Oral Health System: Pandemic Response

Virtual Meeting

June 17, 2020

2:30-4:00 pm EDT

Group Memory

Convenor:
Michael Monopoli, Vice President, Grants Strategy
DentaQuest Partnership for Oral Health Advancement

Facilitator:
Patrick Finnerty, Strategic Advisor
DentaQuest Partnership for Oral Health Advancement

Content Manager:
Sara Oaklander, Interaction Institute for Social Change

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I. Start-Ups

A. Welcome

Pat welcomed everyone to the meeting and thanked everyone for their participation on behalf of all of us at the DentaQuest Partnership.

B. Introductions

Participants and Guests

- American Association of Dental Boards (Dr. Robert Zena and Tonia Socha-Mower) **New members*
- American Dental Association (Marko Vujicic, PhD, Chief Economist and Vice President; Jane Grover, DDS, MPH, Director, Council on Advocacy for Access and Prevention)
- American Dental Hygienists Association (Ann Battrell, MDSH, Chief Executive Officer)
- Association of Dental Support Organizations (Mitch Goldman, JD, MBA, Executive Committee ADSO and CEO of Mid-Atlantic Dental Partners, a Dental Support Organization)
- Association of State and Territorial Dental Directors (Chris Wood, Executive Director)
- Delta Dental of Washington (Diane Oakes, MSW, MPH, Chief Mission Officer)
- Dental Trade Alliance (Sarah Miller, MPA, Development Coordinator)
- DentaQuest Partnership for Oral Health Advancement (Myechia Minter-Jordan MD, MBA, President and CEO, DQP and Catalyst Institute) (Michael Monopoli, DMD, MPH, MS, Vice President for Grants Strategy) (Brenda Cocuzzo, Executive Assistant)
- Henry Schein (Steve William Kess, MBA, Vice President of Global Professional Relations)
- National Association of Dental Plans (Eme Augustini, Executive Director)
- National Association of Community Health Centers (*Represented by:* Vicki Young, PhD, Chief Operating Officer S.C. Primary Health Care Association)
- Oral Health Progress and Equity Network (Ifetayo Johnson, MA, Executive Director)
- Santa Fe Group (Terri Dolan, DDS, MPH, President-Elect)

Unable to attend:

- Association of State and Territorial Health Officials (Janet Olszewski, Senior Fellow, Michigan Health Endowment Fund) **No longer able to participate due to new work responsibilities*
- Dental Trade Alliance (Gregory Chavez, *CEO*)
- Oral Health Coordinating Committee/IHS/USPHS (RADM Tim Ricks, DMD, MPH, FICD, Chief Professional Officer)

Invited Guests:

- Karen Gregory, Organization for Safety, Asepsis and Prevention (OSAP)
- Michelle Lee, Organization for Safety, Asepsis and Prevention (OSAP)

Strategic Advisors:

- Marcia Brand, former Deputy Administrator, Health Resources and Services Administration
- Patrick Finnerty, former Medicaid Director for the Commonwealth of Virginia
- Laurie Norris, former Senior Policy Advisor for Oral Health, Centers for Medicare & Medicaid Services
- Marianne Hughes, former Executive Director, Interaction Institute for Social Change

C. Purpose of the Effort

To gather key oral health system stakeholders to deepen relationships, build alignment, and develop priorities that will guide our individual, organizational, and collaborative action in order to create economic and point of access stability in the oral health care system, and to begin to envision what the post-pandemic oral healthcare system will look like.

D. Purpose of the Meeting

To deepen our awareness of the inequities in our health care system and how COVID-19 has exacerbated these inequities, and to generate ideas for communicating OSAP's document: *Best Practices for Infection Control in Dental Settings* across all 50 states.

E. Desired Outcomes

By the end of the meeting, the group expected to have:

- A shared appreciation for how the current national conversation about policing and race connects to our work in oral health and health equity
- A shared understanding of OSAP's *Best Practices for Infection Control in Dental Settings*, and feedback on the document to share with OSAP
- A list of ideas for how to communicate and distribute OSAP's *Best Practices for Infection Control in Dental Settings* document across all 50 states
- A shared understanding of the American Association of Dental Boards' communication strategy regarding safety guidelines
- Agreement on next steps to convene a Communications Working Group to develop a plan for distributing best practices, information, and guidelines across the country

II. Current Reality

Pat Finnerty spoke about the current reality in which we all find ourselves.
As we begin our time together, I think it's important to acknowledge the period of profound turmoil and pain in which we convene today. The killing of George Floyd not only was a senseless tragedy…but it re-awakened our awareness of the racial injustices that have existed in this nation for hundreds of years. And, the confluence of that tragedy and the COVID-19 pandemic has exposed the systemic racial inequities that exist in terms of civil rights, access to health care, quality of health care, and basic human decency.

And, in that context, we thought it would be particularly meaningful to begin today by having two of our group members, Dr. Jordan and Ife Johnson, both of whom are influential leaders in this area, to reflect on the current state of health inequities that are one of the factors driving so much of the demand for deep and structural change in our country today.

A. Myechia Minter-Jordan

Dr. Minter-Jordan shared her thoughts about this current reality. Highlights of her remarks:

- Thank you all for being here today, and Pat for laying out where we are.
- We are aware of the economic disparities and disproportionate impact of COVID-19 on communities of color.
- And we have the social justice movement. It has been moving to see the number of allies who have come out in the face of this human rights violation.

- There is a larger conversation to have around how we got here. What system has been developed that would allow for these inequities to happen.
- A few specifics:
- African Americans are 13.4% of the US population
- The uninsured rate for African Americans is 9.7% vs 5.4% for whites
- Even for those with coverage, health disparities exist
- For example, maternal mortality: African American women are 3x more likely to die of pregnancy-related causes that white women
- Infant mortality: African American infants are more than twice as likely to die than white infants
- And these disparities exist for heart disease, diabetes, and cancer.
- With oral health, Blacks are 68% more likely than white adults to have unmet dental needs, the rates of untreated decay are 25% higher for Blacks 65 years or older, and rates of dental caries in children are twice as high for Black children as for their white counterparts.
- With regard to income inequality, the average household income in 2018 for African American households was less than half that of white households.
- And when we look at overall disparities in wealth in Massachusetts, the average white household has a total net worth of roughly $230,000 vs a net worth of $8 for African Americans.
- I know that many of you are aware of most if not all of the data that I just presented. And the data represents the outcomes of systems that we live and work in that are inequitable. And it is important for us all to understand the interconnectivity of these disparities in order for us to build better systems of care.
- Looking at the work we have done, we are thinking about system redesign: access, safety, and more – and part of what I am hopeful for is that we'll apply the lens of diversity, equity, and inclusion as we seek to make these important changes.

B. Ifetayo Johnson

Ife shared her thoughts about this current reality. Highlights of her remarks:

- I'm hoping you will listen with an open heart, and that I make you a little uncomfortable. And that in that discomfort we can all move forward together.
- Wicked problems are problems that are difficult to define, let alone solve. They are intractable and they are collections of problems interconnected with other problems. The more complex the problem, the more challenging it is to address.
- Systems thinking offers us a lens through which to understand and analyze wicked problems so that we can identify pathways to action.
- To create a world that gives all of us an equal opportunity to be healthy, we need to shape the systems that shape our health. We shape systems to address wicked problems like health equity. We can only do this as a community.
- We know that systemic racism is the ultimate wicked problem.
- We have seen its pervasiveness and impact in police departments and other powers of authority
- We have felt the impact of poor legislation on communities of color
- We know that poverty is an outcome of systemic racism
- We have proof of the adverse effects of unemployment and poor housing
- We've seen the result of racism in failed school systems
- We know health disparities' deadly outcomes
- We've discussed racism's influence on the Social Determinants of Health
- We've even seen how racism in oral health can result in the death of a child

- It has taken an inordinate number of decades and the invention of camera phones to capture sufficient evidence to validate the prevalence of racism in **policing**.
- Unfortunately, it is much harder and, in some cases, impossible to video or document the full effects of systemic racism in **education, economics, or health disparities**. These are, however, just as deadly.
- **Systemic racism** underlies all equity issues in America.
- Our call is to be aware of the places it hides and resides.
- Having identified and experienced the infestation we are required to unveil the multitude of places it exists.
- Our charge is to pull out our systems thinking lens and add our equity lens to reveal the places that systemic racism hides and resides. It is pervasive in our country because so much of our foundation was built upon it. As we identify the hiding places, we have to shine a light on the places it has infested and unveil it wherever it is.
- What we must work for is **systemic equity**.
    - The systems we create codify either equity or racism.
- Systemic equity requires a concerted and deliberate effort to examine where equity lives in our workplaces
- Systemic equity requires the willingness to be tenacious doers who disrupt with inclusion.
    - And it requires the ability to get comfortable in our discomfort.
- In every environment and every committee, every workplace we are in we help codify either systemic racism or systemic equity. It demands of us a concerted effort to increase equity in our workplaces
- Now we must look at what we can do to be our best selves in all the places we live, work, worship, and play
- We must find ways to address systemic racism where we find it
- We must have the intestinal fortitude to chase out systemic racism and to invite in systemic equity
- At OPEN we are doing "Hear and Heal" - A series of workshops where people are invited to share their stories of racial equity, learn about the history of racism, and what they can to make the world a better place.
- Imagine the impossible and then do it!

C. Full Group Discussion

The following questions were posed to the full group: What things have you been doing differently in your organizations in the context of COVID-19 and health disparities and the racial inequities that exist? What barriers to change do you see moving forward?

- *(Diane Oakes, Delta Dental of Washington and Arcora Foundation)* Thank you for those powerful opening comments. Delta is using the word "racism" now, not just diversity, equity, and inclusion. Now it's how we can be an anti-racist organization. We know we need to do deep learning as well as identify actions we can take. The dam has broken a bit. We're looking internally and externally. Proximity is a barrier. Looking at the dental profession, we are white. We are not close in to communities of color and we need to intentionally bridge those divides.
- *(Terri Dolan, Santa Fe Group)* Of the many ways we put our mission into action, we hold salons. The next is an opportunity to re-examine our agenda and weave in these important topics to a discussion of integration and care delivery. We also have a task force focused on COVID as a

lever to support innovation. We started a COVID workgroup and now it's time to discuss how inequities and racism can be integrated into those discussions. Asking ourselves, what unique role we can play? And looking internally at governance and how we carry out our business.

- *(Steve Kess, Henry Schein, Inc.)* We're also sharing stories – a distinguished African American member of the oral health community has shared stories of his experiences of the difficulties he encountered entering into the profession because of the color of his skin. This had a powerful impact on the group – recognizing we can all do more. We'll be taking on these issues more visibly and vocally over time.
- *(Mitch Goldman, ADSO)* In the process of integrating three different companies and the words racism and racial equality never came up – and now the language is changing. We are realizing we don't know enough. Our board is all old white men…and they are even saying we need to be proactive to really figure this out. This is an issue where everyone wants to do the right thing, but we don't know how. We all need to get educated – and that's not difficult. We just have to extend ourselves. This is a long struggle but at least there is a start.
- *(Jane Grover, ADA)* We have diversity at the ADA in my group. I just let people talk after all the action in Chicago. Listening is a critical piece. Regarding COVID-19, Marko and I are on a team meeting twice/week (it was daily). Nonstop action. Barriers to change – trust is a continual theme and both an opportunity and a barrier. We'll have a town hall meeting devoted to this topic.
- *(Marko Vujicic, ADA)* Our board met recently and it's mostly white men. It feels different. There is meaningful action – such as choosing black and brown people for leadership positions. We'll see. I am hopeful. Listening and empathizing is the most important thing.

Pat shared that the American Medical Association has a lot of resources on their website related to COVID-19 and racism. COVID-19 Health Equity Resources

III. A Perspective on Safety

Ann Battrell, Executive Director, American Dental Hygienists Association (ADHA)

Highlights of Ann's remarks:

- On June 4, we released a public statement on systemic racism, civil unrest, justice, and fairness. The response has been overwhelming. Many hygienists have shared their stories and that has made it very personal for us. We'll be hosting a national leadership conference at the start of the year and racism, diversity, justice, and equity will be a focus. Half of my staff are people of color and younger. I have invited them to create a group to determine how our staff and office culture need to change, and my team wants to impact the Chicago community, as well.
- We created a dedicated COVID email address in the beginning and thousands of hygienists responded with their concerns on three primary areas: the availability of PPE, especially long-term availability; unemployment; and concerns regarding returning to work. We subsequently created a return to work taskforce.
- We've generated an interim guidance document for the dental hygiene community, and it's been met with great support. Our website crashed three time with the demand!
- Conversations are now shifting to psychological trauma on returning to work. Folks later in their careers are having trouble adjusting and questioning if they'll stay. And, at the other end, students are questioning their choice of dental hygiene as a career.

- We are working in partnership with the ADA to develop a survey of the dental hygiene community regarding infection control experiences and anxiety and psychological impact factors in the profession.

IV. Best Practices for Infection Control in Dental Settings

Karen Gregory, RN, OSAP Director of Compliance and Education

Highlights of Karen's remarks:

- The final document looks much different from what you have seen.
- When we started the workgroup – a team of 13 infection control specialists – we came together to combine guidance from OSHA, CDC, ADA, and ADHA into one document to provide a one-stop shopping resource.
- Since we started, the ADA and ADHA have updated their guidance. Our document is a living document that will change as content changes. Goal is for all of this to be user-friendly for the practice.
- In Section #1 there is a checklist to guide a review such that the front-line individual can take the pdf-fillable form and literally review the list as moving around the office and considering all of the necessary details.
- In Section #2 there is a list of resources – from the OSHA site - links and descriptions; from the CDC – pulled most relevant webpages; section on respirators – different levels and types; Tools – screening (basic with caveat that more can be added), written respiratory protection checklist, employee screening, PPE competency checklist.
- There is a heightened need for training. Different roles require different skills. And the anxiety is real and needs to be addressed. We must be upfront in our offices to ensure our staff that we are addressing safety.

Michelle added that there has been a tremendous challenge around images for this document, given how the PPE have changed. And she affirmed that the document will be posted on their website in the morning and available to all.

Mike added that there will be consumer-focused and school-focused companions to this document.

V. Communicating Safety Guidelines to Oral Health Providers in the States

Dr. Robert Zena, President, American Association of Dental Boards (AADB)

Tonia Socha-Mower first spoke about the work of AADB and also Dr. Zena's background.
Highlights of Dr. Zena's remarks:

- AADB is comprised of state board members – current and past – as well as dental service organizations and other supporting organizations that rely on us for information on both national and state issues and challenges.
- We have access to a lot of people.
- We send out directives on occasion to initiate conversation.
- The OSAP document is excellent and we can help facilitate dissemination of that to the Board members.
- The Boards have to deal with clinicians who don't do anything. They think they know everything already. They ask us for guidance on what to do with people who won't comply with guidelines.

- The Boards can make rules, initiate their own guidelines.
- Dentists should minimize treatment – two or three procedures at one time, not stretch it out.
- Patients who come in with their own masks that are often dirty or otherwise compromised need to be given new ones.

VI. Reflecting Together

A. In Small Groups

- What is your feedback to OSAP re: their best practices document?
- What are your ideas for distributing OSAP's recommendations across all 50 states, including how AADB's communications capabilities can be leveraged?

B. Large Group Report Back/Discussion

Feedback on the document

- Re: guidance in general, we need to reinforce that this is guidance as opposed to requirements due to there being a lot of confusion in the marketplace. We need to be clear where there is a choice and where there is not a choice (e.g., N-95 masks).
- We discussed the value of the document. It's great that the various resources can be combined. And it's helpful to have a feedback loop for accountability so that providers are able to share questions and seek clarification as needed.
- The importance of mobile dentistry and using portable equipment needs to come out…particularly as we focus on equity. Bringing care to where people are is critical if we are addressing issues of equity – the priority needs to be to give people the care they need and want in ways it's easy for them to access.
- Issues of what patients should be looking and asking for
- Talked about information gap – the data that is needed – more technical stuff, such as where there is confusion about dental equipment, particularly around the requirements of different devices.
- Public/private partnership could delve deeper into that research, perhaps.

Distribution

- Underscored importance of distribution.
- Between all the people in this group, this will be widely disseminated.
- Concerns regarding this as an opportunity to do things differently butting up against another point of view about how quickly we can get back to doing things the way we always did them.
- Question about distribution: What have been the primary sources of information for dentists so far? These should be utilized for distribution.

Other

- We recognize that there are costs related to implementing these recommendations – perhaps we could share information about resources for assistance.
- There is a general lack of federal leadership from the start – convening of all of these voices early on would have made a significant difference.
- We need a hotline for dentists!

VI. Close

Mike Monopoli thanked everyone for being here, for the rich discussion at the start, and for everyone's input. Other key closing remarks included:

- There is an invite to a resource platform we are putting together. We will create a section on equity there, as well. Please take a look and give us feedback. http://pandemic.openoralhealth.org/
- We want to look at the additional priorities we named at the start of this group's work so we will bring the group together again on July 8 or 9 to agree on what we will focus on next…as we get to defining a clear ongoing role for this group.
- We'll be reaching out to you all to see who is interested in joining a communications working group.