



**Equity and Community
Engagement in Statewide
Oral Health Policy Advocacy:
An Analysis of the Field and
Recommendations for Improvement**

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Equity and Community Engagement in Statewide Oral Health Policy Advocacy: An Analysis of the Field and Recommendations for Improvement

INTRODUCTION

Good oral health is essential to overall health, yet millions of Americans go without the care they need to thrive, and in severe cases, survive. Like other areas of health, there are documented [disparities in access to oral health prevention, coverage and care](#). The result is that some populations—namely, [Black, Indigenous and people of color](#); [low-income](#) populations; [older adults](#); [people with disabilities](#); and [LGBTQ+ populations](#)—face greater barriers to care. As a result, these communities are more likely to suffer from untreated dental disease and [related health complications](#). Despite ongoing efforts, access to care barriers and inequities continue to exist. This is why advocacy for oral health policy change is critical for effecting significant, sustained improvements to our failing oral health delivery system and for promoting more equitable health outcomes.

Over the course of 2020, Community Catalyst embarked on a research project in collaboration with the CareQuest Institute for Oral Health. We examined how to strengthen advocacy to more effectively promote equity and meet the oral health needs of marginalized communities. Overall, this project found that oral health advocates, community-based organizations (CBOs) and funders alike view fixing our failing oral health delivery system as an equity issue, providing significant common ground for change. In addition, by virtue of their financial resources, results showed that funders play a significant role in elevating awareness and ensuring oral health is a priority issue on the local, state and national levels. Finally, the results spoke to the need for strong partnerships among stakeholders, and a collaborative, intentional process to build momentum to advance longer-term policy change.

This report will outline the in-depth findings of this project and offer recommendations for funders, advocates and other key stakeholders to strengthen and expand oral health advocacy that is equity-informed and that includes community engagement as a core component.

Project Overview

There is an explicit and increasing interest in equity among many key players in oral health advocacy spaces. Specifically, many key stakeholders are interested in creating policy agendas, developing advocacy strategies and pursuing collective action at the national, state and community levels that center oral health equity and incorporate community engagement. As the oral health advocacy community continues to grow, all stakeholders, including funders, policy and advocacy organizations and community partners, should have a shared understanding of effectiveness in oral health advocacy and strategies to pursue it.

While many entities engaged in oral health advocacy name equity and community engagement as core values in pursuing the objectives of their work, oral health advocacy spaces, writ large, lack a common understanding of how this occurs under optimal conditions and what holds stakeholders back from

achieving this vision. Currently, there are differing opinions on the facilitators and barriers to effective advocacy; the role of community engagement; and how to measure policy and advocacy successes.

Additionally, members of marginalized communities often cite oral health as a priority issue area. However, it has been unclear what factors facilitate or create barriers to advocates from those communities becoming involved in oral health policy. It has also been unclear what factors shape their interest in prioritizing oral health among other, related health care and health equity issues.

This project sought to explore questions about oral health advocacy and policy agenda-setting that is grounded in equity, with the goal of clarifying:

1. How different stakeholders perceive success;
2. What facilitates or inhibits that success; and
3. Where there is alignment or divergence in strategy, approach and/or understanding among different stakeholder groups.

To answer the above questions, the research process for this project consisted of qualitative interviews and quantitative pre-interview surveys with key stakeholders in oral health advocacy across three cohorts: statewide advocacy organizations, community-based organizations (CBOs) and funders. Given the growing interest of community-driven policy and advocacy, this report will outline the results of our research, which explicitly explored the factors that facilitate or hinder entrance into and continued commitment to oral health as a site of equity-informed advocacy. In addition, this report is intended to clarify how community engagement has been incorporated into oral health advocacy and policy agenda-setting, where community-informed advocacy is working well and how to replicate that in other contexts. Finally, this report will identify common struggles in community-informed advocacy or where, when and why oral health advocacy is occurring without the engagement of communities. These data will inform the oral health advocacy movement, funders and those constituencies disproportionately harmed by lack of access to quality, affordable oral health care.

METHODS

This project consisted of qualitative in-depth interviews and quantitative pre-interview surveys with key stakeholders in oral health advocacy to explore the following research questions:

1. How do different stakeholders set and measure the effectiveness of their oral health advocacy priorities and how is community engagement incorporated into this work?
2. How do different stakeholders perceive facilitators and barriers to equity in oral health advocacy and community engagement?
3. How do different stakeholders define facilitators and barriers to getting and staying involved in oral health advocacy?

Participants and Design

Participants included staff representing organizations invested in oral health advocacy work across three cohorts:

- **Funders of oral health advocacy** (henceforth referred to as “funders”): This category included funders at the national, state, and local levels.
- **Statewide health policy and advocacy organizations** (henceforth referred to as “advocacy organizations” or “oral health advocacy organizations”): This category included state oral health coalitions, oral health advocacy organizations and health advocacy organizations with missions broader than just oral health, but which also engage in oral health advocacy efforts.
- **Community organizers/community-based organization staff** (henceforth referred to as “CBOs” or “CBO staff”): This category included staff of community-based organizations working on oral health advocacy including, but not limited to, community organizing.

Quantitative data on organizational priorities, skills and other background information were collected using an online pre-interview survey. Each participant completed the pre-survey prior to the time of their structured interview. Survey results were reviewed by the interviewers and responses were used to inform the interview.

Qualitative data were then gathered using structured interviews¹ with each participant, conducted by Community Catalyst staff via Zoom. In several cases, multiple participants were present for one structured interview if they represented the same organization. A standardized interview guide was created for each cohort. A total of 22 interviews were conducted (7 funders, 9 advocacy organizations, and 6 CBOs) across all three cohorts, with 12 states represented. This study also received an exemption determination from the Western Institutional Review Board.

Quantitative and Qualitative Analyses

Analysis of results was conducted using mixed methods. After all surveys and interviews were completed, quantitative analysis was conducted on aggregate survey results. A codebook was developed from the survey questions and then descriptive analyses were conducted using Stata.

Qualitative analyses of interview data were conducted in Atlas TI. All interviews were audio recorded by interviewers and then transcribed verbatim by a professional not involved in the interviews.

¹ Full text of structured interview guides for each cohort are available in the appendix

Completed transcriptions were reviewed by the interviewers who de-identified the transcripts by removing names of people, organizations and states, any information about specific programs and any other identifying information.

Two analysts conducted qualitative analyses who were not involved in the interview or transcription phase of the project. Analysts only received anonymized interview transcripts, thus being blinded to any identifiable information about participants. A grounded theory and inductive analysis approach was used to develop interview codes and analyze themes that arose across interviews. Inductive analysis minimizes the potential for “forcing” a preconceived result and provided a more valid reflection of participants’ actual experiences, as they reported them.

Transcripts were coded to identify connections and interrelationships between specific themes across interviews. A large network of interrelated codes emerged and networks were developed to demonstrate how the codes were associated to each other as well as how groups of codes related to the research questions. These networks help to graphically display the codes and their relationships to the overarching themes.

KEY FINDINGS AND DISCUSSION

The Role of Equity and Community Engagement

Key Takeaways

- Oral health advocates, community organizations and funders alike viewed oral health as an equity issue. Each recognized the importance of focusing on barriers to oral health within the context of the social determinants that shape them.
- Each cohort cited input from, and/or involvement of, directly affected communities as an important factor in the success of their advocacy. However, each cohort had varying views on how to best operationalize community engagement. CBOs were more likely than advocacy organizations to have formal processes for community engagement.
- Successful incorporation of community engagement strategies and centering the needs of communities in oral health advocacy requires time, planning and dedicated resources to sustain.

Consensus on the Value of Equity in Oral Health Advocacy

Across all three cohorts, there was near universal acknowledgement of the importance of centering oral health advocacy work in the principles of equity and community engagement ([Figure 3](#)). Participants noted that doing so can facilitate effective advocacy to advance policies that meet people's needs and can help address long-standing inequities in access to care and outcomes. Among oral health advocacy organizations and CBOs, 85% of participants reported that health equity was a factor in making decisions about oral health advocacy and policy priorities. Further, 75% reported that community engagement was a factor. Similarly, almost two-thirds of funders indicated that the priorities of marginalized communities or CBOs were involved in their decision to fund oral health work.

Finally, funders and advocates consistently mentioned the increasing weight they are giving to social determinants of health (SDOH) when considering their policy agendas and funding priorities ([Figure 1](#)). Participants discussed the importance of understanding how factors outside the dental and health care systems impact the oral health of people and communities and how framing around SDOH can help build the case that oral health is health. As one funder stated:

“people are realizing that if we really want to change health outcomes, we need to look at more than just visiting a dental office and medical office, we need to look at broader social contexts of how people are living.”

This near universal commitment to equity (including SDOH) and community engagement represents a key facilitator in the process to build a broad movement for oral health equity.

CBOs, by definition, center community organizing and engagement in their structure and function. This makes them key leaders and partners on advocacy campaigns that seek to center community voice and work toward oral health equity. Many CBOs reported

“People are realizing that if we really want to change health outcomes, we need to look at more than just visiting a dental office and medical office, we need to look at broader social contexts of how people are living.”

having a direct line to understanding the actual health issues communities face, an ease in centering these needs in their advocacy agendas and a reputation among community members as trusted advisors. As one CBO participant described:

“no matter what our policy issues are that we pursue, it doesn’t necessarily come from me or our other members of our small advocacy team. It comes from the people who are living it day by day.”

Many CBOs also reported that, in conversations with communities about their health care and unmet needs, oral health consistently rose to the top, driving these organizations to prioritize oral health as a key issue in their work.

Varying Approaches to and Degrees of Community Engagement

Despite consistent acknowledgement of the importance of community voice, we found a variety of definitions, approaches and strategies for community engagement. While funders frequently reported requiring grantees to incorporate community engagement, specifically how they wanted grantees to do that and what measures they used to assess outcomes varied. Many participants also named that while the sincere desire is there, coalitions (and the organizations that comprise them) don’t always have the funding, skills or capacities needed to authentically engage with CBOs or marginalized communities. Ultimately, this often led to communities or CBOs that represent them not being involved in oral health advocacy or policy decisions, to the detriment of building a robust and diverse oral health advocacy movement that is grounded in equity. As one CBO staff member stated:

“they [the coalition] made concessions that we would never make as grassroots organizations...there are some issues that communities face that have some nuances that may not directly come across to somebody who is working at a top-level, who’s not embedded in a community.”

Additionally, most funders and oral health advocacy organizations lacked consistent, long-term planning mechanisms to ensure input from CBOs and marginalized communities. Clear mechanisms for continued community input need to be created, so that community voice remains a consistent and central part of oral health advocacy agenda setting. This is particularly key as policy environments and dynamics shift, as compromises need to be made and as priorities are re-evaluated over time.

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Partnerships for advancing equity and community engagement worked best where all parties understood the time and commitment necessary to forge and sustain deep, authentic relationships with communities. For example, one oral health advocate stated:

“we’re trying to figure out how to do that, how to find ways to not just create a table that we’re inviting people to come talk at, but to figure out how do we support organizations that are coming from the community to create the table that will work for them.”

Additionally, funding for oral health advocacy was helpful, especially where CBOs and grassroots groups themselves receive financial support.

Facilitators of Effective Oral Health Advocacy

Key Takeaways

- Strong partnerships, particularly between funders, advocacy organizations and CBOs, is seen as an important component to effective advocacy.
- All three cohorts consistently cited community engagement and/or hearing directly from marginalized communities as important for advocacy efforts.
- Advocacy organizations and CBOs cited relationship building and coalition development as a cornerstone of effective oral health advocacy.
- Among factors that facilitate effective advocacy, groups consistently cited funders' willingness to incorporate longer-term outcome measures, such as coalition/relationship building, rather than relying exclusively on short-term or specific policy wins.

The Importance of Investing in Coalition² and Relationship Building

Participants spoke to a broad range of interconnected factors that shape statewide oral health advocacy agendas and the success of advocacy efforts. Across all three cohorts, relationship and coalition development was among the most salient of these factors (Figure 1). Oral health advocacy organizations and CBOs both mentioned the importance of establishing trusted relationships with partner organizations. Doing so is valuable for building greater support for policy initiatives and grounding advocacy efforts in the needs of communities facing the greatest barriers to oral health.

Oral health advocacy organizations, as well as some funders, often play the role of convening coalitions of partners to identify shared priorities, but both rely heavily on CBOs for direct or indirect connections to marginalized communities. Multiple health advocacy and funder participants described concerted efforts to generate discussion of oral health issues among potential partners across their state with an eye toward ensuring diverse voices at the table. One oral health advocacy organization participant recalled planning a convening and developing a seating chart in much the same way one would for a wedding, to ensure that no one table was dominated by a single constituency or special interest. Another described their convener role as an opportunity “to really facilitate and not do a lot of the talking,” to generate new thinking on potential solutions to the oral health problems facing many people in their state.

“establishing trusted relationships with partner organizations... is valuable for building greater support for policy initiatives and grounding advocacy efforts in the needs of communities facing the greatest barriers to oral health.”

² While we did interview some staff of formal State Oral Health Coalitions, here we use “coalition” to refer primarily to groups of advocates coming together around shared statewide advocacy agendas, more generally. Where we mean formal coalitions, we use the term “(State) Oral Health Coalition”.

Conversely, CBO staff, while sometimes participants in broader coalitions working on oral health, tend to focus on relationship building either at the community level or with organizations similar in scope and mission to their own. Multiple CBO participants noted that this commitment to the needs identified by the communities they serve positions them as trusted voices in the eyes of oral health advocacy organizations, funders and policymakers alike.

In addition to purposefully funding coalitions of oral health-focused organizations, multiple funders spoke to the importance of strengthening relationships between long-time oral health advocates and organizations for whom oral health has not historically been a priority. These relationships can broaden and diversify the base of advocates working on oral health issues.

Some funders currently see relationship building as a primary outcome for their grantees, whereas previously, they were simply focused on the success of a given project or policy initiative. As one funder put it, “we fund coalitions to exist and work, recognize the barriers, determine solutions and then collectively move forward.” Another funder emphasized the importance of funding relationship building as an initial step toward successful collective advocacy. They framed their funding efforts as a way to help disparate stakeholders identify common areas of focus: “Here’s a pot of money, it’s okay to not always have a focused strategy; let’s be open to partnerships and talking to one another about what we could be doing.”

Funding Drives Advocacy

Both oral health advocacy organizations and CBOs described the ways in which funding shapes their oral health advocacy efforts. Many of the oral health advocacy organizations were either created solely for the purpose of oral health advocacy, or have been funded to make oral health a primary organizational focus. In some instances, oral health funders have approached both oral health advocacy organizations and CBOs with offers of funding to work on oral health as an issue area. However, CBOs frequently cited oral health as a concern raised by the communities they serve, elevating it as a priority even when their organization’s focus and funding may be broader than oral health.

Participants in both the oral health advocacy organization and CBO cohorts discussed the fact that flexible funding facilitated more authentic and successful oral health advocacy ([Figure 2](#)). This allows them to identify emerging policy issues and adjust their focus as community needs and environmental factors necessitate. In general, many CBOs reported that their organizations found natural flexibility in incorporating oral health as a priority among other issues facing their communities such as access to health care, housing, transportation, and environmental justice.

Some funders mentioned that their funding strategy involves suggesting specific oral health-related topics and activities that potential grantees can pursue. However, many also highlighted what seems to be a shift in strategy to address oral health in the context of other health and social justice issues. One funder explained this shift in scope and strategy by describing the need to address social determinants of health and oral health: “The foundation is moving away from traditional health work or moving further towards social drivers of health.”

Funders also emphasized their view of the importance of CBOs and grassroots groups to the success of oral health advocacy efforts. For example, one funder described the potential of expanding the field of statewide oral health advocacy by funding community organizations that are active in other issue areas:

“Maybe we need to find these community activists or advocates that are doing other things and educate them on oral health, use [sic] their powers in a different way.” Similarly, another funder described the importance of CBOs and grassroots organizations to the success of coalition work in oral health: “We are relying on coalition building a lot. It is sort of the miracle that happens in our strategy is [sic] like, “we’ll find the grassroots.””

Engaging Communities in Advocacy

Particularly for CBOs, elevating community voice was identified as a key factor in their oral health advocacy efforts (Figure 3). Multiple participants who reported having recent success in advancing oral health policy also discussed the strategies they employ in empowering members of the community to share their stories or other strategies to communicate to policymakers how barriers to oral health care have harmed their constituents. One oral health advocacy organization developed a campaign that sent postcards to state legislators written by patient advocates and members of marginalized communities about the need for dental coverage. More than one CBO participant described efforts to bring members of the community to legislative sessions or hearings to describe their own experiences in seeking dental care. Participants felt that such efforts helped put a face on the issue while building new champions for oral health among policymakers who might not be swayed by other advocacy strategies.

Oral health advocacy organizations also spoke to the value of soliciting input from stakeholders in the community, either through direct outreach, like listening sessions, or by inviting community representatives to coalition meetings or convenings. One oral health advocacy organization did establish a standing advisory board of parents of children served by the programs and policies for which the organization advocates. In this case, this community advisory board serves as a sort of steering committee that helps shape the organization’s policy and advocacy agenda.

Challenges to Effective Oral Health Advocacy

Key Takeaways

- **Traditional power brokers (e.g., dental societies, other provider groups, state dental directors) have a disproportionately strong influence on advocacy efforts to change oral health policies.**
- **Formal statewide Oral Health Coalitions often function more as information sharing spaces or drivers of traditional policy initiatives, than as spaces where advocates or CBOs develop a shared policy/advocacy agenda.**
- **Short-term grants and a lack of diversity of funders that support oral health advocacy (or any direct advocacy) create barriers to the planning and power building needed for successful policy change.**
- **CBOs and grassroots organizations lack sufficient funding to support operations and infrastructure for coordinated statewide oral health advocacy.**
- **Environmental factors like COVID-19 can affect policy development. Many advocates, however, were able to implement innovative virtual strategies during the pandemic.**

Coalition-related Barriers to Coordinated Advocacy

All three cohorts reported that having a strong coalition of diverse advocacy partners was one factor that facilitated successful advocacy. However, participants also discussed barriers that prevent them from building these coalitions and sustaining them in the long term.

First, lack of capacity to maintain coalition operations and infrastructure was raised as a specific barrier. Without a centralized hub to bring diverse partners together, facilitate conversations across different partners and coordinate the priorities and agendas of various partners, a shared statewide advocacy agenda is difficult to achieve. This barrier often arises from lack of funding—not just for individual organizations to participate in a coalition, but for general support for at least one entity to offer staffing, operations and infrastructure. As one oral health advocate stated:

“[the oral health coalition] just fell apart, mainly because of funding and because of lack of organization, like who was going to run it. We needed a full-time staff person, and there wasn’t really a full-time staff person anywhere.”

Another major barrier discussed by all three cohorts was the influence of traditional power brokers in coalition spaces, especially with respect to oral health advocacy agenda setting. Such power brokers included dental associations, other dental provider groups and other private or governmental entities that have traditionally driven the oral health policy agenda in the state. Participants discussed the outsized power of provider groups and how it is frequently not balanced by a strong community voice in oral health advocacy spaces. Participants also discussed how providers’ priorities do not always align with those identified by marginalized communities, or do not serve to advance systems change. One funder explained:

“we’re dealing with the world we have, and that’s our limitation. Some of that is the stakeholders involved...the dental society is always sitting there. I think that was the piece. Nobody ever said, ‘How would you want it to be different?’”

Funding-Related Barriers to Advocacy

Across all three cohorts, one key barrier participants discussed was a lack of available funding to support oral health advocacy. For example, many participants described a hesitancy on the part of some funders to invest in direct advocacy (though many also reported that this trend was changing). Where funding was available for advancing oral health advocacy, participants identified several barriers related to its effectiveness. In particular, short-term grants were identified as a barrier; they can make it difficult to sustain work and plan for long-term policy fights. As one oral health advocacy organization participant stated, “honestly, we’re spending so much time chasing money that we’re doing what we have to on our project grants and chasing money all the rest of the time.”

Without a centralized hub to bring diverse partners together, facilitate conversations across different partners and coordinate the priorities and agendas of various partners, a shared statewide advocacy agenda is difficult to achieve.

Lack of robust funding to CBOs or grassroots groups, in particular, was also named as a barrier. Their direct connections to members of marginalized communities and their likelihood of having concrete community engagement strategies make their involvement integral for centering equity and community engagement in oral health advocacy campaigns. Targeted funding is often needed to make this happen. One funder reported, “the people who see the most need for substantive change are the people with the least time and money to actually act on that.”

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Oral health advocacy organizations, in particular, also spoke about barriers related to how funding drives advocacy priorities ([Figure 2](#)). Several advocacy organization participants discussed the feeling of needing to set their advocacy agendas around the stated priorities of their funders to obtain, keep and generate additional funding for their oral health work. Participants reported that it was more difficult to secure investments for needs or priorities that arose directly from communities, rather than those advanced by funders. Without funding, it was harder for organizations to work on these issues. This surfaced some incongruence in expectations between some funders and the groups they support; while most funders did not perceive their grantmaking to be prescriptive, potential grantees do often feel pressure to adapt their work to the stated or unstated priorities of funders. In general, both advocacy organizations and CBOs described highly targeted funding, such as grants that prescribed work on specific policies or that was not flexible enough to cover general operating funds, as a barrier.

Finally, siloed funding was also frequently named as a barrier, especially as it intersected with another barrier: lack of a shared statewide advocacy agenda. In several states, only one or a small number of organizations were funded specifically to work on oral health advocacy. Even if several groups were funded in a given state, it was rare for them to be funded specifically to work together, or on the same policies or toward the same goals. Participants reported that this siloing can create a patchwork of policy priorities and limit organizations’ ability to move a coordinated, statewide oral health advocacy agenda. One funder noted that it is uncommon for them to explicitly fund multiple organizations to work together on a given issue: “we rarely have funding collaborations where we’re funding a couple of different partners, fiscally, both of them.”

COVID-Related Challenges

While it represents a particular moment in time, it is important to note that most participants, across all three cohorts, raised that the ongoing COVID-19 pandemic posed specific challenges to oral health advocacy work. One commonly-noted challenge was “right-sizing” where to focus advocacy energy, in light of pressing community needs related to COVID-19 testing and treatment. Groups also had to work within the context of a desire by legislators and other key stakeholders to focus exclusively on COVID-19 response.

Additional challenges included that many state legislatures adjourned early, and that all or most work needed to shift onto virtual platforms. Virtual work created particular challenges for community engagement and outreach. Despite these challenges, advocacy organizations and CBOs remained nimble, shifting efforts where needed to continue to advance oral health priorities. In some cases,

groups even developed virtual strategies to reach more people in more places. For example, one CBO participant described how their partners, including community members, continued to meet virtually:

“during COVID, [we were] meeting every other week, not only about dental, a lot of different things...Those meetings would be a variety of things from hearing from people about what are some issues that are coming up in your life that you think we might be able to help with, to updates about what’s happening with the legislature or digging deeper into...a specific area.”

Agenda-Setting Processes

Key Takeaways

- **Marginalized communities elevating oral health as a significant unmet need was a key factor in all three cohorts prioritizing oral health in their work.**
- **Policy agenda-setting processes were influenced by existing organizational priorities, available funding opportunities and/or perceived opportunities in state legislatures.**
- **Funders view themselves as a mechanism for focusing the attention of advocates on oral health, but do not see themselves as prescribing specific grantee or statewide oral health agendas.**

Beyond direct and indirect community outreach, the strategies for advocacy agenda setting varied widely across participants and cohorts. Some oral health advocacy organizations reported relying heavily on the advice of state oral health officials in identifying policy solutions to pursue, rather than engaging in a formal agenda-setting process. However, both oral health advocacy organizations and CBOs discussed participating in some form of an annual review of policy and advocacy opportunities, often with an eye toward what their respective state legislatures may be poised to consider. In some cases, this included convening external partners to discuss the issues each organization plans to focus on. However, most participants described internal priority-setting processes that may then be reviewed by their board of directors or an external advisory board.

Oral health advocacy organizations were more likely to report having a pre-defined set of high-level priorities (e.g., access to care, coverage, workforce) through which their advocacy work is organized. Despite 90% of oral health advocacy organizations and CBOs reporting that they were part of a coalition focused on oral health advocacy, few reported that their organizational advocacy priorities are directly influenced by those of the coalitions. Instead, both cohorts tended to view formal Oral Health Coalitions less as a mechanism for shared agenda setting with other organizations than an opportunity to share information and engage in collective action on common issues or policies. In addition, less than half of oral health advocacy and CBO participants reported that their organization contributes to a shared oral health advocacy agenda all of time. This finding reinforced that most agenda setting takes place at the organizational level, rather than at the coalition level.

How Funding Shapes Policy Agendas

Similarly to how participants described the role funding plays in shaping if and how groups get and stay invested in oral health advocacy, both oral health advocacy organizations and CBOs reported that

funding opportunities often influence their policy agendas ([Figure 2](#)). For some participants, issue-specific grant funding is the primary determinant of their advocacy agenda, resulting in annual changes to their work based on funding availability. Among organizations for whom oral health is not their top priority, several participants reported that funding was a key factor in their decision to include oral health as part of their advocacy agenda. This mirrors the results of the pre-interview survey, in which funders' priorities were the second most commonly cited factor in choosing to focus on oral health, slightly behind the priorities of marginalized communities.

In general, funders did not see themselves as playing a prescriptive role in determining grantee or statewide oral health agendas, but rather as a mechanism for focusing the attention of advocates on oral health. Most funders responded that they did not specify which policies grantees should pursue, but some did mention efforts to emphasize prevention and social determinants in their grantmaking strategies. One funder, however, did report continued success as a result of their intimate involvement in grantee and coalition agenda setting. In this case, they served as a regular convener of coalition partners, as a leader in the development of a statewide oral health action plan, and as the primary oral health funder in the state.

Measuring Success in Oral Health Advocacy

Key Takeaways

- **Demonstrating success over the course of a single grant year can be challenging, especially when the ultimate objective is policy change.**
- **Funders and advocates alike recognize the importance of relationship and coalition building as milestones of successful advocacy.**
- **While community engagement is a stated priority of advocacy organizations and funders, both struggle to measure it and lack consistent coordinated measures of success.**

Most oral health advocacy organization and CBO participants described having long-range oral health advocacy goals (e.g., expanding coverage, improving access to care, increasing delivery of preventive services). At the same time, most participants focused on either the passage of specific policies or the renewal of funding as indicators of success. The majority of participants (80%) reported relying on internal evaluations of their advocacy work. Similarly, most funders reported that they either evaluate the success of their grantees based on apparent policy change (50%) or evaluation measures set by grantees themselves (37.5%). And while most oral health advocacy organizations and CBOs felt that the expectations of funders were clear most of the time, many reported challenges in securing funding to sustain multi-year advocacy efforts. This finding suggests potential incongruity between funder expectations and grantee perception of success.

When asked about the expected outcomes of their grantmaking, many funders indicated that they rely on grantees to define and report on their own outcomes rather than taking a prescriptive approach. This would seem to benefit advocacy organizations and CBOs, which report thriving in a more flexible funding environment, but it may also contribute to a lack of shared agenda setting or effective collaboration among funded partners in a state – a frustration with State Oral Health Coalitions that some funders raised. In discussing the perceived lack of statewide momentum around oral health

advocacy, despite the existence of an Oral Health Coalition, one funder said, “they bring all the people together, but there’s not a lasting purpose or north star that supports like [sic] creativity and ambition around what next.”

Participants across all cohorts noted the importance of influencing policy change as an indicator of success; however, multiple oral health advocacy organizations and CBOs noted that achieving policy change as an outcome of their advocacy efforts is rarely possible in a single grant year. Participants consistently reported achieving incremental progress toward policy change in the form of partnership development, cultivating policymaker champions and educating policymakers and other stakeholders. Some funders explicitly identified these activities as measures of success in and of themselves. As one funder put it:

“... policy is [not] just driven by whether or not a bill is passed. You can get two groups in the room that have, from inception, argued or [have] differing opinions to agree on initiatives to move forward. I believe that in itself...can be a form of trust on those initiatives. That is success.”

As previously discussed, participants across all three cohorts emphasized the importance of community engagement as a core component in advocacy efforts. However, there was no consistent approach to measuring or evaluating community engagement or its impact on the success of oral health advocacy.

RECOMMENDATIONS

Strategies to Build Power and Engage Communities in Oral Health Advocacy

Key Takeaways

- 1. Cultivate funders outside of oral health.** Funders may consider strategies for doing outreach and education to other, non-oral health funders to maximize their investments and further diversify the needed resources for longer-term systems-change initiatives.
- 2. Invest in effective coalition building.** Many advocacy organizations and CBOs are skilled and interested in power building, but often don't have dedicated resources to invest in coalition building or staff an effective campaign structure in oral health. Funders may consider direct funding to advocacy groups and CBOs aimed specifically at coalition and partnership development.
- 3. Strengthen advocates' competency in community engagement.** Advocacy organizations often bring experience and processes for coalition and campaign building, but they may need to invest in training and capacity building around equity and community engagement. Investments in these capacities may help ensure advocacy organizations are engaging communities authentically and respectfully.
- 4. Equitably boost resources for community-based organizations.** CBOs are a source of community voice, through their direct or indirect connections to communities. Funding efforts that prioritize resourcing these types of organizations, especially in collaboration with advocacy organizations, may contribute to successful community-informed policy change that is grounded in equity.
- 5. Evaluate if advocacy strategies are centering communities.** To address inequities, advocates, CBOs and funders may need to work together to assess how policy agendas are being set and ensure community voice is being centered in decisions. This can balance power dynamics in coalition spaces, creating the opportunity for greater community involvement in advancing systems change.
- 6. Dedicate funding for long-term success.** Funding efforts that bring flexible and multi-year grants as well as direct funding to CBOs and grassroots groups can provide the needed foundation for the longer-term planning and resources needed to advance successful policy initiatives.
- 7. Assess progress in many ways.** Incorporating process-related and longer-term measures of success in evaluating oral health advocacy efforts is one way for funders to set oral health policy initiatives up for long-term success.

Oral health funders, advocacy organizations and CBOs seem to have significant common ground to advance long-term policy changes efforts. That said, policy advocacy aimed at changing our health care delivery systems can be daunting and complicated work. It requires effective planning and timely execution of multi-year strategies, supported by adequate resources. The recommendations presented in this section go beyond building capacity in single organizations and point toward developing an organized approach to building partnerships that promotes more sustainable, community-driven health advocacy.

Although not covered in this report, entities that do advocacy work may have different approaches and sets of competencies to advance policy change. Community Catalyst employs our own [System of Advocacy](#) as a framework for building power and supporting community partners in their efforts to change health policy. This framework includes strengthening capacities in a few key areas, such as policy analysis, campaign development and coalition building. We bring this framework to the following recommendations, focusing on elements of policy advocacy that may be unique to the field of oral health.

Pursue more flexible and multi-year investments to support oral health advocacy. By and large, one of the most common themes from advocacy organization and CBO interviews was the presence (or absence) of flexible funding and multi-year grants. While many advocacy organizations and CBOs are skilled and interested in power building, they identified not having sufficient dedicated resources to invest in coalition building or staff an effective oral health campaign structure. Where this type of funding did exist, it created the necessary space for relationship-building; developing shared, community-informed agendas; and advancing strong policy over the course of several legislative sessions. Where it was lacking, advocacy organizations and CBOs often struggled to support their long-term policy visions and needed to spend more of their time “chasing” grants.

Shifts in funding approaches funders may consider include:

- General operations funding and/or grants that build in more space for overhead;
- Targeted funding for coalition building or similar coordinating hubs that serve to facilitate a shared statewide advocacy agenda;
- Process measures, rather than (or in addition to) outcomes measures;
- Multi-year grants that allow for longer term planning, honoring the reality that policy change takes time; and
- Outreach and education to non-oral health funders to maximize investments and further diversify the needed resources for longer-term systems-change initiatives.

Offer targeted investments in the skills and capacity building of state and national organizations to engage in authentic community engagement. Many participants discussed the reality that good advocacy, especially when strategy and policy decisions include community voice, takes time and intentionality. To support this, funders may consider strategies that provide flexible funding for organizations to pursue “soft” successes—that is, those that build the strength of their advocacy capacity and relationship-building in preparation for more targeted policy campaigns. This could include grants and other economic investments for organizations to pursue education in community engagement and health equity principles, and/or direct provision of training or technical assistance to grantees.

Good advocacy, especially when strategy and policy decisions include community voice, takes time and intentionality.

Provide financial support to CBOs, grassroots groups and marginalized communities. Community input at the level of problem identification and developing solutions is integral to advancing equity. Operating with smaller budgets and limited staff capacity, CBOs and community groups may not be able to respond to requests or participate at the level needed for successful campaigns or coalition efforts.

Their work and expertise warrants additional investment. It is important to note that investing in grassroots groups necessitates respect for the needs and priorities identified by their communities. As stated previously, offering flexible, multi-year funding, without prescribing particular policy outcomes or priorities, cultivates authentic community engagement and investment. In addition, funding process outcomes to measure success may be particularly important for facilitating trust and authentic relationships between funders and community groups.

Offering flexible, multi-year funding, without prescribing particular policy outcomes or priorities, cultivates authentic community engagement and investment.

Consider adopting evaluation metrics and measures of success that focus on process, rather than just short-term policy

outcomes. One frequently reported barrier was a lack of consistency in how participants from different cohorts and organizations measure the success of their advocacy efforts. However, the fact that no universal measure of success is currently used creates space for the oral health advocacy community to be creative in developing a collective strategy for measuring success. Moreover, participants across all three cohorts reported that successful advocacy often requires multi-year cultivation of partnerships and depends heavily on the policy and political environment. If the only measure of “success” is the passage of a particular bill or a discrete policy change, we are likely to miss integral successes associated with community engagement.

Instead, we recommend incorporating measures like:

- Improved strength of relationships among partners;
- Growth and diversity of coalitions; and
- More and deeper relationships with marginalized communities.

These factors lay the groundwork for effective community-centered advocacy that is more likely to address oral health equity. Many funders reported understanding the necessity and benefits of this type of shift in measuring success.

We also recommend that the oral health advocacy and funding communities consider developing consistent definitions and strategies around equity and community engagement within and across states. Doing so can facilitate more meaningful inclusion of communities in the development of multi-year advocacy agendas.

CONCLUSION

This research showed the commitment among all cohorts – funders, advocacy organizations and CBOs – to elevate community voice. In particular, it revealed that there is a shift in priorities among some funders to support individual groups and initiatives that prioritize community engagement and equity-focused policy agendas. It also revealed key barriers for advocates in fully realizing their commitment to engaging marginalized communities and allowing their policy agendas to be defined by community needs. While it appears the tide is shifting toward prioritizing community voice, there is more work for funders and advocates to do to deepen the inclusion of communities in all facets of oral health advocacy. This report offers a roadmap for partners to strengthen our commitment to centering the voices of communities directly affected by lack of access to oral health care.

ABOUT COMMUNITY CATALYST

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill. For more information, visit <http://www.communitycatalyst.org>. Follow us on Twitter @CommCatHealth.

ABOUT THE CAREQUEST INSTITUTE FOR ORAL HEALTH

CareQuest Institute for Oral Health is a national nonprofit championing a more equitable future where every person can reach their full potential through excellent health. We do this through our work in grantmaking, research, health improvement programs, policy and advocacy and education as well as our leadership in dental benefits, care delivery and innovation advancements. We collaborate with thought leaders, health care providers, patients and local, state and federal stakeholders, to accelerate oral health care transformation and create a system designed for everyone. To learn more, visit carequest.org.

APPENDIX

Figure 1: Network displaying factors influencing successful oral health advocacy

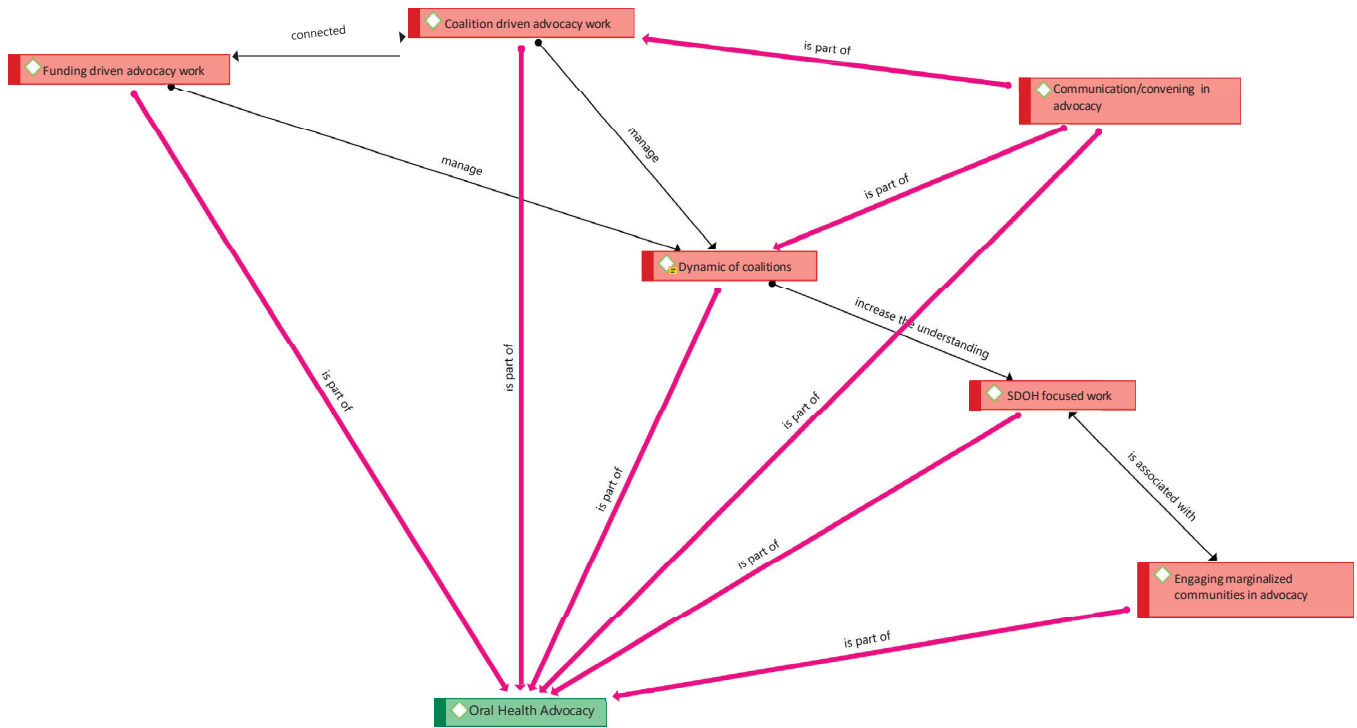


Figure 2: Network displaying how funding influences advocacy priorities and policy agendas

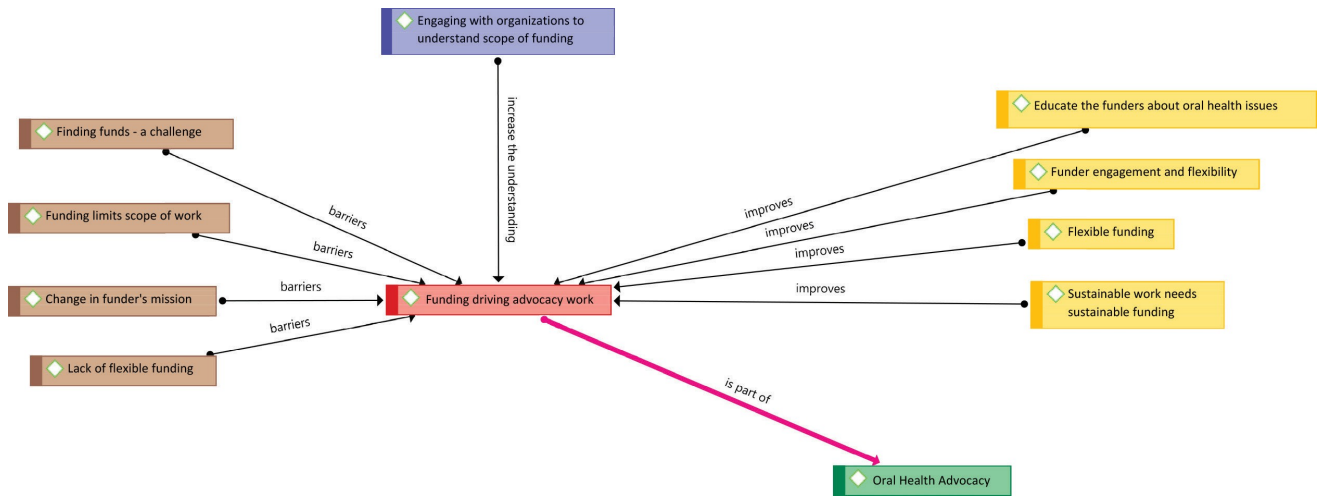
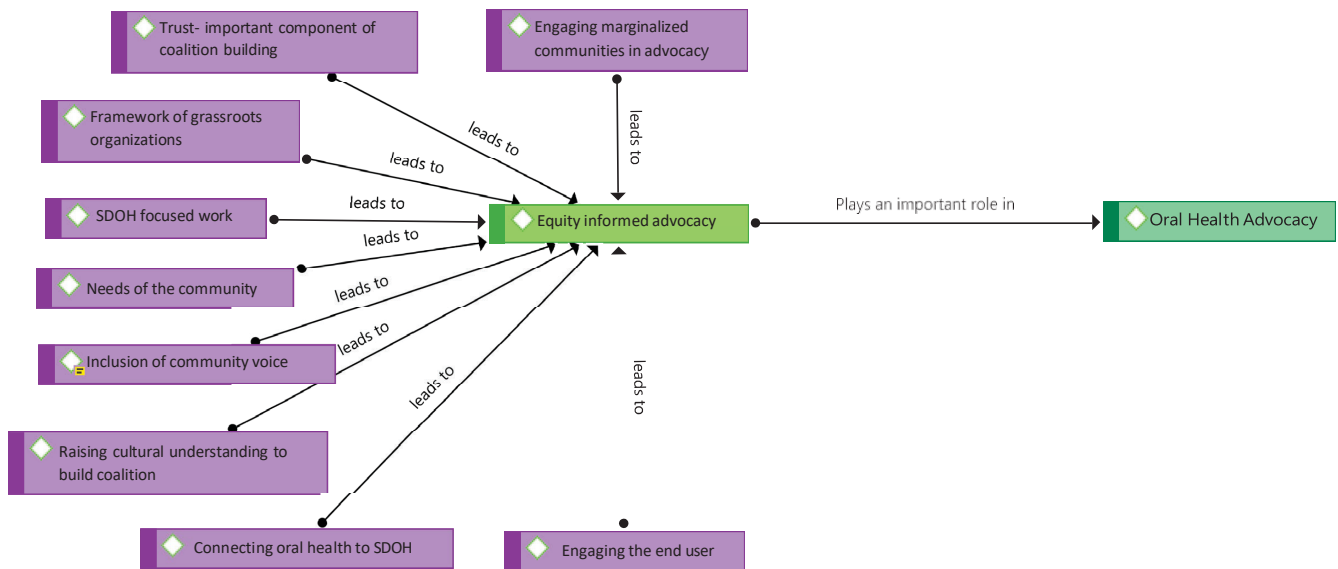


Figure 3: Network displaying the important role equity and community engagement play in oral health advocacy



STRUCTURED INTERVIEW GUIDE – ADVOCACY ORGANIZATIONS

Policy Advocacy and Political environment

1. In the pre-interview survey you indicated that your organization’s priorities include a focus on oral health. Can you please elaborate on how this priority was developed? Can you provide an example of how state or national partners, marginalized communities or funders helped you develop your organization’s priorities?
2. Could you discuss the process of developing your organization’s policy agenda?
3. In the pre-survey, you indicated that there are oral health champions in your state. Can you please provide some background on your organization’s relationship with the oral health champion(s)?
4. What factors do you think have contributed to or hindered the advancement of oral health policies within your state?

Coalition, stakeholders and community organization

1. In the pre-survey, you indicated that your organization is part of a coalition working on oral health. What is your organization’s unique role in the coalition’s agenda-setting process?
 - a. Are there specific issues that your organization “owns”, specific expertise you bring to the table, or specific roles you play in advancing this agenda?
 - b. If you share a similar role with other organizations, how do you allocate work, collaborate, or avoid duplication?
 - c. How do you collaborate with other organizations that have different roles or areas of expertise?
2. Can you give us an example of how community members/representatives are involved in your day-to-day work or advocacy efforts?
3. Can you give us an example of how your organization has used/uses storytelling in your advocacy or campaigns work?
4. Can you speak to the role of community engagement in the success of your oral health advocacy efforts? What role do community members play?
 - a. What role do your funders play in your organization’s incorporation of community engagement practices?
5. What key stakeholders do you regularly communicate with about your policy priorities/advocacy agenda-setting or other aspects of your oral health advocacy work?

STRUCTURED INTERVIEW GUIDE – COMMUNITY-BASED ORGANIZATIONS

Policy Advocacy and Political Environment

1. In the pre-interview survey you indicated that your organization’s priorities include a focus on oral health. Can you please elaborate on how this priority was developed? Can you provide an example of how state or national partners, marginalized communities or funders helped you develop your organization’s priorities?
2. Does your organization have its own policy agenda?
 - a. If so, could you discuss the process of developing it?
 - b. If not, how does your organization make decisions about which oral health policy priorities to work on?
3. In the pre-survey, you indicated that there are oral health champions in your state. Can you please provide some background on your organization’s relationship with the oral health champion(s)?
4. What factors do you think have contributed to or hindered the advancement of oral health policies within your state?

Coalition, stakeholders and community organizing

1. In the pre-survey, you indicated that your organization is part of a coalition working on oral health. What is your organization’s unique role in the coalition’s agenda-setting process?
 - a. Are there specific issues that your organization “owns”, specific expertise you bring to the table, or specific roles you play in advancing this agenda?
 - b. If you share a similar role with other organizations, how do you allocate work, collaborate, or avoid duplication?
 - c. How do you collaborate with other organizations that have different roles or areas of expertise?
2. Can you give us an example of how community members/representatives are involved in your day-to-day work or advocacy efforts?
3. Can you give us an example of how your organization has used/uses storytelling in your advocacy or campaigns work?
4. Can you speak to the role of community engagement in the success of your oral health advocacy efforts? What role do community members play?
 - a. What role do your funders play in your organization’s incorporation of community engagement practices?
5. What key stakeholders do you regularly communicate with about your policy priorities/advocacy agenda-setting or other aspects of your oral health advocacy work?

STRUCTURED INTERVIEW GUIDE – FUNDERS

Advocacy and Community Engagement

1. In the pre-interview survey you indicated that your funding priorities include a focus on oral health. Can you please elaborate on how this priority was developed? Can you provide an example of how state or national partners or marginalized communities helped you develop your organization's funding priorities?
2. In the pre-interview survey, you gave us some information about how your organization's funding agenda is decided. Can you talk through that process a bit more?
 - a. Are health equity or community engagement factors that your organization considers when deciding on advocacy efforts to fund?
 - b. What other factors are important to you when considering entities or initiatives to fund?
 - c. How do you communicate these priorities to grantees or potential grantees?
3. Overall, you rated the effectiveness of state-level oral health advocacy as [insert rating] and rated the ability of state advocates to advance policy change as [insert rating]. Can you tell us a bit more about your perspective on this?
 - a. What factors do you think have contributed to or hindered the advancement of oral health policies at the state level?
4. In general, what do you feel the oral health advocacy community needs in order to be more successful in accomplishing your shared objectives?

Coalition, stakeholders and community organizing

1. In the pre-interview survey, you indicated that you fund oral health coalitions. Can you talk a bit more about any support you provide to grantees with regard to coalition building? In general, how effective have these coalitions been in advancing oral health policies or programs?
2. As a funder, how do you perceive your role and your grantees' role in shaping or contributing to a shared oral health advocacy agenda at the state level?
 - a. Are members of marginalized communities or CBOs involved in setting this shared agenda?
3. Tell us a bit more about your grantees' interactions with marginalized communities and/or other community-based organizations.
 - a. What formal or informal mechanisms have you seen advocates use to communicate with marginalized communities or seek input from them?
4. To what degree do you see alignment between community-identified priorities and policy advocacy priorities of organizations working on these issues?
5. How, if at all, do you think the current level of community engagement among your grantees affects the success of their advocacy efforts?

Funder Relations

1. In the pre-interview survey, you indicated that you communicate with other funders about oral health advocacy. To what degree do you feel like other funders prioritize community engagement and/or health equity in their oral health funding priorities?
2. You provided us with some information on how you measure the success of funded work on oral health advocacy. How, if at all, have your organization's measures of success changed on this area of funding in recent years?
 - a. How often do you check in with grantees or otherwise require reporting on funded activities, aside from end-of-cycle reports?
3. Do you have any specific requirements or guidelines for grantees when it comes to demonstrating community engagement and/or addressing health equity or racial inequities?
4. How often, if at all, do you set forth policy objectives for grantees to accomplish, either individually or as part of a coalition?
5. Do you strategically fund different groups with the expectation that they will work in coalition with one another?