Oral Health System: Pandemic Response

Virtual Meeting

July 29, 2020

4:00-5:30 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:
Maureen White, Interaction Institute for Social Change

Table of Contents

I. Start-Ups

A. Welcome

Pat welcomed everyone to the meeting with these comments.
Each time we get together it seems another landmark event has occurred…and today is no different. Since our last meeting…not only has the pandemic continue to surge in several states and now in other countries…but we also lost three civil rights leaders in the passing of Congressman John Lewis, Reverend C.T. Vivian and Charles Evers. The loss of these three gentlemen in a time when the need to address racial injustice and disparities is such a major part of our national dialogue is especially hard…but, our work pushes on….

B. Introductions

Participants and Guests

- American Association of Dental Boards (Robert Zena, DMD, President; Tonia Socha-Mower, RDH, Executive Director)
- American Dental Association (Jane Grover, DDS, MPH, Director, Council on Advocacy for Access and Prevention; Marko Vujicic, PhD, Vice President and Chief Economist, Health Policy Institute; Chelsea Fosse, DMD, MPH, Senior Health Policy Analyst, Health Policy Institute)
- 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)
- 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)
- Edwin A. del Valle-Sepulveda, DMD, JD, President, Hispanic Dental Association; Manuel A. Cordero, DDS, Executive Director)
- National Association of Dental Plans (Eme Augustini, Executive Director)
- Oral Health Coordinating Committee/IHS/USPHS (RADM Tim Ricks, DMD, MPH, FICD, Chief Professional Officer)
- National Dental Association (NDA), (Sheila L. Armstrong, DDS, President; Hazel Harper, DDS, MPH, Past President)
- National Dental Hygienists Association (NDHA) (Latisha Canty, RDH, Interim President)
- National Rural Health Association (NHRA) (Alan Morgan, MPA, Chief Executive Officer)
- Oral Health Progress and Equity Network (Ifetayo Johnson, MA, Executive Director)
- Santa Fe Group (Terri Dolan, DDS, MPH, President-Elect)

Unable to attend today's meeting

- Vicki Young, PhD, Chief Operating Officer S.C. Primary Health Care Association, representing the National Association of Community Health Centers
- Diane Oakes, MSW, MPH, Chief Mission Officer, Delta Dental of Washington

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 build alignment on the timing for a public messaging campaign, on actions to lessen disparities during the pandemic, and on the work of envisioning what the post-pandemic oral health care system will look like.

E. Desired Outcomes

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

- An update on developing a public messaging campaign and on OSAP's consumer and school-based settings safety checklists
- A list of actions to take to address the system's inequities now during the pandemic
- An awareness of the transformational moment provided to the field by the pandemic, and the need for this group to take up the work of change and envisioning a more equitable future
- An agreement on next steps

F. New Member

Pat welcomed new member Chelsea Fosse (ADA, HPI) and invited her to introduce herself to the group.

II. Update on Communicating to the Public

A. Setting the Context

Mike Monopoli opened this section of the meeting.
I'd like to start with an update on our work with OSAP. We've sent a link to the consumer checklist. We will do a webinar on August 6 to talk about the components of it and how it unfolded. The next step is to work with them to pull together OSHA and CDC guidelines around school-based dental care, which is delayed a bit because of everything happening with schools. We hope you can help distribute both the provider and consumer components of these guidelines.

B. Large Group Discussion

Pat invited the participants to discuss …

- What ideas do we have to ensure these reach the largest audience possible
- List ideas and next steps specific to distribute the Consumer guide
- How can we link the Provider and Consumer guides together in support of each other?

Comments from the group . . .

- Is someone able to highlight if there are significant differences from what the ADA produced for their patients? Nothing jumped out at me. I did notice lots of things saying, "Your provider may," not "Your provider should."
- The differences are minimal. The main thing is, this is what your provider should be doing. They are fairly comparable.
- What I would offer for consideration are some comments regarding the fact that this time period we are in is one where words really matter. There are some terms in here that are of concern to me, and that might impact our ability to distribute the documents. I completely understand that this is written for a consumer. But things like referring to people as furniture... "desk person" concerns me. If dental office managers where on this call... I bristle at defining them that way. There is a line towards the bottom that "These measures should protect you and your dentist from becoming sick." It doesn't represent an oral heath team approach, it's very dentist-centric. There is one mention of dental staff in the entire document. I know how my board thinks; that will come up right away. We are in a heightened stage of words mattering.

(Myechia) I want to make sure we are acknowledging Ann's point. We've talked about this as being an iterative process. How might we be able to address some of her concerns?
(Mike) It's an online document, so we have the ability to make those changes. If you give the corrections to me, we can make sure they are addressed. When we do the webinar we will have time to make those changes.
(Myechia) Ann, get in touch with Mike to make suggestions. I appreciate that I am usually the one making these comments, I want to make sure we are addressing it. We want to get to where people are comfortable distributing it. If there are other barriers to doing that, we need to know that. Please let us know other concerns.

- I looked at it again, and I think every sentence starts with, "Your dentist may..." Is there any way to make it stronger to say, "Your dentist should," or start with "You may want to ask your dentist if they are doing these things"?

(Myechia) The hesitancy with "should" is understanding the different resources different dentists have; some don't have resources to put certain things in place. It's a fine line to balance. We could say "Your dental team" or "Your dental providers."
(Mike) There are also differences in different places in terms of the environment that dentists and teams are working in. If you have specifics, let me know. We've been continually working to get it at a more accessible literacy level. This feedback is important to add to what we are doing.

- This is framed as guidance. There's got to be some disclaimer that the practice may not have all of these things. With my association, every day there's something different out there; is it required? Is it best practice? Do we have resources to respond to it? My thinking is that I'm hopeful the majority of our association has a positive response to it. They are responding to so many kinds of guidance at once, and then they change. I hope the majority of our dental teams can comply with it. It's about communication. I agree that words matter; we need to be clear what we are putting out there.
- My question is, if we share it and it says "they may," and they don't... are they unsafe? It's confusing. I don't want to sandbag this, but if my dentist doesn't have it I may think they are not safe.

- This is for consumers, not dentists. It's for the person trying to decide if it's safe to go back to the dentist. What should I be asking my dentist about so I feel safe going there? The checklist is things I need to see if my dentist is doing; if they are not doing lots of them, it may be not safe to go there.
- Would it be useful to translate this into other languages, or use a graphic version for people with lower literacy levels?

(Mike) Yes to different languages. If there is a sense we should do something more visual, we can do that as well.

- I think we need to be more specific. If it's for the consumer, we should narrow down what they should be looking at, not have all the possibilities. Keep in mind that the levels of literacy will be very, very diverse. Keep it simple, not overwhelming, because people are scared. Help them come back for care they need, and not be scared. Maybe make it more precise than the ADA guidelines.

(Mike) Thank you all for this feedback, it's extremely important and helpful. We will go back and revise and make sure that what we are presenting fits the feedback you gave us.

I want to also give an update on the communication campaign. We talked at our last meeting about communication and developing key messages about oral health, who are the right messengers, and what are the right messages. But given the spread of the virus in certain parts of country, and the lack of clarity on how phase one of the pandemic is going to turn out, I've heard from folks that this probably isn't the time to start that campaign, and that we should wait and see how things play out over the next month or two. Anyone have comments or objections to that?

- I agree. Three-fourths of all rural counties are now in the red zone.
- To clarify, are you saying we should hold off on promoting this document?

(Mike) No, I'm onto the larger communications campaign. Once we make revisions to this newest document it's important we have something for the public.

- I agree, Mike. I don't believe the public would be listening for a safety issue that they haven't raised. There is no identifiable anxiety currently; the public is remarkably comfortable with their dental visit. There are no reports of transmission from a dental team to their patient, or vice versa. At a time less than 100 days from an election, it would be a luxury that I don't think the oral health community could fund or is necessary. I'd rather keep our powder dry, and have resources to respond later when a need materializes.

C. Comments from the Group in the Chat

From Latisha Canty: social media
From jane Grover: Health care journalists
From Stevie's: press conference and health editors for a start.
From Chelsea Fosse: Community facing organizations like the National Association of Local Boards of Health, National Library Association, PTAs, etc. All are looking for "easy" pre-packaged content as they still rely heavily on virtual offerings/information sharing.

From Sarah Miller: Could we also get it to elected representatives? I know that some will share out on their social media resources or information helpful for their constituents
From Teresa (Terri) Dolan: Will this be translated into other languages?
From emeaugustini: Possible space for interchangeable authors, particularly if community groups would like to brand this as part of a broader health campaign
From Manuel A. Cordero, DDS: I agree with the caution of making this mandatory or judgmental to those that may not have the means of providing all the suggested measures.
From Ann Battrell: agree with Alan's point. What if they don't?
From Hazel Harper: Association of Health Care Journalists
From RADM Tim Ricks: Marko, what % of consumers said that they needed assurances that returning to the dentist was safe? "May" doesn't convey safe.
From Ann Battrell: Agree with Dr. Ricks
From Christine Wood: And if they are not complying, is it safe?
From RADM Tim Ricks: On a positive note, the reading level of the document is good - 5.3 on the Flesch-Kincaid, with an 81.2% readability level.
From Myechia Jordan: not sure that we can say with certainty that anything is safe right now.
From Myechia Jordan: we have to use our best judgement…with the information that we have
From Christine Wood: Agree!
From Steve.Kess: Agree completely.
From Ifetayo Johnson: Agreed.
From Myechia Jordan: please do feel free to reach out to Mike with suggestions for continued improvement of the document. Many thanks for your input
From Teresa (Terri) Dolan: Other ways to make this important information accessible to consumers, you could consider developing a "graphic" version, and one that is appropriate for children, for example.
From emeaugustini: Graphic/picture/icon version is a good idea
From Manuel A. Cordero, DDS: excellent point, sometimes it is the child who translates to the parents.
From Marko Vujicic: Agree with Steve. The research shows there is really no major issue among the public in visiting the dentist. There is no need for any type of campaign now in my view.

III. Current Reality: Disparities and Impact

A. Presentation

Pat introduced Dr. Minter-Jordan to lead the group through a look at the current reality about disparities.

We know our oral health system doesn't work for everyone. The pandemic has highlighted inequities; I want to walk us through some of the data that speaks to some of the root causes of inequities. Today I hope we can come away with answers to the question, what can we do as leaders to re-thinking how we are thinking of provision of oral health to underserved populations?

Myechia went through the presentation: New Oral Health Data Reflects Inequities and Barriers
The point of sharing this information is it's important ground setting as we think about what we can do as leaders. What can we do now? Hopefully we can understand what the inequities are we are seeing in our own organizations- from boards to those on the frontline. I'd like us to come away with concrete action steps to move the needle on inequities within oral health.

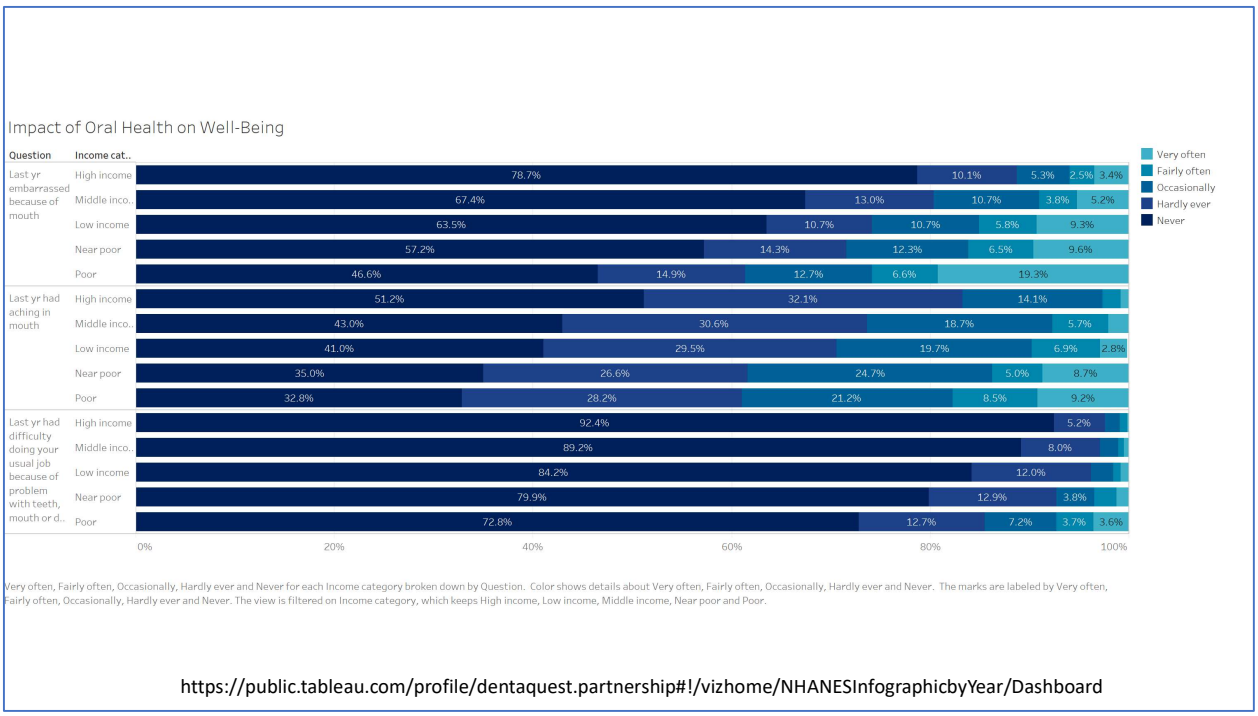
Top Reasons for Unplanned Dental Visits

- Before COVID-19, access to routine dental care was limited for many Americans, and low income adults face a greater challenge because of the cost of care or lack of coverage through Medicaid, which can lead to an increase in unplanned dental visits.
- In 2017 to 2018, 63% of the population had a dental visit within the past 12 months, BUT nearly 1 in 13 of these visits were for unplanned dental services due to pain or another problem.
- In addition, nearly 1 in 4 dental visits were made by those in "near poor" families. People in these families are more than twice as likely to have an unplanned dental visit compared to high-come families.

Unmet Dental Needs are Common and have a Profound Impact

- It is also clear that these unmet dental needs are common and have a profound impact on low-income Americans.
- They are 2.2 times more likely than those at higher incomes to have unmet dental needs due to lack of insurance coverage.
- Also, those living in poverty are 102 times more likely to have difficulty doing their job because of oral health conditions and they are 215 times more likely to have oral pain than those at high incomes. The graph on the next page will give you a better visual of this disparity.

Impact of Oral Health on Well-Being



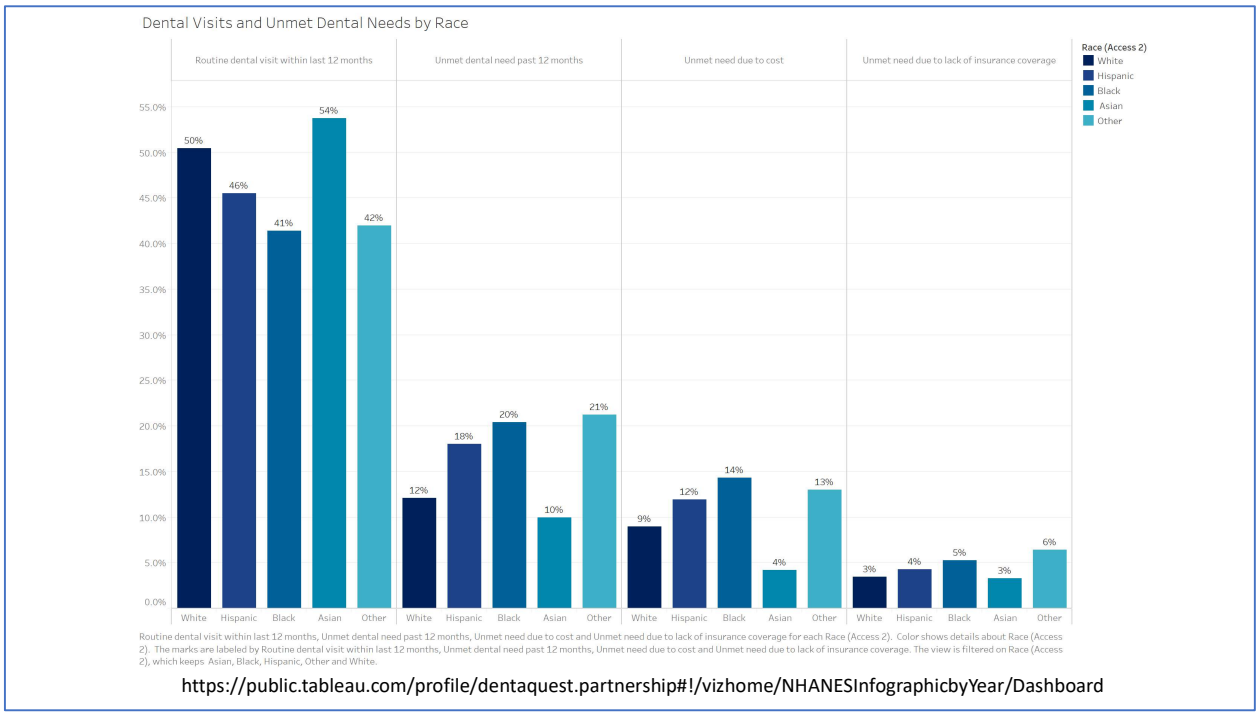
https://public.tableau.com/profile/dentaquest.partnership#!/vizhome/NHANESInfographicbyYear/Dashboard

- The graph shown here was taken from our live data dashboard that allows for interactivity and you can access the dashboard using the link included in the PowerPoint slide. Our data dashboard shows that inequities and barriers to oral health care has always been an issue.
- This graph, in particular, demonstrates the burden of oral health conditions between high- and low-income Americans.
- As you can see, those with low income and below poverty level are more likely to experience these oral health conditions compared to the high-income individuals. This graph also shows how important it is to maintain your oral hygiene because it can impact your overall health which can ultimately affect daily functioning.

Unmet Dental Needs are Common and have a Profound Impact

- Not only that, racial disparities continue to persist in access to oral health care among different groups.
- The data shows that Black adults are disproportionately impacted by lack of access to preventive services. Black adults are 68% more likely than White adults to have unmet dental needs for any reason and 22% less than White adults to have had a routine dental visit in the past year.
- In addition, Latino adults also are affected by this issue. Latino adults are 52% more likely to report having difficulty doing their jobs due to poor oral health.

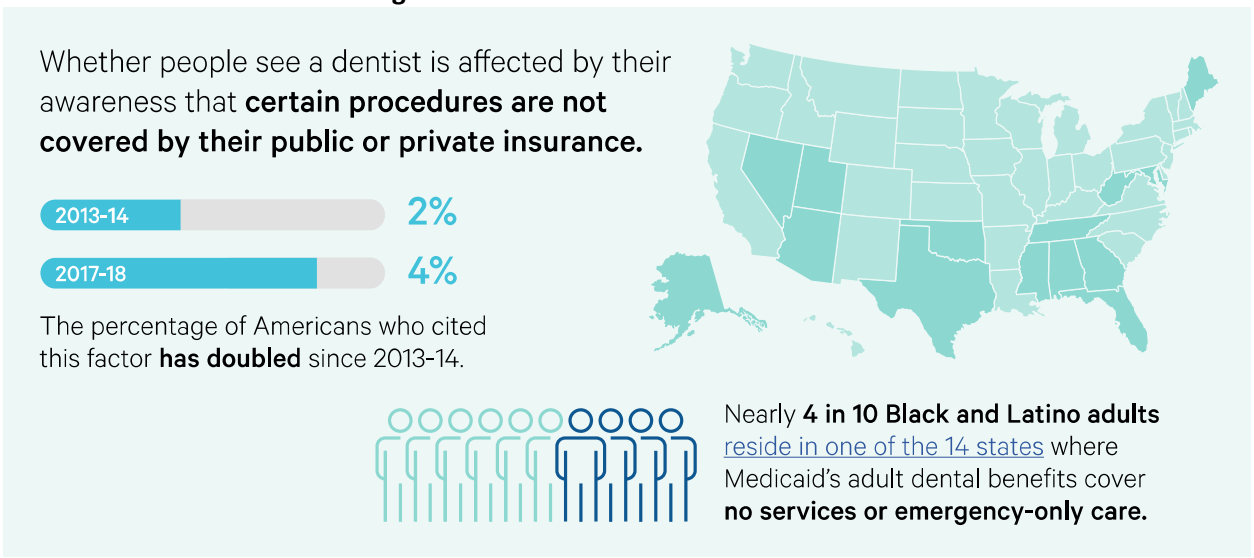
Dental Visits and Unmet Dental Needs by Race



https://public.tableau.com/profile/dentaquest.partnership#!/vizhome/NHANESInfographicbyYear/Dashboard

- Here is another graph from our data dashboard that shows the percentage of dental visits and unmet dental needs by race. Blacks and those of other races had higher rates of unmet dental needs due to cost and lack of insurance than other racial groups.

Lack of Dental Insurance Coverage Matters



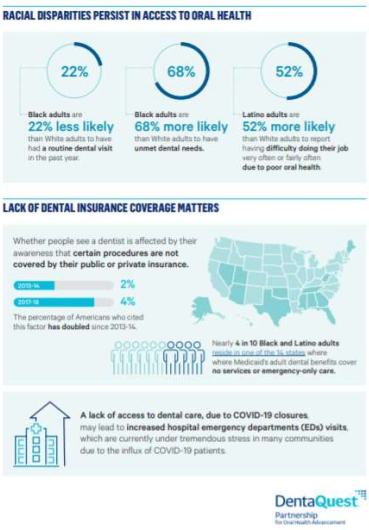
- More importantly, dental insurance coverage is critical for all Americans because cost remains the key reason for not seeing a dentist. As you can see, the percentage of Americans who reported this factor had doubled since 2013 to 2014.

- In addition, nearly 4 in 10 Black and Latino adults reside in one of the 14 states where Medicaid's adult dental benefits cover no services or emergency-only care.

A lack of access to dental care, due to COVID-19 closures, may also lead to increased hospital emergency department visits, which are currently under tremendous stress in many communities due to the influx of COVID-19 patients.

Access to DQP's Infographic & Dashboard

https://www.dentaquestpartnership.org/research



For more information on health disparities, please visit our website to access our latest infographic and dashboard.

B. From the Chat

From jane Grover: The American College of Emergency Physicians (ACEP) actually told us directly in May that ED visits for "dental" were greatly reduced
From Teresa (Terri) Dolan: Knowing that COVID disproportionately impacts older adults and those with chronic conditions, is this the time to focus on advocacy for a dental benefit in Medicare?
From Ifetayo Johnson: ED use may be reduced because of COVID use of the ED and fear. Not a reduction of need.
From Myechia Jordan: yes!!!! @TerriDolan
From jane Grover: Right- not decreased need. But decreased use of the ED- perhaps temporarily. The Associate Executive Director of ACEP is on our ED Referral Workgroup
From Myechia Jordan: would be interesting to understand if that data is by race/ethnicity

B. Remembering Congressman John Lewis

(Pat Finnerty) We are going to move into small groups to discuss the disparities that have become even more pronounced in the pandemic. But I first want to share some inspirational words from Congressman Lewis about what it takes to make real change.

https://www.youtube.com/watch?v=5_dUlqbACGc&feature=youtu.be

(Dr. Minter-Jordan) I've had the immense privilege of meeting Congressman Lewis many times. In my former job he graced us with his presence at the community health center. The words he shared were incredibly powerful, and I use them for inspiration.

If this man, who was bloodied and beaten, can keep talking about being hopeful... in that spirit, how can any of us not be hopeful? How can we not do this work? Given all the things he did in his lifetime, I have no right not to be hopeful.

(Pat Finnerty) The other thing that strikes me is how his words have even greater relevance today. We've lost him but we can't afford to lose his spirit. It's up to us in the oral health world to keep that hope and passion alive.

C. Breakout Groups

Participants worked in small groups, and then reconvened to report back on their discussions in response to this question: What actions can we take now, in the middle of the pandemic, to begin to address the disparities in the oral health care system?

Group 1: We need research on the impact of COVID on underserved communities and communities of color and break out data on communities with high African American populations. And the impact on communities with rural health clinics or no clinics. Have they seen a decrease in visits? What has been the impact on underserved communities? We are seeing the potential for shutdowns of oral health facilities in underserved communities. Integrating oral health with primary care is so important at this time. What ways are there to incentivize this now, during COVID, so that oral health questions and referrals happen during wellness visits?

Group 2: We talked about the need for data and research and understanding, but also not viewing all these groups as monolithic. There are specific communities that have different realities and experiences that could be represented in the data that is collected. Another point is using telehealth visits for the promotion of oral health. We were also commiserating over the funding for benefits, and for the challenge at the state level for Medicaid benefits and reimbursements. We need to protect the progress we've made.

Group 3: We talked about similar things as group 1. What are the racial and ethnic implications of the disparities we see? On top of the initial disparities and barriers to access, COVID has demonstrated some more areas we need more data on. What are the new barriers to care that COVID has created? As we determine the strategies to come up with the messages and the delivery of the messages, there must be an inter-professional approach to developing the strategies and to address anxieties that are in communities of color. Need to be working more with psychologists and social workers, and dentists have a role in being more empathetic to the struggles.

Group 4: We talked about the importance of education and educating in the schools, looking at dental students as well as the current oral health practitioners. Are there ways to encourage state dental boards to accept public health certificates? We'd like to see all practitioners be eligible to take public health CE's. Also the importance of understanding equity; we want to see if there are public health CE's that really delve into that topic.

Group 5: We talked about some of the initiatives already being undertaken. The Santa Fe group is attempting to diversify their membership, and there is a new mentorship program. As well as making the table more inclusive for an inter-professional conference coming up in 2021. The ADA had one of their first town hall meetings focused on diversity, equity and inclusion (DEI), and there is a work group to focus on staff and DEI. At the council level they are working on diversifying the membership and being inclusive of different perspectives. We talked about potentially reconvening the National Oral Health Alliance, and that the Access to Care Summit can be inclusive and diverse in the planning. The landscape is about how to make the table more diverse and inclusive, and make sure the upcoming events reflect that as well. We also talked about working with dental schools to promote diversity and inclusion among them, changing the perception at the educational level.

Group 6: We talked about improving public health infrastructure; increasing awareness of opportunities in community health centers; increasing awareness of funding opportunities for health clinics and looking at funding structures; and addressing any education gaps in public health. Also working with dental students. And the increasing advocacy efforts around looking at Medicare and Medicaid benefits.

IV. Moving Forward

A. Closing Comments

(Mike Monopoli) Thanks for your valuable input. There are lots of great ideas to move forward on. We are in a time of extraordinary opportunities and challenges. Institutions are teetering, and there is suffering around the world. There is also a profound opportunity to rebuild and rethink a more equitable healthcare system. We have been talking about seizing that opportunity and aligning around what that new system might look like. As the pandemic unfolds, we'd like to propose how we might adapt this group to implement a re-envisioning of where the world can go. We propose taking a bit of a break in August, and we'll reach out to you for feedback, and then we'll reconvene in September with a proposal.

(Pat Finnerty) Laurie has posted a doodle poll in chat for a next meeting time. Please let us know what works best for you. As we prepare to close, we have a few minutes to get initial reactions to what Mike shared about the potential role of this group in a post-pandemic world.

- I'd like to recognize Tim Ricks who has been running a COVID task force. We know it's going to need to continue longer than anticipated. It's provided a forum for organizational dialogue. It really needs to think itself through, separately from an organization like this one. There's an important role for a government agency to be a liaison with both the public and private sector. Hopefully it will continue through the pandemic and beyond. We should be aware of it. We also have an opportunity to think about where does the talent and engagement of individuals in the group convene during COVID, with an intention to exist post-COVID. Until the elections are over, we are not sure what agencies will be able to do in 2021. I think the pause is a good idea, and also work needs to be done. We need to plan for day one regardless and should think

about reconstituting the energy and sprit of what took place 10 years ago, and maybe reshape how we implement change with some stakeholder involvement in the mission. There are a number of organizations that could find financial support for it.

- I want to commend Mike and Pat and your team, the value you brought in having these pandemic calls is that we got to know each other better, and it provoked a lot of thoughts. I think this group has done a lot as far as being catalysts for different thoughts and changes we should think about. With the COVID group, we have about 20 organizations and it's beginning to grow. I'm going to invite all of you. In a post-COVID world, I think we do have an opportunity. There is more that unites us than divides us. We have strength in numbers, especially in getting non-dentist opinions. A lot of times, it's dentist-centric, getting other perspectives is important. I see this alliance growing and including non-traditional stakeholders and all of you.

Pat closed the meeting by saying thanks. We are grateful to everyone for being with us. Stay healthy and we'll see you in September.

B. From the Chat

From RADM Tim Ricks: The U.S. Public Health Service is now accepting student applications - www.usphs.gov. Please help spread the word! We have hundreds of vacancies across the federal government for dentists and dental hygienists in multiple agencies. www.usphs.gov. Previously, you had to be a graduate and be licensed before you could apply to the USPHS. Now a 3rd or 4th year student can start their application.
From jane Grover: Would like to hear the consumer voice among our discussions. Thank you
From Ann Battrell: Need to consider rising poverty and unemployment rates on the impact of consumer health care choices.
From Chelsea Fosse: Agreed, Jane! Perhaps an invitation could be extended for a consumer voice(s) via Families USA, Family Voices, AARP, etc.
From Ifetayo Johnson : Can we take a brave vision of moving away from the status quo and daring NOT to get back to "normal" and instead looking at ways we can challenge the systems we have come to depend on by bringing in the voices of those we hope to serve to help us rethink how we can better address their needs.