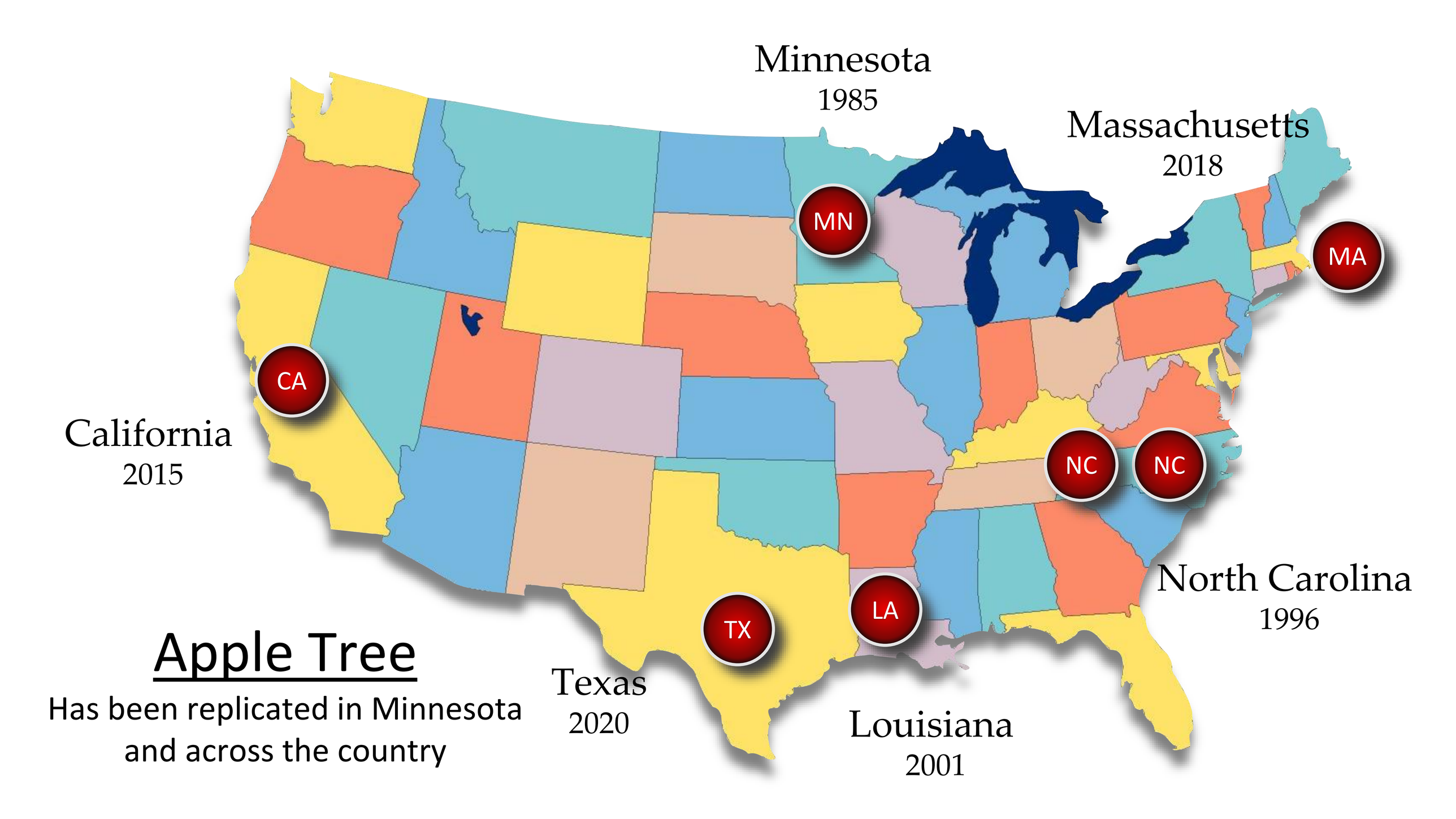
Founded in 1985, we are a nonprofit *Critical Access Dental* provider.

APPLE TREE DENTAL

Access • Compassion • Excellence

Our mission is to overcome barriers to oral health

Our vision is to foster partnerships that create healthy communities



Apple Tree

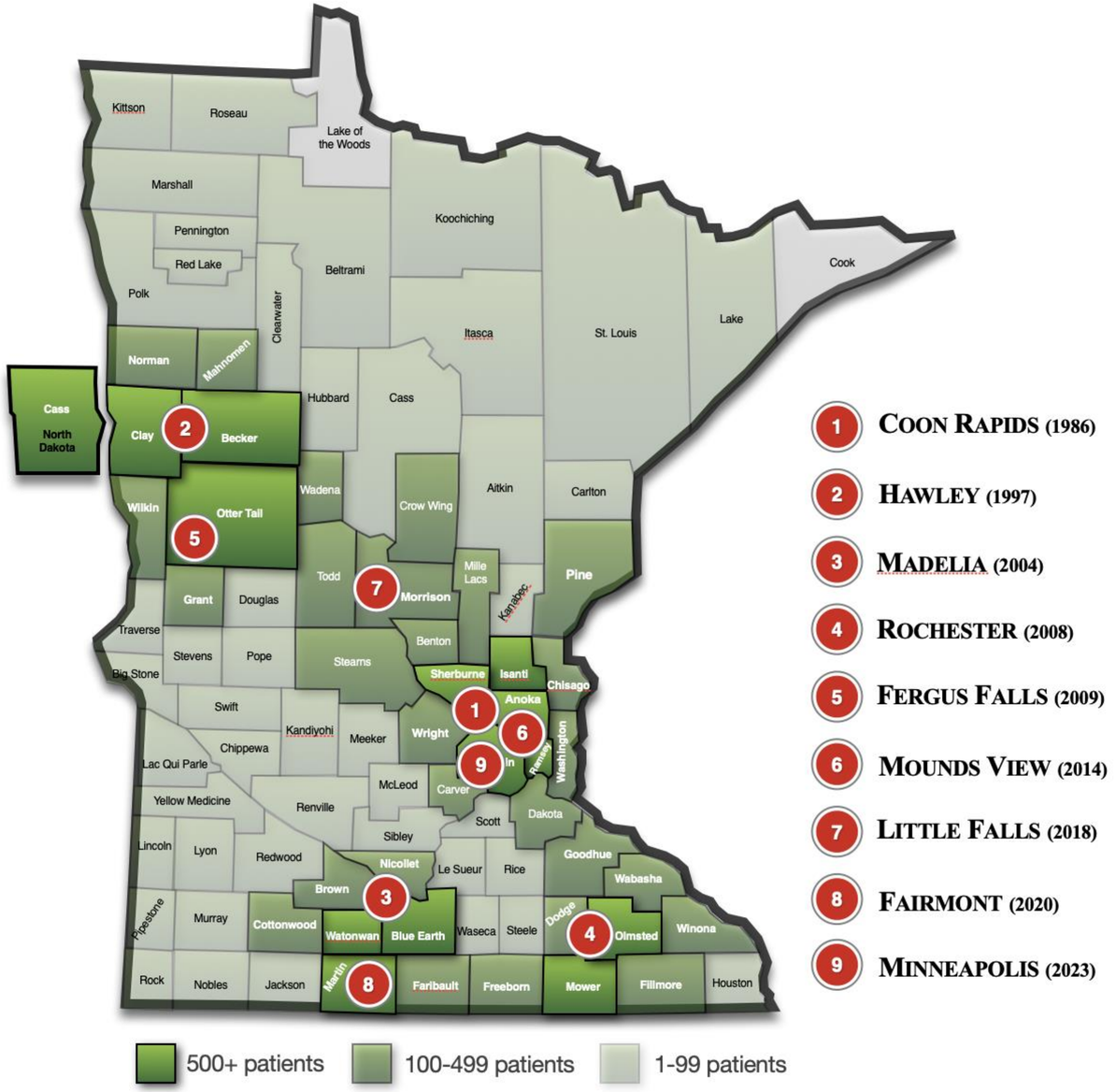
Has been replicated in Minnesota and across the country

Apple Tree operates 9 Centers for Dental Health

and delivers mobile care at 150 community sites serving:

- Low income children and their families
- Adults with disabilities
- Seniors and elders in long-term care

We serve patients from all 87 counties in Minnesota

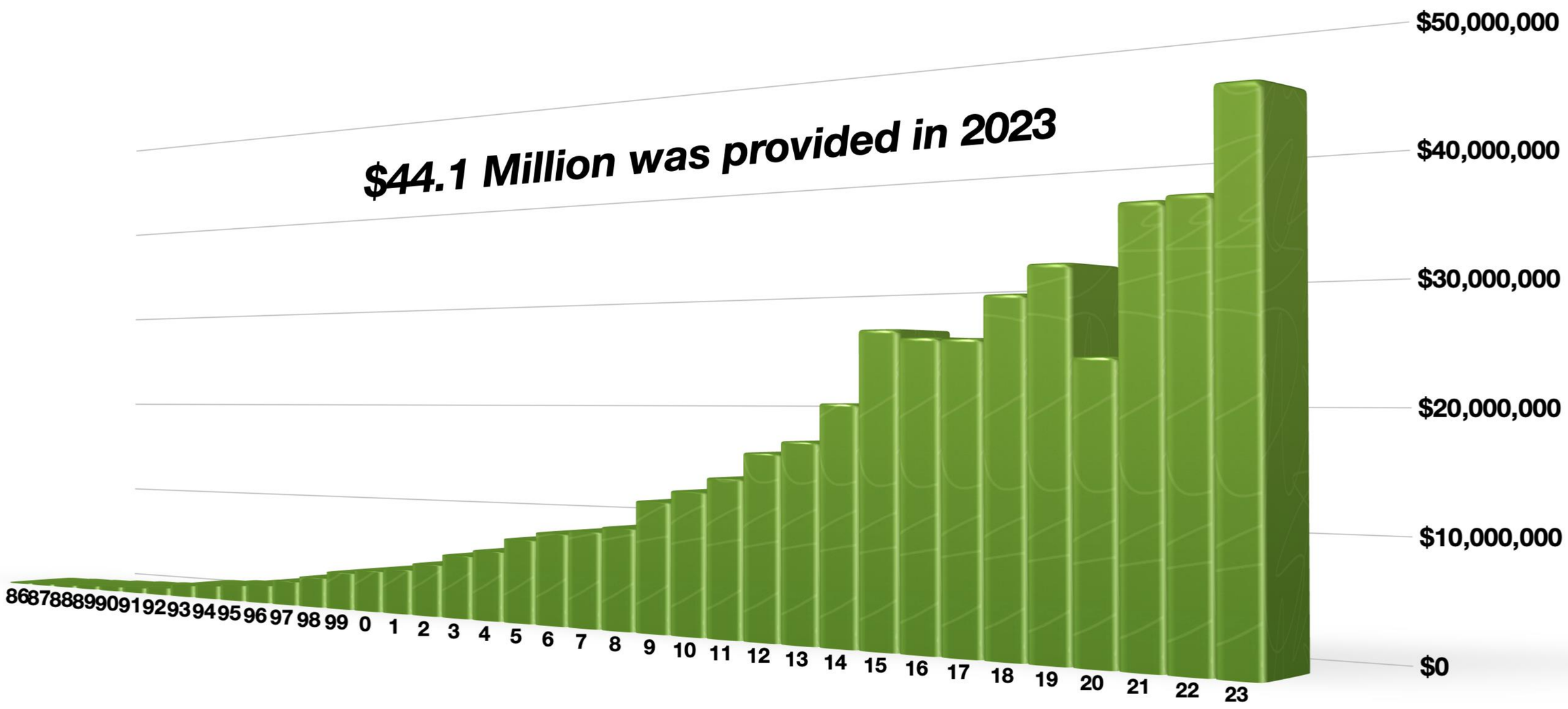


Three of Apple Tree’s Centers are integrated with hospitals and medical primary care, including a Center located within the Mayo Clinic in Fairmont


MAYO CLINIC
HEALTH SYSTEM
Emergency
Clinic
Hospital
Lutz Cancer Center
Urgent Care
Apple Tree Dental


10
11
12
13
14

Apple Tree Service Value: 1986 to 2023



Our Teams

Our Board members have expertise in…

- Nonprofit Governance
- Medicine
- Public Health
- Dental Education
- Long-term Care
- Special Care Dentistry
- HeadStart and Early Childhood
- Banking
- Medicaid
- Advocacy
- Dental Research
- Law
- Epidemiology
- And more…

Our Staff Teams have expertise in…

- Geriatrics, pediatrics, public health and special care
- IV sedation, oral surgery, hospital dentistry
- Prosthodontics and implantology
- Dental education, residency, and student rotations
- Fundraising and nonprofit development
- Public policy leadership and advocacy

By the numbers… Clinical Team

60	Clinical Assistants
44	Dentists
43	Dental Assistants
30	Dental Hygienists
10	Advanced Dental Therapists
5	Dental Therapists
192	**Clinical Team Members**

December, 2023

By the numbers… Support Team

38	Clinic and Community Care Coordinators
20	Corporate Team members
8	Center Directors and Office Managers
8	Transportation and Maintenance
10	Lab Technicians
10	Billing and Collections
94	**Support Team Members**

December, 2023

By the numbers… Grand Total

192 **Clinical Team Members**

94 **Support Team Members**

286 **Apple Tree's Team**

December, 2023

Who chooses to work at Apple Tree?

Apple Tree’s
Centers for Dental Health

Let’s take a 90 second tour of the Mounds View Center for Dental Health

How does Apple Tree help create local oral health delivery systems?

Apple Tree partners with community leaders to help design and launch local programs…

Apple Tree's Community Collaborative Practice Model

Community Collaborative Practice

- Fundamentally an interprofessional practice model
- Actively engaged with other health, education, and social services professionals
- Integrates dental care into health homes

Collaborative Practice in Action…

The Rochester Center


Sarah Crane MD
Mayo Clinic Geriatrician

Dr. Sarah Crane, a Geriatrician

- Saw the impact of oral neglect on her elderly patients, and reached out to Apple Tree
- She helped activate the Rochester community
  - City, County and State Leaders
  - Foundations, Businesses and Other Donors
  - Dental and Medical Society Leaders
  - Long-Term Care and Behavior Health Leaders
  - And many others…
- She lead the fundraising effort to establish Apple Tree's Rochester Eldercare Program

First Impact

In 2008, the Rochester Eldercare Program was launched

Apple Tree's "Multi-Site Delivery Vehicle"

2 Years Later…


MAYO CLINIC
Dr. Sarah Crane
Geriatrician, Mayo Clinic
Medtronic

Second Impact

In 2014, the Rochester Center for Oral Health was launched


973
APPLE TREE DENTAL


973
APPLE TREE DENTAL
APPLE TREE DENTAL
507-424-1040


a-dec

Rochester Center Team

Successful Local Replications Are…

- Driven by passionate local leaders
- Aligned with Apple Tree’s mission, nonprofit structure and values
- Carefully designed with feasibility studies and business planning that fully engage local stakeholders
- Broadly supported within the region and designed for long-term sustainability

Interprofessional Education Experiences

Collaborating educational institutions

Normandale Community College

Minnesota State University Mankato

Northwestern College St. Paul, Minnesota

Hennepin Technical College

Metropolitan State University

Minnesota State Community and Technical College

South Central College

CLC Central Lakes College

Dentistry

ATSU A.T. Still University

M|State

Rochester Community and Technical College

Types of Students

- Practicing Professionals
- Dental Residents
- Dental Students
- Dental Hygiene Students
- Dental Therapy and Advanced Dental Therapy Students
- Dental Assisting Students
- Nursing Students
- Certified Nursing Assistants (CNA’s)
- Personal Care Assistants (PCA’s)
- High School Students


Ashley Johnson, DDS
Director of Equity and Compliance


Apple Tree Dental
Apple Tree Dental
Apple Tree Dental


APPLE TREE DENTAL

Types of Clinical Experiences…

Long-Term Care Experiences

- On-site collaborations with nurses, physical and occupational therapists and other team members
- Care planning with nursing staff, including writing daily mouth-care plans
- Admission screenings and completing the oral and nutritional sections of the minimum-data set
- Physician consultations and coordinated care planning

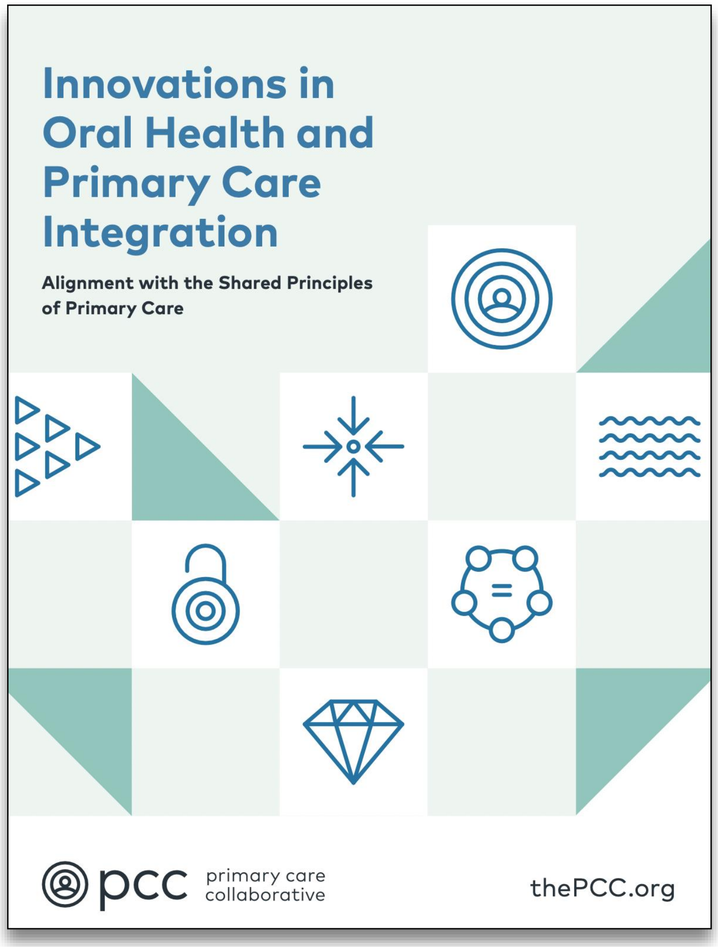
Special Care Dentistry Experiences

- Working with behavioral health professionals, on-site in group homes, mental health campuses, and structured work sites
- Collaboration on behavioral techniques to make routine dental evaluations possible, often avoiding the need for sedation or hospital based care
- Advanced special care services with our team of anesthesiologists and nurse anesthetists


Christine Foulkes, DDS
Director of Special Needs

Medical-Dental Experiences

- Three of our Centers for Dental Health are located within hospitals and medical primary care campuses
- We collaborate with Emergency Departments, Urgent Care staff, and Medical Primary Care providers
- We work with our medical colleagues to incorporate bi-directional referrals for patients with a variety of conditions



3. How can policy makers help?

Continue moving towards “Value-based care”

$$\textbf{Patient value} = \frac{\text{patient-relevant } \textbf{outcomes}}{\textbf{costs} \text{ per patient to achieve these outcomes}}$$

“Value-based healthcare is a healthcare delivery model in which *providers …*

are paid based on patient health outcomes.”

NEJM catalyst

The Value-Based Care journey…

Could lead to a more just and equitable healthcare system

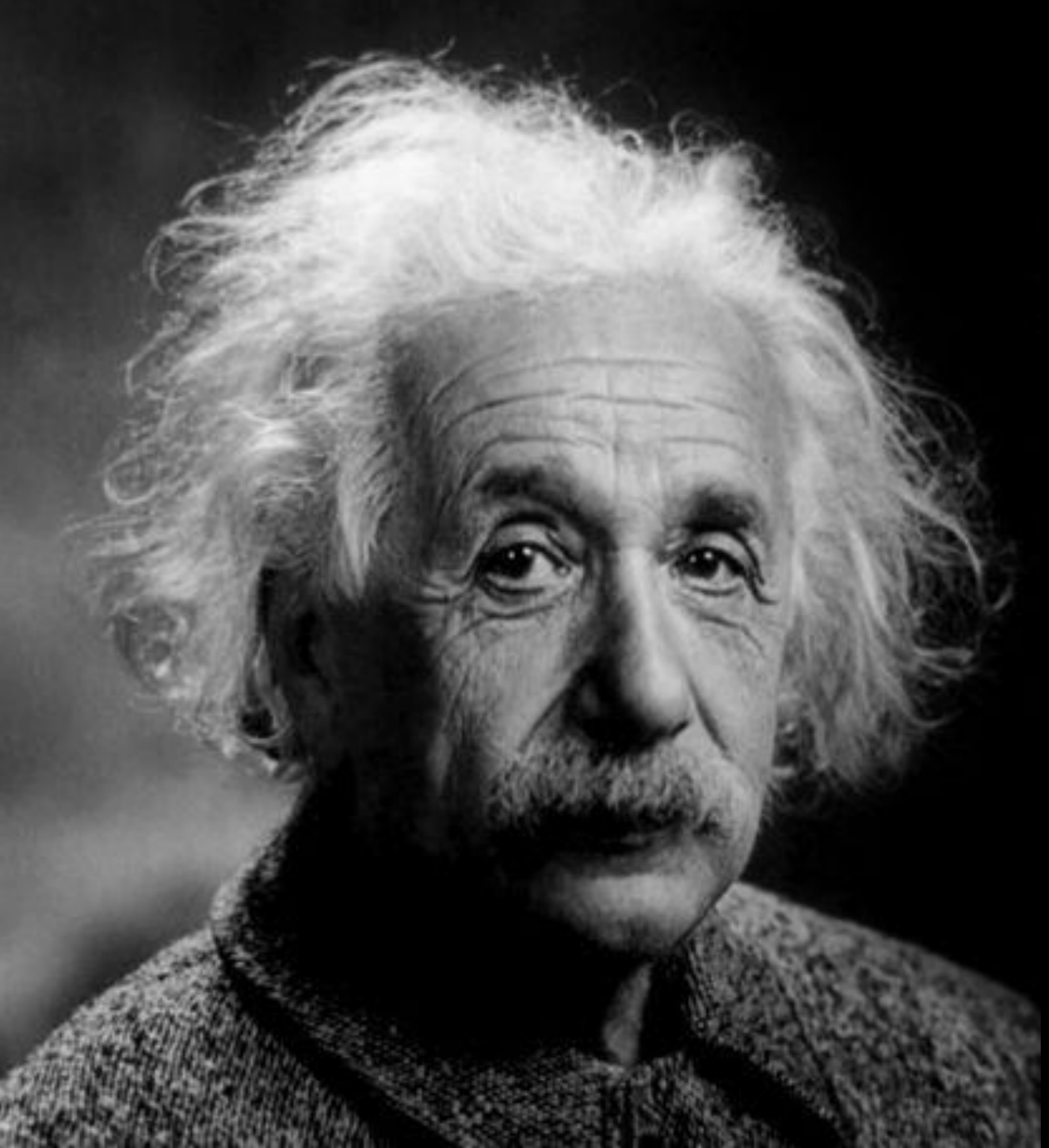
1. Focusing on oral health for people with disabilities and seniors has the best potential for generating total health cost savings and accomplishing the quadruple aim

2. Starting from the current system, and adding special needs dental benefits to Medicaid is great first step

3. Collaborating with early adopters, like Apple Tree on pilot projects can accelerate the journey!

4. Measuring things that matter, along the way is the only way to know if new approaches are working

Measuring things that matter

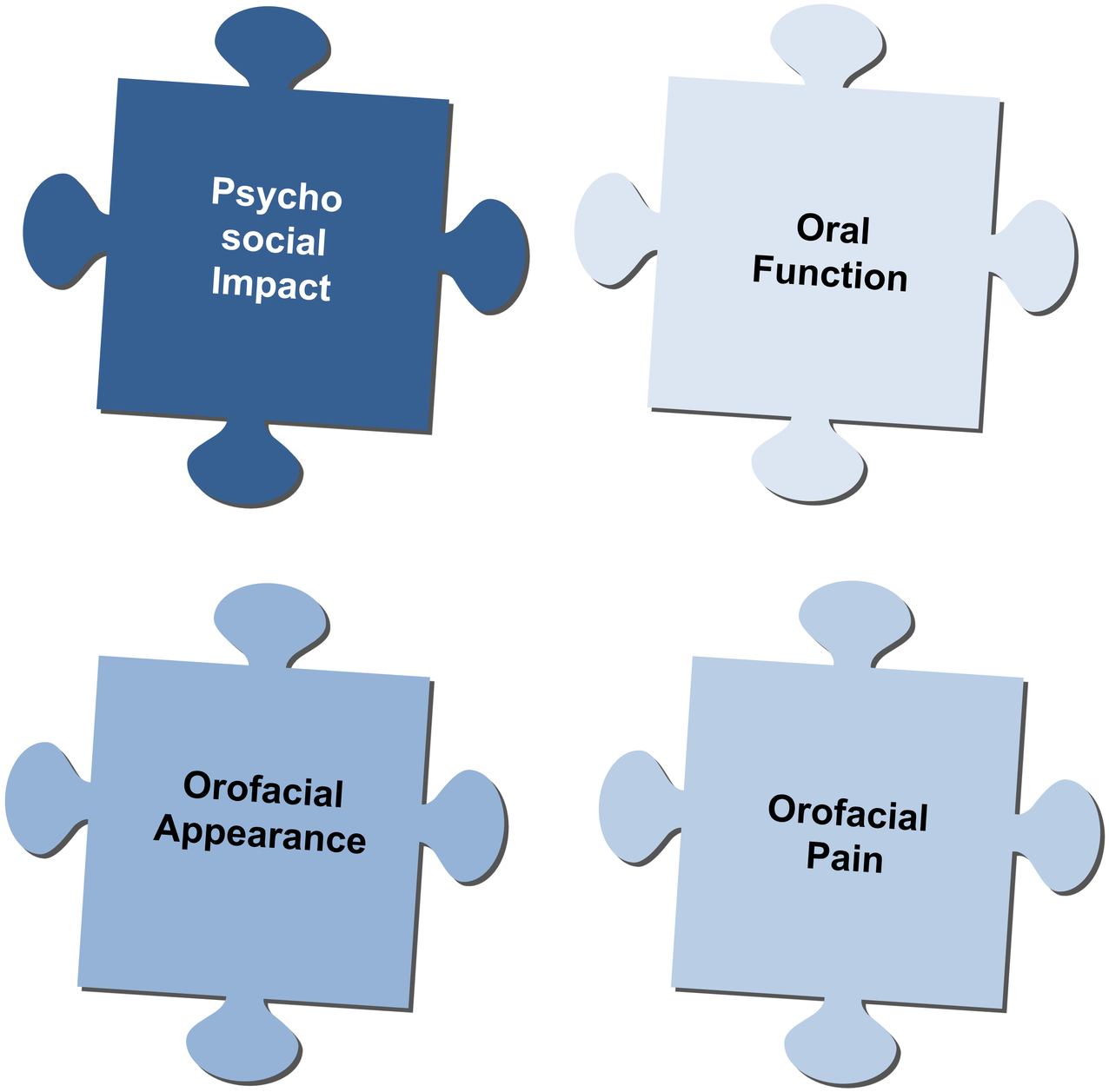


"Not everything that counts can be counted, *and not everything that can be counted counts.*"

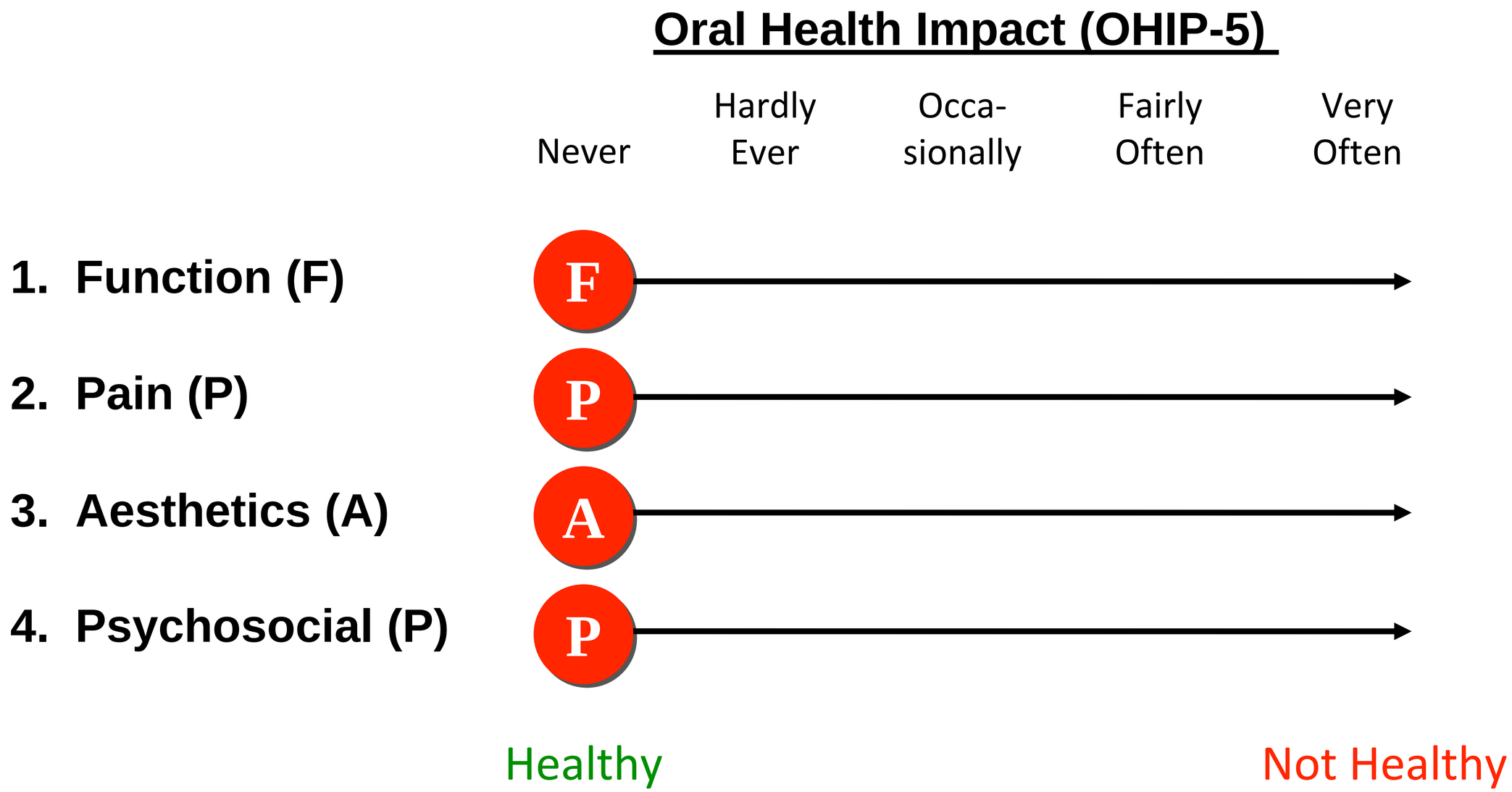
Albert Einstein

The 4 Dimensions of *Patient* Oral Health Outcomes

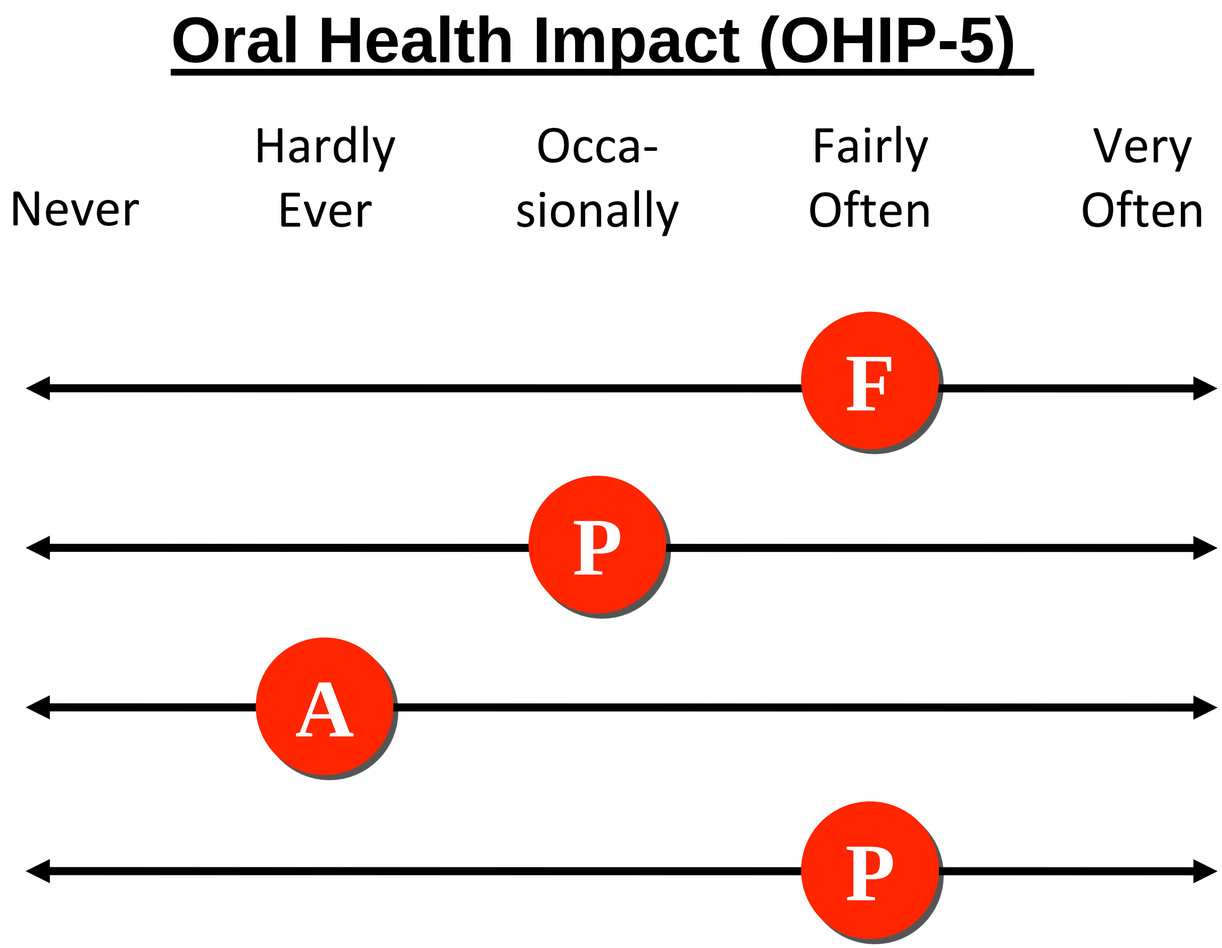
Dr. Mike John



How can we measure oral health?



What is the goal of oral health care?



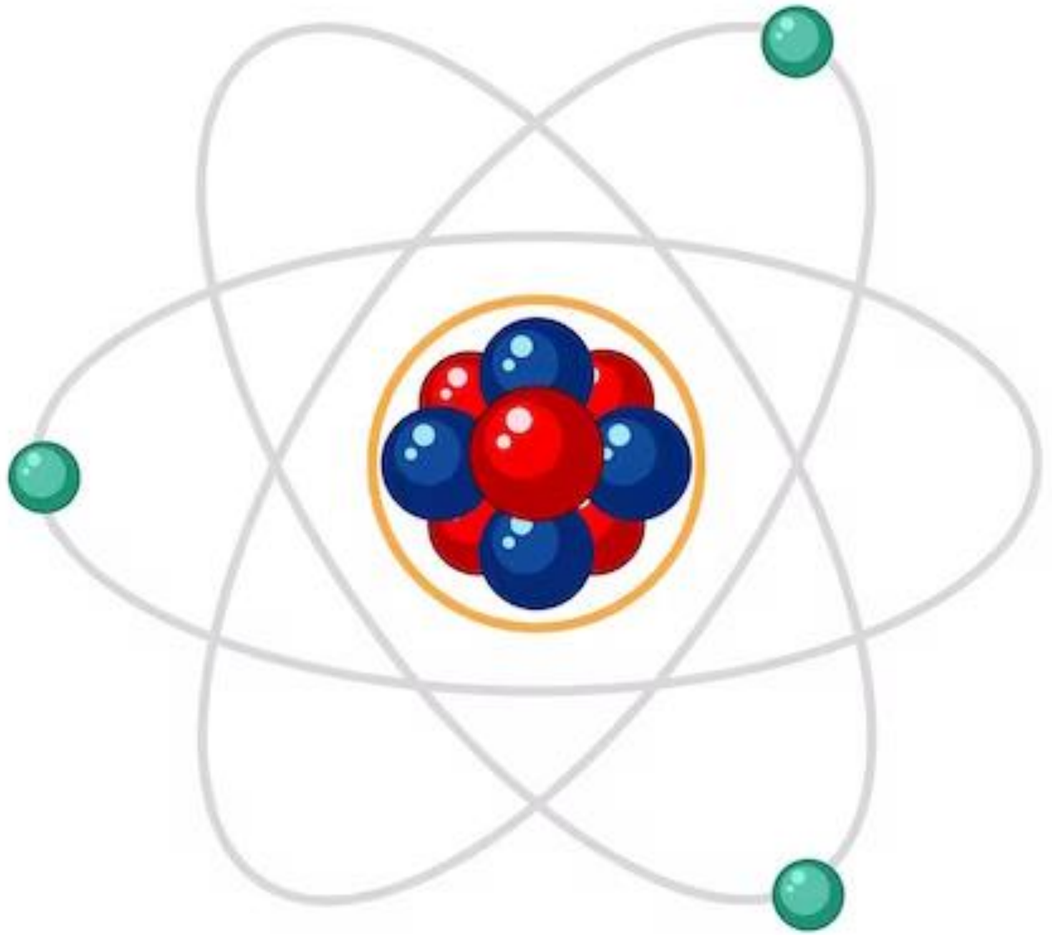
The 4 Dimensions of All Matter

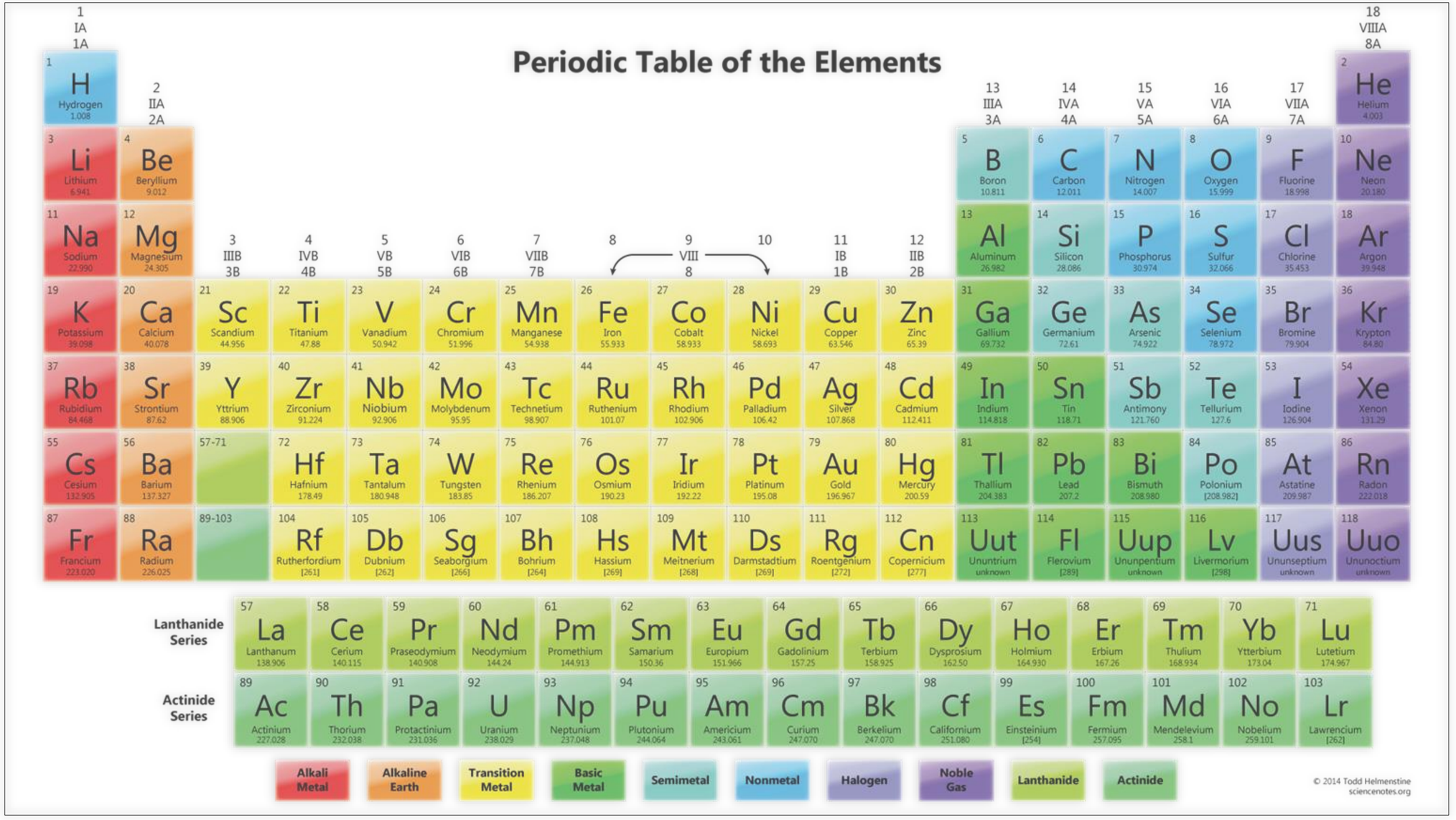
Nucleus

Electron

Neutron

Proton




Periodic Table of the Elements
1 IA 1A
2 IIA 2A
3 IIIB 3B
4 IVB 4B
5 VB 5B
6 VIB 6B
7 VIIB 7B
8
9 VIII 8
10
11 IB 1B
12 IIB 2B
13 IIIA 3A
14 IVA 4A
15 VA 5A
16 VIA 6A
17 VIIA 7A
18 VIIIA 8A
1 H Hydrogen 1.008
2 He Helium 4.003
3 Li Lithium 6.941
4 Be Beryllium 9.012
5 B Boron 10.811
6 C Carbon 12.011
7 N Nitrogen 14.007
8 O Oxygen 15.999
9 F Fluorine 18.998
10 Ne Neon 20.180
11 Na Sodium 22.990
12 Mg Magnesium 24.305
13 Al Aluminum 26.982
14 Si Silicon 28.086
15 P Phosphorus 30.974
16 S Sulfur 32.066
17 Cl Chlorine 35.453
18 Ar Argon 39.948
19 K Potassium 39.098
20 Ca Calcium 40.078
21 Sc Scandium 44.956
22 Ti Titanium 47.88
23 V Vanadium 50.942
24 Cr Chromium 51.996
25 Mn Manganese 54.938
26 Fe Iron 55.933
27 Co Cobalt 58.933
28 Ni Nickel 58.693
29 Cu Copper 63.546
30 Zn Zinc 65.39
31 Ga Gallium 69.732
32 Ge Germanium 72.61
33 As Arsenic 74.922
34 Se Selenium 78.972
35 Br Bromine 79.904
36 Kr Krypton 84.80
37 Rb Rubidium 84.468
38 Sr Strontium 87.62
39 Y Yttrium 88.906
40 Zr Zirconium 91.224
41 Nb Niobium 92.906
42 Mo Molybdenum 95.95
43 Tc Technetium 98.907
44 Ru Ruthenium 101.07
45 Rh Rhodium 102.906
46 Pd Palladium 106.42
47 Ag Silver 107.868
48 Cd Cadmium 112.411
49 In Indium 114.818
50 Sn Tin 118.71
51 Sb Antimony 121.760
52 Te Tellurium 127.6
53 I Iodine 126.904
54 Xe Xenon 131.29
55 Cs Cesium 132.905
56 Ba Barium 137.327
57-71
72 Hf Hafnium 178.49
73 Ta Tantalum 180.948
74 W Tungsten 183.85
75 Re Rhenium 186.207
76 Os Osmium 190.23
77 Ir Iridium 192.22
78 Pt Platinum 195.08
79 Au Gold 196.967
80 Hg Mercury 200.59
81 Tl Thallium 204.383
82 Pb Lead 207.2
83 Bi Bismuth 208.980
84 Po Polonium [208.982]
85 At Astatine 209.987
86 Rn Radon 222.018
87 Fr Francium 223.020
88 Ra Radium 226.025
89-103
104 Rf Rutherfordium [261]
105 Db Dubnium [262]
106 Sg Seaborgium [266]
107 Bh Bohrium [264]
108 Hs Hassium [269]
109 Mt Meitnerium [268]
110 Ds Darmstadtium [269]
111 Rg Roentgenium [272]
112 Cn Copernicium [277]
113 Uut Ununtrium unknown
114 Fl Flerovium [289]
115 Uup Ununpentium unknown
116 Lv Livermorium [298]
117 Uus Ununseptium unknown
118 Uuo Ununoctium unknown
Lanthanide Series
57 La Lanthanum 138.906
58 Ce Cerium 140.115
59 Pr Praseodymium 140.908
60 Nd Neodymium 144.24
61 Pm Promethium 144.913
62 Sm Samarium 150.36
63 Eu Europium 151.966
64 Gd Gadolinium 157.25
65 Tb Terbium 158.925
66 Dy Dysprosium 162.50
67 Ho Holmium 164.930
68 Er Erbium 167.26
69 Tm Thulium 168.934
70 Yb Ytterbium 173.04
71 Lu Lutetium 174.967
Actinide Series
89 Ac Actinium 227.028
90 Th Thorium 232.038
91 Pa Protactinium 231.036
92 U Uranium 238.029
93 Np Neptunium 237.048
94 Pu Plutonium 244.064
95 Am Americium 243.061
96 Cm Curium 247.070
97 Bk Berkelium 247.070
98 Cf Californium 251.080
99 Es Einsteinium [254]
100 Fm Fermium 257.095
101 Md Mendelevium 258.1
102 No Nobelium 259.101
103 Lr Lawrencium [262]
Alkali Metal
Alkaline Earth
Transition Metal
Basic Metal
Semimetal
Nonmetal
Halogen
Noble Gas
Lanthanide
Actinide
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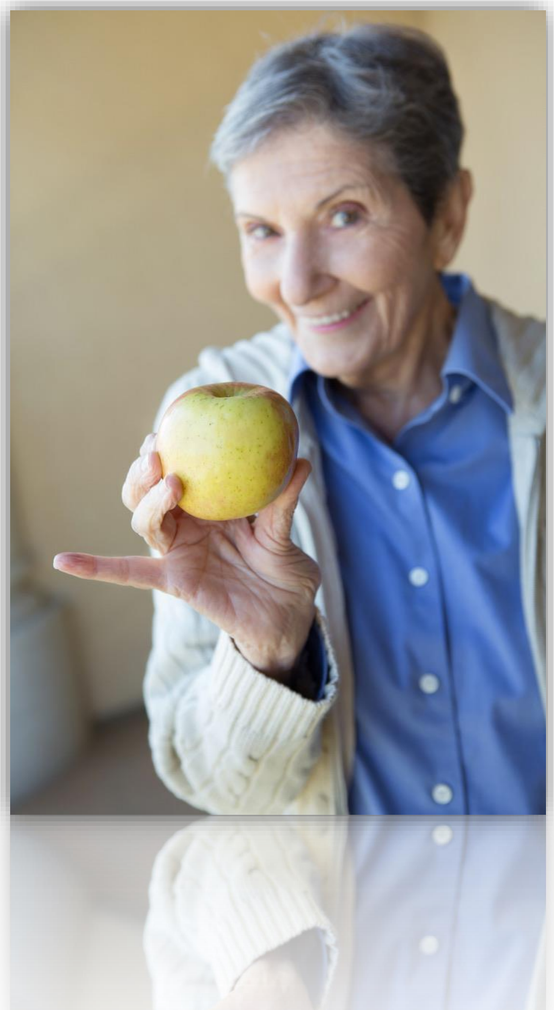
Piloting models with early adopters

A Pilot Serving “Dual Eligible” Seniors

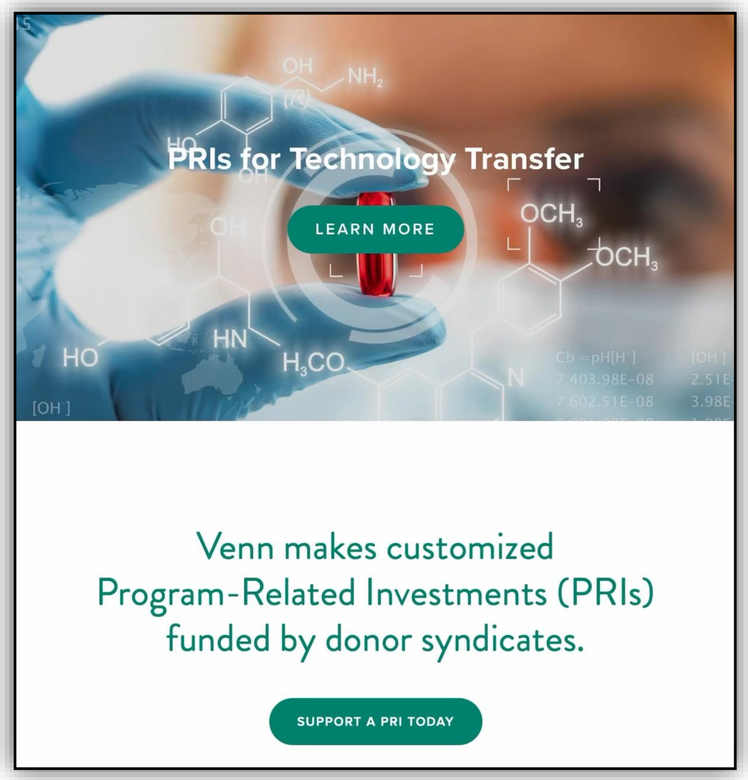
Adding oral health to whole-health delivery systems



- Minnesota Senior Health Options
- “Dual-Eligible” seniors have both Medicare and Medicaid
- Creating integrated care coordination system
- Measuring using OHIP-5, a measure “that counts”
- Creating new whole-health pathways using teledentistry

A Pilot expanding Medicaid dental providers…

A new model that invests capital to expand Critical Access Dental nonprofits



- Expansion of nonprofits can be geographically targeted to meet community needs
- Program Related Investment (PRI) loans can be combined with grants to expand programs more rapidly
- Health plans can make investments that expand their oral health provider network and generate a return on investment

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Discussion

- What sounds interesting?
- Was something confusing?
- Is there something you'd like to hear more about?

WORKSHOP

Sharing Models of Whole-Person Oral Health Education

February 15, 2024 | 11 a.m. to 5 p.m. ET

February 16, 2024 | 9 a.m. to 12 p.m. ET

NATIONAL ACADEMIES *Sciences Engineering Medicine*

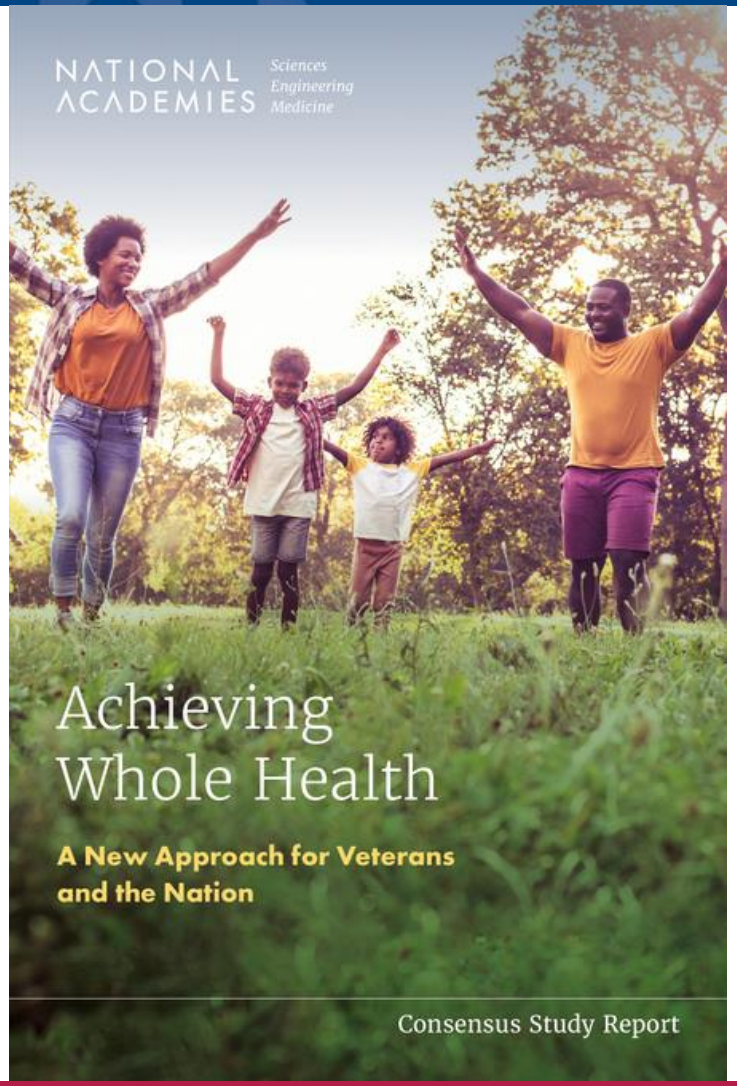
Health and Medicine

Penn Dental Medicine

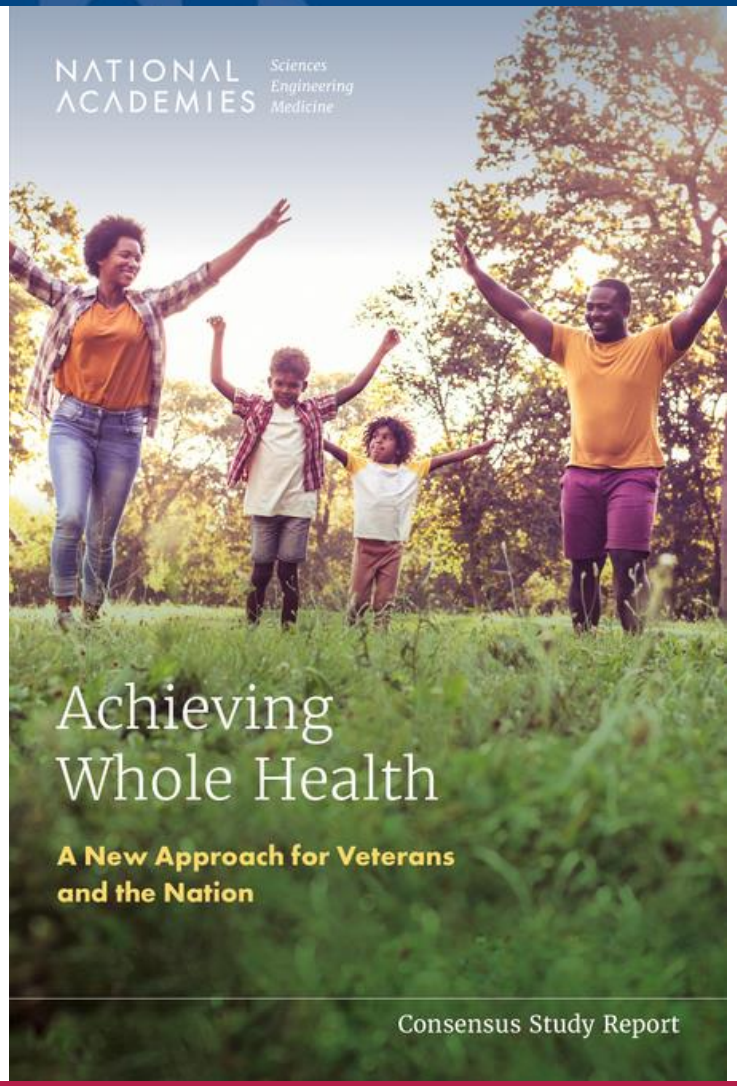
University of Pennsylvania

Embracing the need for a Whole Health Home

Michael Glick, D.M.D.
Fields-Rayant Professor
Executive Director, Center for Integrative Global Oral Health
School of Dental Medicine, University of Pennsylvania
glickmi@upenn.edu



"Whole health is physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities. Whole health care is an interprofessional, team-based approach anchored in trusted relationships to promote well-being, prevent disease, and restore health. It aligns with a person's life mission, aspiration, and purpose. It shifts the focus from a reactive disease-oriented medical care system to one that prioritizes disease prevention, health, and well-being. It changes the health care conversation from 'What's wrong with you?' to 'What matters to you?' "



Definitions

WHOLE HEALTH DEFINITIONS[1]

Go to:

whole health—physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities.

whole health care—an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease, and restore health. It aligns with a person's life mission, aspiration, and purpose.

whole health system—a collaborative health delivery system that encompasses conventional medical care, comprehensive and integrative health, community programs, social services, and public health. It addresses the five foundational elements of whole health (people-centered, holistic and comprehensive, upstream-focused, equitable and accountable, and team well-being). Whole Health System (WHS) (capitalized) refers to VA's WHS.

SYSTEMS INVOLVED IN WHOLE HEALTH

Go to:

community programs—programs and services designed to address the needs and wants of a local population. Examples of community programs include spiritual and religious programs and health behavioral change programs.

health system—an organization or practice engaged in the delivery of health care services, including innovative models.

public health system—a broad range of federal, state, and local health agencies, laboratories, and hospitals as well as nongovernmental public and private agencies, voluntary organizations, and individuals working together or in parallel to promote and protect the health of given community.

social services—programs and services provided by government or local organizations that help individuals, families, and communities address unmet needs related to health, housing, employment, nutrition, and other social needs.

WHOLE HEALTH CONCEPTS

Go to:

complementary and integrative health—practices and modalities that are not currently part of conventional medical care and often include acupuncture, massage, yoga, wellness coaching, and meditation. Also commonly known as complementary and integrative medicine.

conventional medical care—care that includes acute, chronic, preventive, reproductive, and mental health care, dental care, hearing care, vision care, and health behavior counseling.

scale—to expand, adapt, and sustain successful models within an organization, locality, or health system.

spread—to replicate a successful model elsewhere in other organizations, localities, or health systems.

people-centered care—an approach to care that focuses on values, priorities, and life-course needs of people, families, and communities.

upstream factors—the root causes of poor health, including health behaviors; social, economic, and education needs; and the natural and built environments in which people and communities reside.

Definitions - Achieving Whole Health - NCBI Bookshelf (nih.gov)

Achieving Whole Health: A New Approach for Veterans and the Nation.

< Prev Next >

Show details

Contents Hardcopy Version at National Academies Press

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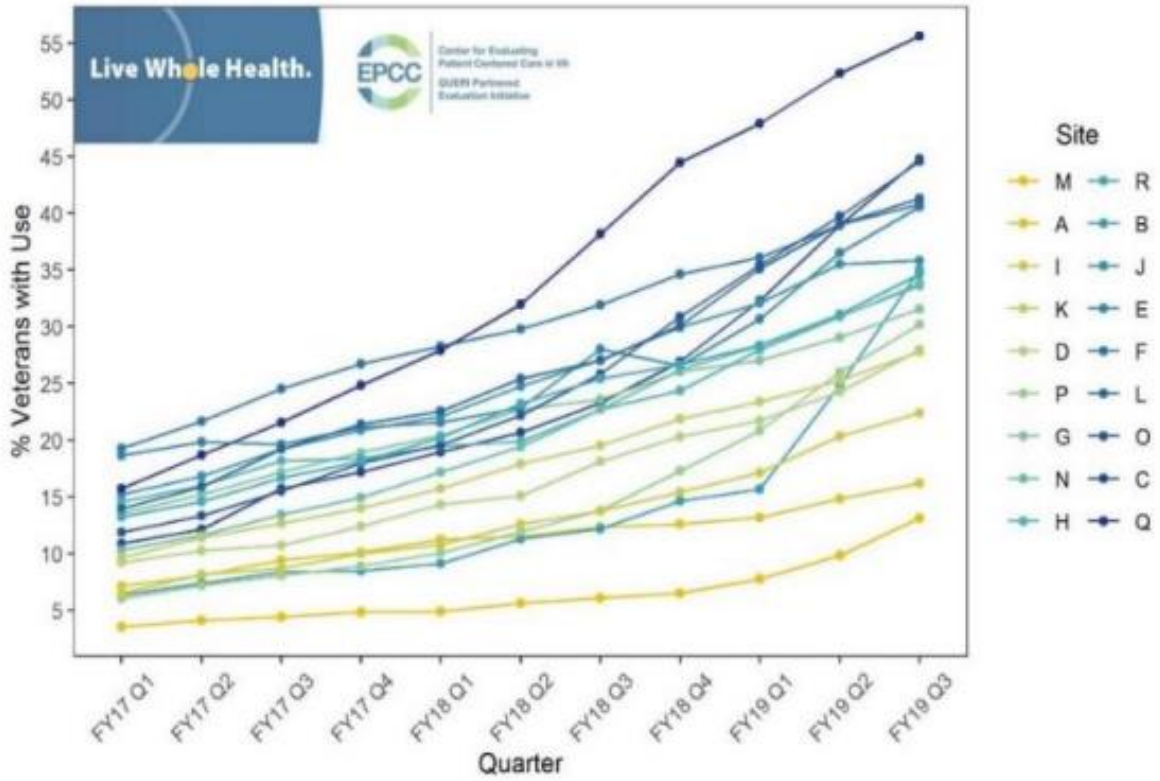
NATIONAL ACADEMIES Sciences Engineering Medicine

Scaling the Whole Person Approach to Health: Meeting #1

The National Academies of Sciences, Engineering, and Medicine Committee on Transforming Health Care to Create Whole Health: Strategies to Assess, Spread, and Scale the Whole Person Approach to Health will be holding a public session on October 19, 2021 from 2 PM-4:30 PM ET.

"[t]ransforming health care to create Whole Health: strategies to assess, spread, and scale the Whole Person approach to health."



Changes in WHS Utilization Among Veterans with Chronic Pain

- **Utilization: 31% of Veterans with chronic pain engaged in some WH services across the 18 sites (Q3FY19).**
- At 1 flagship site, engagement = 55%. Expectation: 44% Veterans with chronic pain will engage in WH services by the end of 2020.
- Increases in utilization since 2017:
  - Veterans with chronic pain: 193%
  - Veterans with MH diagnoses: 211%
  - Veterans with chronic conditions: 272%
- CIH utilization:
  - 26% of Veterans with chronic pain
  - Includes services delivered in the community
  - Increasingly being delivered within VA

Benjamin Kligler MD MPH
Executive Director, Office of Patient Centered Care & Cultural Transformation, Veterans Health Administration

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1445
Transmittal Sheet
October 13, 2023

WHOLE HEALTH SYSTEM

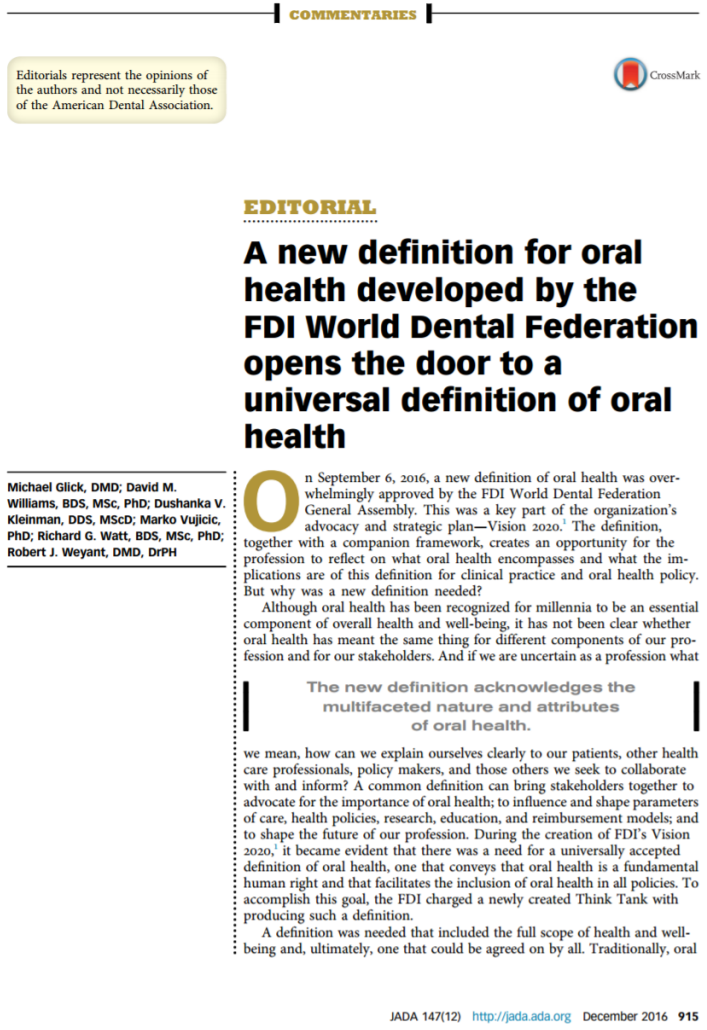
1. SUMMARY OF CONTENT: This new directive:

a. Establishes the Whole Health System (WHS) model of health care within the Veterans Health Administration (VHA) and outlines requirements and responsibilities for WHS implementation across Veterans Integrated Services Networks (VISNs) and Department of Veterans Affairs (VA) medical facilities in paragraphs 2 and 3.

b. Establishes full-time equivalent employees and associated responsibilities for the VISN Whole Health Coordinator, VA medical facility Whole Health Clinical Director, VA medical facility Whole Health Coordinator and VA medical facility Employee Whole Health Coordinator in paragraph 2.

"Oral health is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex."

JADA 2016;147(12):915



COMMENTARIES

Editorials represent the opinions of the authors and not necessarily those of the American Dental Association.

CrossMark

EDITORIAL

A new definition for oral health developed by the FDI World Dental Federation opens the door to a universal definition of oral health

Michael Glick, DMD; David M. Williams, BDS, MSc, PhD; Dushanka V. Kleinman, DDS, MScD; Marko Vujicic, PhD; Richard G. Watt, BDS, MSc, PhD; Robert J. Weyant, DMD, DrPH

On September 6, 2016, a new definition of oral health was overwhelmingly approved by the FDI World Dental Federation General Assembly. This was a key part of the organization's advocacy and strategic plan—Vision 2020.[1] The definition, together with a companion framework, creates an opportunity for the profession to reflect on what oral health encompasses and what the implications are of this definition for clinical practice and oral health policy. But why was a new definition needed?

Although oral health has been recognized for millennia to be an essential component of overall health and well-being, it has not been clear whether oral health has meant the same thing for different components of our profession and for our stakeholders. And if we are uncertain as a profession what we mean, how can we explain ourselves clearly to our patients, other health care professionals, policy makers, and those others we seek to collaborate with and inform? A common definition can bring stakeholders together to advocate for the importance of oral health; to influence and shape parameters of care, health policies, research, education, and reimbursement models; and to shape the future of our profession. During the creation of FDI's Vision 2020,[1] it became evident that there was a need for a universally accepted definition of oral health, one that conveys that oral health is a fundamental human right and that facilitates the inclusion of oral health in all policies. To accomplish this goal, the FDI charged a newly created Think Tank with producing such a definition.

> The new definition acknowledges the multifaceted nature and attributes of oral health.

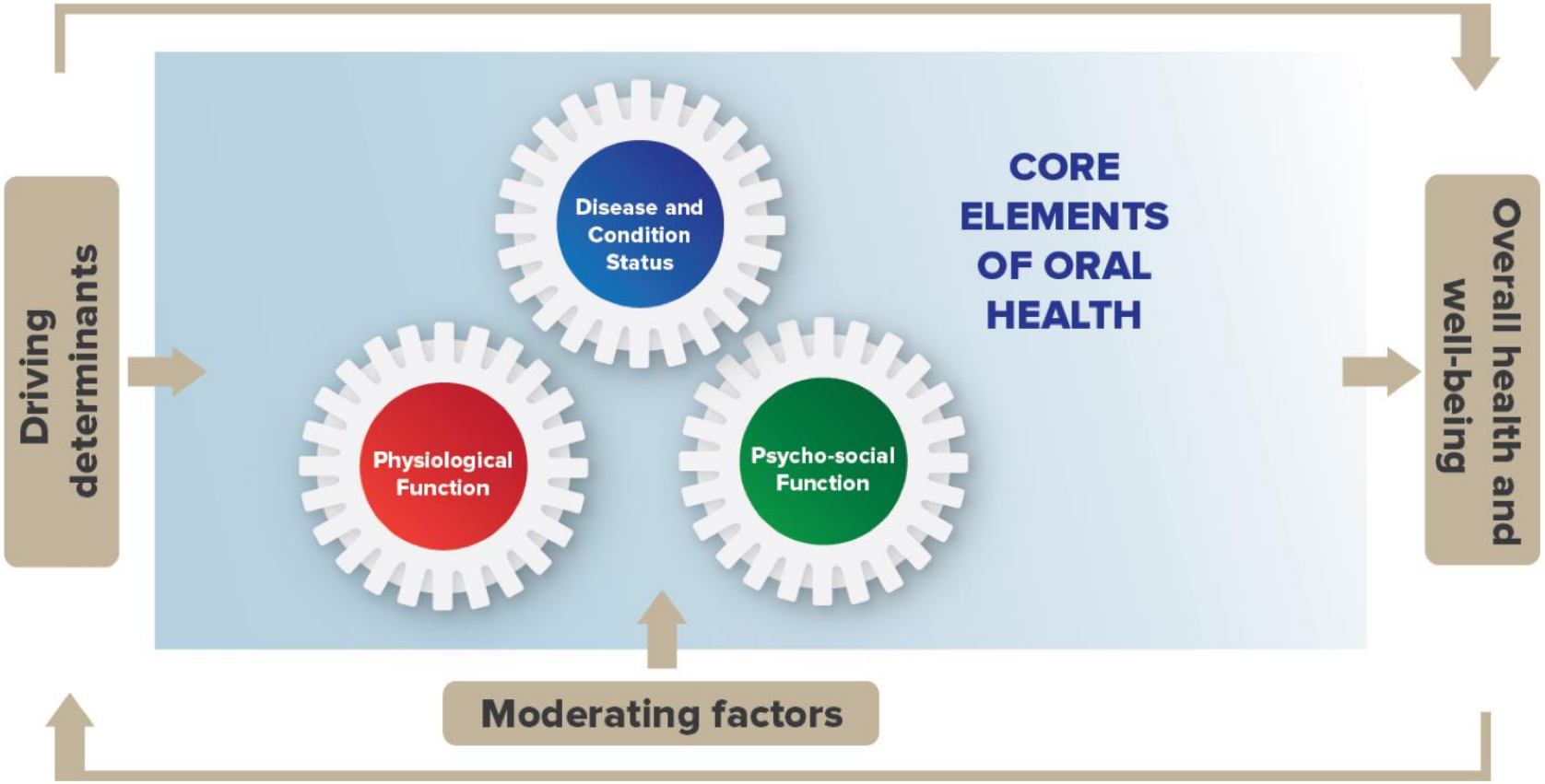
A definition was needed that included the full scope of health and well-being and, ultimately, one that could be agreed on by all. Traditionally, oral

Further attributes of oral health

Oral health:

- is a fundamental component of health and physical and mental well-being. It exists along a continuum influenced by the values and attitudes of individuals and communities;
- reflects the physiological, social and psychological attributes that are essential to the quality of life; and
- is influenced by the individual's changing experiences, perceptions, expectations and ability to adapt to circumstances.

Framework for the definition of oral health



Driving determinants

- genetic and biological factors
- social and economic factors
- social support network
- cultural factors
- physical environment
- access to and quality of care
- health behaviors
- education and health literacy

Moderating factors

- age
- culture
- income
- experience
- expectations
- adaptability

Oral health doesn't exist in a vacuum but is intertwined with both co-morbidities and multi-morbidities.

Inter-disciplinary education and care:

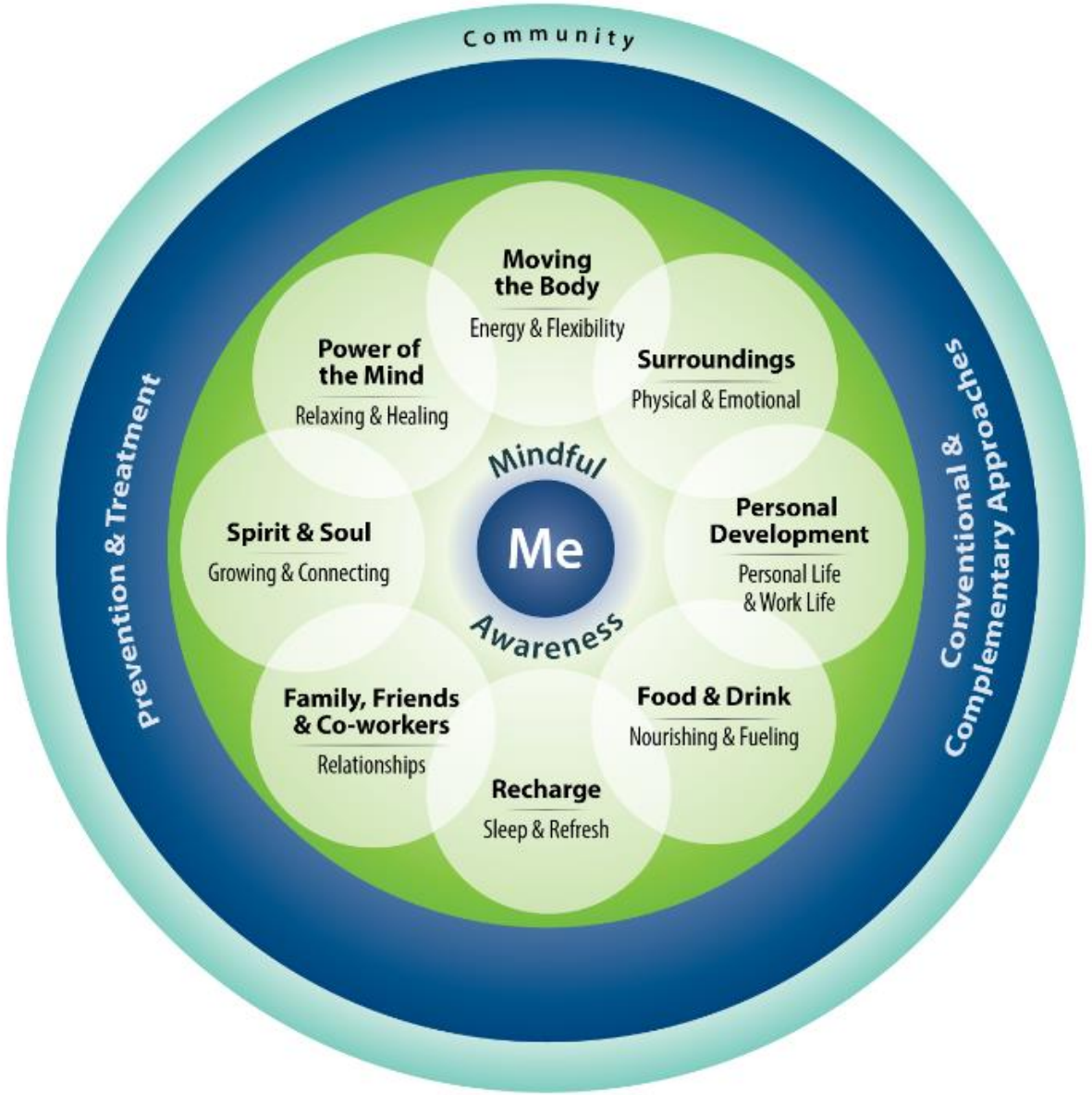
- primary care physicians
- nurses, and pharmacists
- public health professionals
- school teachers and childcare providers
- community health workers
- occupational therapists
- mental health workers
- social workers
- speech pathologists
- dietitians

Oral health doesn't exist in a vacuum but is intertwined with both co-morbidities and multi-morbidities.

Trans-disciplinary education and care:

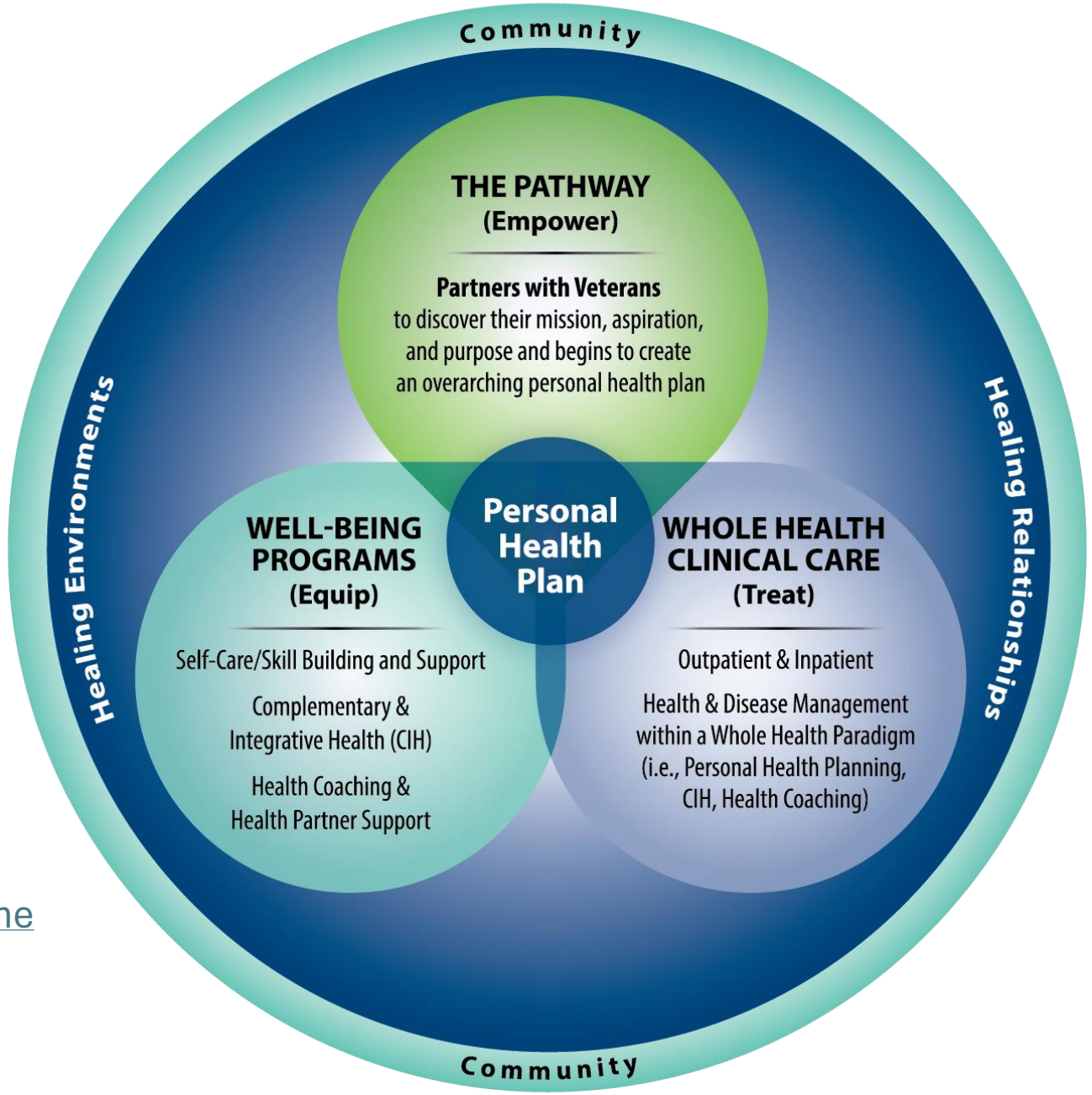
- urban planning
- transportation
- law
- education
- biomedical informatics
- sociology
- anthropology
- political science
- economic development
- sustainability

… and more

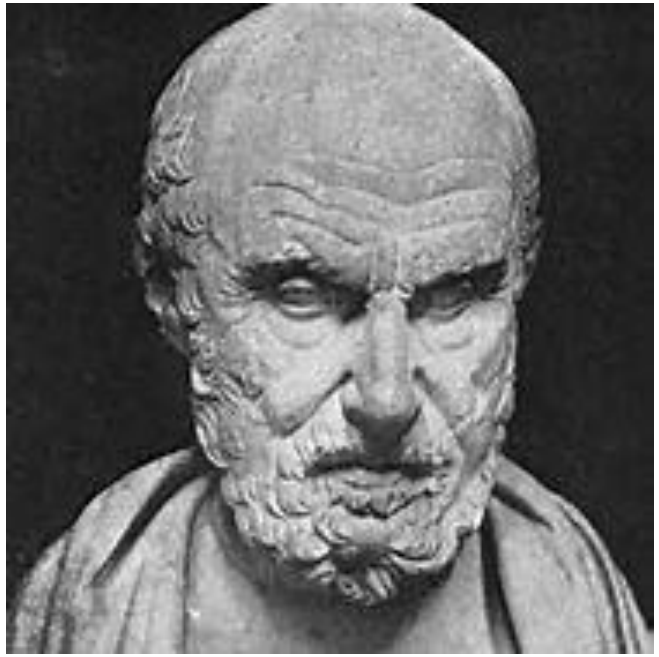


[Whole Health Library Home (va.gov)]

The Whole Health System



[Whole Health Approach Helps Vets Reach Their Health Care Goals - Vet Time in America (vrnnow.com)]



"It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has"

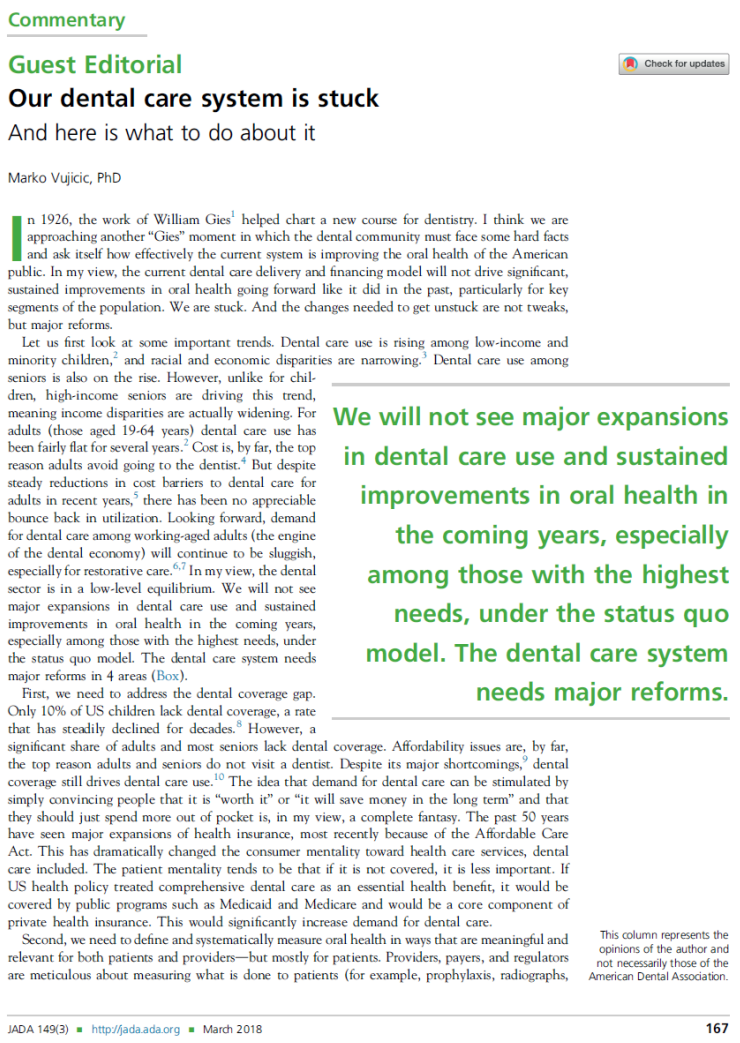
Hippocrates
c.460-c.377 BC

“Never treat a stranger"

William Osler
1849-1919

"Define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers, but mostly for patients. Measure what is done for patients, not just what is done to patients."

JADA 2018;149(3):167



Commentary

Guest Editorial

Check for updates

Our dental care system is stuck

And here is what to do about it

Marko Vujicic, PhD

In 1926, the work of William Gies[1] helped chart a new course for dentistry. I think we are approaching another "Gies" moment in which the dental community must face some hard facts and ask itself how effectively the current system is improving the oral health of the American public. In my view, the current dental care delivery and financing model will not drive significant, sustained improvements in oral health going forward like it did in the past, particularly for key segments of the population. We are stuck. And the changes needed to get unstuck are not tweaks, but major reforms.

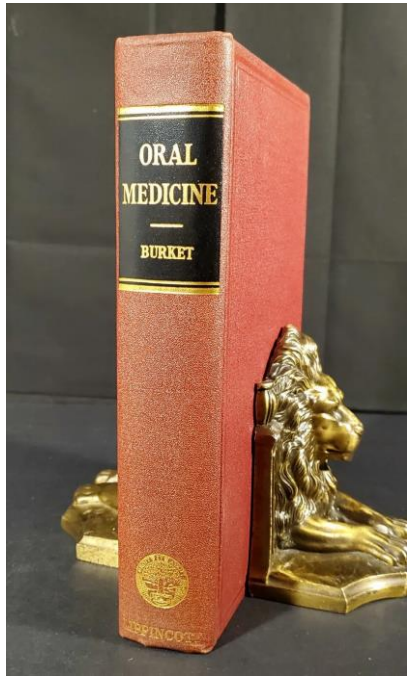
Let us first look at some important trends. Dental care use is rising among low-income and minority children,[2] and racial and economic disparities are narrowing.[3] Dental care use among seniors is also on the rise. However, unlike for children, high-income seniors are driving this trend, meaning income disparities are actually widening. For adults (those aged 19-64 years) dental care use has been fairly flat for several years.[2] Cost is, by far, the top reason adults avoid going to the dentist.[4] But despite steady reductions in cost barriers to dental care for adults in recent years,[5] there has been no appreciable bounce back in utilization. Looking forward, demand for dental care among working-aged adults (the engine of the dental economy) will continue to be sluggish, especially for restorative care.[6,7] In my view, the dental sector is in a low-level equilibrium. We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms in 4 areas (Box).

We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms.

First, we need to address the dental coverage gap. Only 10% of US children lack dental coverage, a rate that has steadily declined for decades.[8] However, a significant share of adults and most seniors lack dental coverage. Affordability issues are, by far, the top reason adults and seniors do not visit a dentist. Despite its major shortcomings,[9] dental coverage still drives dental care use.[10] The idea that demand for dental care can be stimulated by simply convincing people that it is "worth it" or "it will save money in the long term" and that they should just spend more out of pocket is, in my view, a complete fantasy. The past 50 years have seen major expansions of health insurance, most recently because of the Affordable Care Act. This has dramatically changed the consumer mentality toward health care services, dental care included. The patient mentality tends to be that if it is not covered, it is less important. If US health policy treated comprehensive dental care as an essential health benefit, it would be covered by public programs such as Medicaid and Medicare and would be a core component of private health insurance. This would significantly increase demand for dental care.

Second, we need to define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers—but mostly for patients. Providers, payers, and regulators are meticulous about measuring what is done to patients (for example, prophylaxis, radiographs,

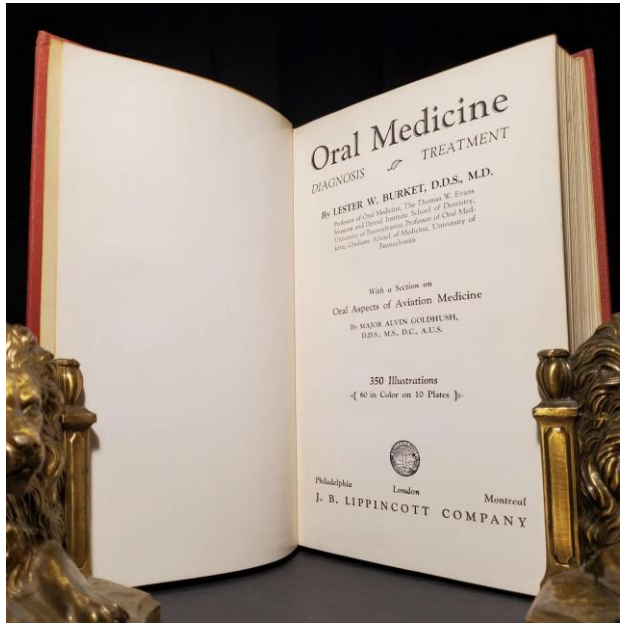
This column represents the opinions of the author and not necessarily those of the American Dental Association.



"The practitioner of medicine, physician and internist, would do well to read at least the Table of Contents. If he does that, I believe he'll delve deeper. It should convince him that the mouth contains much more than that doubly unruly member, the tongue. There are many situations and ways in which he can help the neighboring dentist, and the dentist can in turn help him, to speedy recovery. Both physician and dentist will benefit, but the patient will benefit most.

Between the covers of this book, the dentist will find much which he should know in order to do his clinical job, the job that is his for the asking. Here is a "must" for those who are eager to accept a larger share of responsibility for their patient's health, and to meet that responsibility competently and with inner satisfaction."

J. L. T. Appleton
Dean, School of
Dentistry University of Pennsylvania



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

1967: The medical home concept and terminology is introduced by the American Academy of Pediatrics (AAP) to describe a central location for a child's medical record The focus was on children and youth with special health care needs, in particular.

The principles underlying the medical home model, also known as the patient (or person)-centered medical home (PCMH), include:

- Comprehensive care
- Patient (person)-centered approach
- Coordinated care
- Accessible services
- Quality and safety
- Team-based care
- Population health management

By adhering to these principles, the medical home model aims to **improve health outcomes**, **enhance patient experiences**, and **reduce healthcare costs** through a **focus on preventive care**, **care coordination**, and **patient engagement**.

Medicaid.gov
Keeping America Healthy

Health Home

The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to **coordinate care** for people with Medicaid **who have chronic conditions**. The Centers for Medicare & Medicaid Services (CMS) expects states health home providers to operate under **a "whole-person" philosophy**. Health Homes providers will integrate and coordinate **all primary, acute, behavioral health, and long term services and supports to treat the whole person**.

Health Homes | Medicaid

Medicaid.gov
Keeping America Healthy

Health Home Providers

States have flexibility to determine eligible health home providers.
Health home providers can be:
A designated provider: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider
A health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative practitioners

Health Homes | Medicaid

Whole Health Home

A collaborative, transdisciplinary, preventive care model where peoples' values, i.e., issues which are important to them, take center stage, with goals for disease prevention, improved health outcomes and well-being through the life course.

A Whole Health Home approach for persons with disabilities offers:

- **Comprehensive Care**: Whole Health considers the interconnectedness of physical, mental, emotional, social, and spiritual well-being.
- **Holistic Support**: Persons with disabilities often face unique challenges related to their condition, such as mobility limitations, chronic pain, or psychological distress.
- **Person-Centered Care**: Whole Health prioritizes the individual's preferences, values, and goals, empowering them to actively participate in their healthcare decisions.
- **Preventive Care**: Persons with disabilities are at increased risk of certain health conditions due to factors such as physical inactivity, medication side effects, and barriers to healthcare access.

- **Improved Quality of Life**: By addressing all aspects of health and well-being, a Whole Health approach enhances the individual's overall quality of life.
- **Empowerment and Self-Advocacy**: Whole Health encourages individuals with disabilities to take an active role in managing their health and advocating for their needs.
- **Reduced Health Disparities**: Persons with disabilities often experience disparities in healthcare access, quality, and outcomes.
- **Enhanced Care Coordination**: Whole Health involves a multidisciplinary team of healthcare professionals, caregivers, and support services working collaboratively to provide integrated care.

Embracing the Whole Health Home concept represents a transformative step towards a more integrated, person-centered healthcare system, promising improved outcomes and enhanced well-being for individuals and communities.

Whole Health Home

This can only be achieved through:

- a healthcare system that prioritizes a transdisciplinary coordinated care model;
- increased awareness and engagement with contemporary health concepts and partners;
- improved integration of oral health within not only overall health but also well-being; and
- recognition, understanding, and addressing equity, diversity, and inclusion, across different, marginalized and disadvantaged communities and throughout the life course.

Thank you for your attention

Michael Glick, D.M.D.
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School of Dental Medicine, University of Pennsylvania
glickmi@upenn.edu