Oral Health System: Pandemic Response

Virtual Meeting

September 9, 2020

4:00-5:30 pm ET

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.
Welcome back from our August hiatus. With schools reopening, the upcoming flu season, and more anticipated coronavirus spread, this will be a busy fall.

Pat read aloud the purpose of the effort in which we're engaged. See below.

B. Introductions

Participants and Guests

- American Association of Dental Boards (Tonia Socha-Mower, RDH, Executive Director)
- American Dental Association (Jane Grover, DDS, MPH, Director, Council on Advocacy for Access and Prevention; Chelsea Fosse, DMD, MPH, Senior Health Policy Analyst, Health Policy Institute)
- Arcora Foundation (Vanetta Abdellatif, President and CEO)
- 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)
- 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)
- Hispanic Dental Association (Edwin A. del Valle-Sepulveda, DMD, JD, President; Manuel A. Cordero, DDS, Executive Director)
- National Association of Community Health Centers (Vicki Young, PhD, Chief Operating Officer)
- National Association of Dental Plans (Eme Augustini, Executive Director)
- National Dental Association (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)

Unable to attend today's meeting

- American Association of Dental Boards (Robert Zena, DMD, President)
- American Dental Association (Marko Vujicic, PhD, Vice President and Chief Economist, Health Policy Institute)
- American Dental Hygienists Association (Ann Battrell, MDSH, Chief Executive Officer)
- Delta Dental of Washington (Diane Oakes, MSW, MPH, Chief Mission Officer)
- Dental Trade Alliance (Sarah Miller, MPA, Development Coordinator)
- Oral Health Coordinating Committee/IHS/USPHS (RADM Tim Ricks, DMD, MPH, FICD, Chief Professional Officer)
- Santa Fe Group (Terri Dolan, DDS, MPH, President-Elect)

Guests

- Julie Frantsve-Hawley, Director of Analytics and Evaluation, DentaQuest Partnership for Oral Health Advancement.

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 understand the most recent data on safety and infection control in communities and schools, and to build alignment on the purpose and focus of this group moving forward.

E. Desired Outcomes

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

- An update on OSAP's school-based safety guidelines and on their listening sessions re: infection control
- An opportunity to dive in on relevant topics and issues to discern the purpose and focus of the group going forward
- An agreement on next steps

II. Update from OSAP

Mike Monopoli opened this section of the meeting.
As always, OSAP has been doing extraordinary work, advising providers, federal agencies, and the public about oral health safety. This has included hosting a series of listening sessions to learn more about current safety and infection control concerns. To learn more about both of those efforts, and because OSAP was unable to attend today's meeting, we will be hearing from Julie Frantsve-Hawley, Director of Analytics and Evaluation, DentaQuest Partnership for Oral Health Advancement.

A. OSAP Update: Julie Frantsve-Hawley, Director of Analytics and Evaluation, DentaQuest Partnership for Oral Health Advancement

Julie shared the following updates:

- There were a series of listening sessions that OSAP was contracted to do by the CDC, a wide range of topics were discussed, including mobile and school-based programming. Mobile dental care providers are waiting for CDC guidance on infection control procedures for care in alternative settings.
- OSAP is eager to move forward with interpreting and publishing the above guidance, but since OSAP does not create its own guidance, but rather gathers guidance from others, there is a delay. To that end, an OSAP team is beginning on September 15 to work with the CDC on suggested guidance for the school based and mobile providers. Once a document is completed,

it is unclear how long the CDC clearance process will take, so the release date of the mobile infection control guidance is unknown.
- An update to the OSAP/DentaQuest Best Practices document was published on August 26, 2020 aligning with the August 4 CDC guidance.
- On August 28, 2020 the CDC again published updated guidance with clarity upgrades but no content change.
- The OSAP/DentaQuest patient checklist on what to expect during dental visits, has been released in a Spanish version.

C. Large Group Discussion

Pat invited the participants to ask questions and share comments regarding Julie's update.

(Chris Wood) In the absence of guidance from the CDC regarding schools, we did a survey of state dental directors regarding school-based care. We were surprised at how many dental directors have been contacted by schools to invite them to restart school-based care. To find out more, we've scheduled interviews with those states – to be completed by September 22. We're trying to gather examples of letters or emails they've sent to superintendents and principals, examples of revised consent forms, examples of revised MOUs, and info about what challenges they've encountered in returning to schools. We will compile this information in a toolkit to share with other school-based programs.

(*Dr. Jordan)* Could you apply a lens of race and ethnicity to the data you're collecting? It would be interesting to understand as we look at access in schools if there are differences. Please consider reporting out on which programs are agreeing to have school-based services resume, and if there are differences in the populations that are being served by those programs.

Other requests for data included:
- The effect of COVID on communities of color…many of these students may have had higher exposure…and it would be interesting to have any information that can be gathered to reflect the implications of this.
- Which of these schools are Title I schools so we know more about the social determininant factors while we're at it?

(Chris) Yes, we always ask schools to gather data on the kids they see. What's germane is that we're hearing that the decisions are being made on a school by school basis. We'll do more interviews once the dental programs are into the schools. We're starting with how the decisions are being made as to which schools they're going into.

From the Chat:
(Christine Wood) When talking about collecting data about successfully returning to schools, I wrote myself a note that ASTDD should find out the race/ethnicity makeup of the students in schools that have agreed to let oral health programs back in. Are schools with a greater percentage of minority students more likely to allow oral health programs back in? Also, we should find out if schools that want oral health programs back in are more likely to be located in communities that have suffered disproportionately from COVID-19? There was a third request, but I didn't capture. Can you refresh my memory?

(Hazel Harper) Is there a significant difference between percentage of Title I schools and non-Title I schools and their receptivity to allowing oral health programs back in?

III. Open Space Conversations

A. Setting up the Process

Pat explained the process for today's small group conversations.

We are borrowing heavily from the Open Space Conversations methodology, where folks get to participate in the conversations that most interest them. The belief here is that the outcomes from these conversations will guide our purpose and focus moving forward. Over the course of our time together, you have already identified areas of importance, including ideas and action steps, a summary of which you received by e-mail. Today we will build upon those areas and give you the opportunity to go deeper and make recommendations to the group for how to follow-up.

The areas of importance identified by you are:

A. Advocating for better oral health coverage in Medicaid and a dental benefit in Medicare
B. Increasing the use of tele-health and other new technologies in oral health care
C. Addressing structural racism in the oral health system so that we move instead toward structural equity
D. Diversifying leadership in the dental industry
E. Improving the oral health public health infrastructure
F. Understanding the root causes of the obstacles to achieving equitable access to oral health care in the U.S.
G. Envisioning a post pandemic oral health system that prioritizes equity and moves from procedures to treat disease to promoting oral health
H. Increasing equitable access to oral health services across the U.S.
I. Improve the availability of data and research by sub-populations to support better-informed policy decision-making
J. Integrating oral health into primary care and amplifying opportunities for interprofessional care
K. Developing and deploying effective messaging and communications about oral health

We are assuming that, over the next period of time, this group will have the bandwidth for only a few of these topics - in addition to our continuing focus on safety for patients and clinicians. We asked you ahead of the meeting to choose the topics of most interest to you, and a few of them were not selected by more than one person: B, D, E, G, H. The desired outcome for your breakout group conversations is to prepare to make the case as to why your topic should be prioritized and is one that this group is best positioned to have an impact on going forward.

B. Breakout Group Reports

Pat invited the groups to report back by making their case as to why their topic should be a priority in the sequence of issues to be taken up by the group.

Breakout Group A - Advocating for better oral health coverage in Medicaid and a dental benefit in Medicare (*Vanetta, Mitch, Steve)*

This is important because if we're able to get dental as an essential, mandated service it will be a game changer. It won't assure access, but it will be a huge advantage. Given all that is going on, it's more evident than ever that this is needed.

- Dentistry has to be funded, especially with respect to health care disparities. A lack of access is a huge issue. Dental needs a primary place in primary care.
- Our one recommendation for a strategy is to have a high-level conference of all stakeholders and expose them to why this message is so important – the total impact on health care costs…so we can elevate this message to policy makers. Dentistry is so inexpensive compared to what it costs to take care of problems later on.
- We could also learn as a group from those who have been ahead of the curve for a long time – figuring out how to make changes ahead of us.

Breakout Group C - Addressing structural racism in the oral health system so that we move instead toward structural equity (*Dr. Jordan, Hazel, Vicki)*
See appendix for additional notes from this group.

- We started talking about the incredible work the NDA is doing…because there is a need for leadership to step up and contribute to ways to move from structural racism to structural equity.
- Looking at the other topic areas, everything relates to moving to a system that is structurally equitable, so we believe it needs to be at the core of this group's focus.
- We want each of you as leaders to see yourselves in this work. We think each of us can use data to drive systemic change. It's not just programmatic, but also how people are trained.
- We looked at community health center structures – looking at creating a system that produces more equitable results.
- We think leaders in this group can influence policy – policy reform, education, and how policy is established – to affect the structures that produce oral health inequities.
- It is critical that we gather data to identify where there are opportunities to address structural racism and prevent it in new systems that are being designed. This is especially important given the pandemic.

Breakout Group F- Understanding the root causes of the obstacles to achieving equitable access to oral health care in the U.S. (*Ife, Latisha, Mike)*

- To understand something as difficult as root causes, we have to travel upstream and challenge the status quo. To envision what the system should look like, we need to think about those we are trying to serve. They need the right information in the right environment.
- The Pandemic Response Workgroup came together for this reason. We are well positioned to take this on – we are part of the problem – we helped build the system – and we can be part of the solution. We can shine light on the issues. We've created a safe space to have these conversations about root causes.
- And as America is changing demographically, those in the elite that our system is designed to serve are becoming smaller and a more diverse cultural group is growing. We need to serve that larger population in a more equitable way – either that or we go broke.

From the Chat *(ifetayo)* Last thought for Group F. For any of these things to be accomplished, we must first start with the root causes so that we will be in agreement on what we want to change, how we want to change them and what our messaging should be.

Breakout Group I - Improve the availability of data and research by sub-populations to support better-informed policy decision-making (*Chelsea, Tonia, Chris)*
See appendix for additional notes from this group.

- We started talking about how data is the starting point for all of the identified goals. We need it to demonstrate the need for change in all areas. Without it we can't make informed, evidenced based decisions. Data has a role to play in every other area. The challenges we have with data are at the patient level – no uniform records or diagnostic codes, issues of proprietary information, hurdles with accessing or producing evidence-based research, variability in how we collect data on measures that are seemingly similar…makes it difficult to collaborate.
- Different approaches need to be taken at local, state and national levels.
- Info needs to be made accessible and digestible
- Difficulties with data sharing
- The data has to date not always had a health equity lens – need to re-evaluate how we collect data with that lens.
- Need to shift to outcomes research from performance-based research. We rarely reach out past our silos to learn what would help support others' efforts.
- More work on the workforce side but highly variable.
- Public/private partnerships in data reporting are also needed.
- Lots of opportunity, and need for collaboration.

Breakout Group J- Integrating oral health into primary care and amplifying opportunities for interprofessional care (*Alan, Jane, Edwin)*

We love this topic and believe there are three reasons for it to be our focus:

- If you peel back layers, it addresses all of the other topics. The lack of interprofessional care and understanding in the medical field is a cause of many of our challenges. Having the medical voice amplifies our voice to expand and leverage all of our other efforts.
- This topic engages in continuous provider improvement and works throughout the life span of the patient and the provider. The patient can be truly at the center, with the medical and dental world revolving around them.
- The economies of training will lead to economies of scale. The more we know about each other's work, the more team-based will be our approach. It saves patient time and provider time and achieves better outcomes.

Perfect for this group because it's like no other. We are provider-facing and action-oriented.

Breakout Group K- Developing and deploying effective messaging and communications about oral health (*Eme, Sheila, Manuel)*

- The most compelling reasons communication and education should be a project for this group is that when COVID spread, we heard folks say directly or indirectly that dental is not essential. This clearly indicates a lack of understanding. There are short-term challenges if COVID continues, and long-term messaging underlies all other efforts we've talked about.
- We need better communication with health care, policy makers, and patients.

- This group is in a unique position to understand the messaging we're already engaged with, to quantify the message, and to coordinate the messaging as we move forward.
- It's important to impart that education is for all involved – oral health and health care communities, and communities-at-large. When we talk about oral health literacy we think about patients, but providers need to be educated as well. There has been a lot of miscommunication and mishandling during this epidemic. It's not about teeth, it's about health.

IV. Next Steps and Close

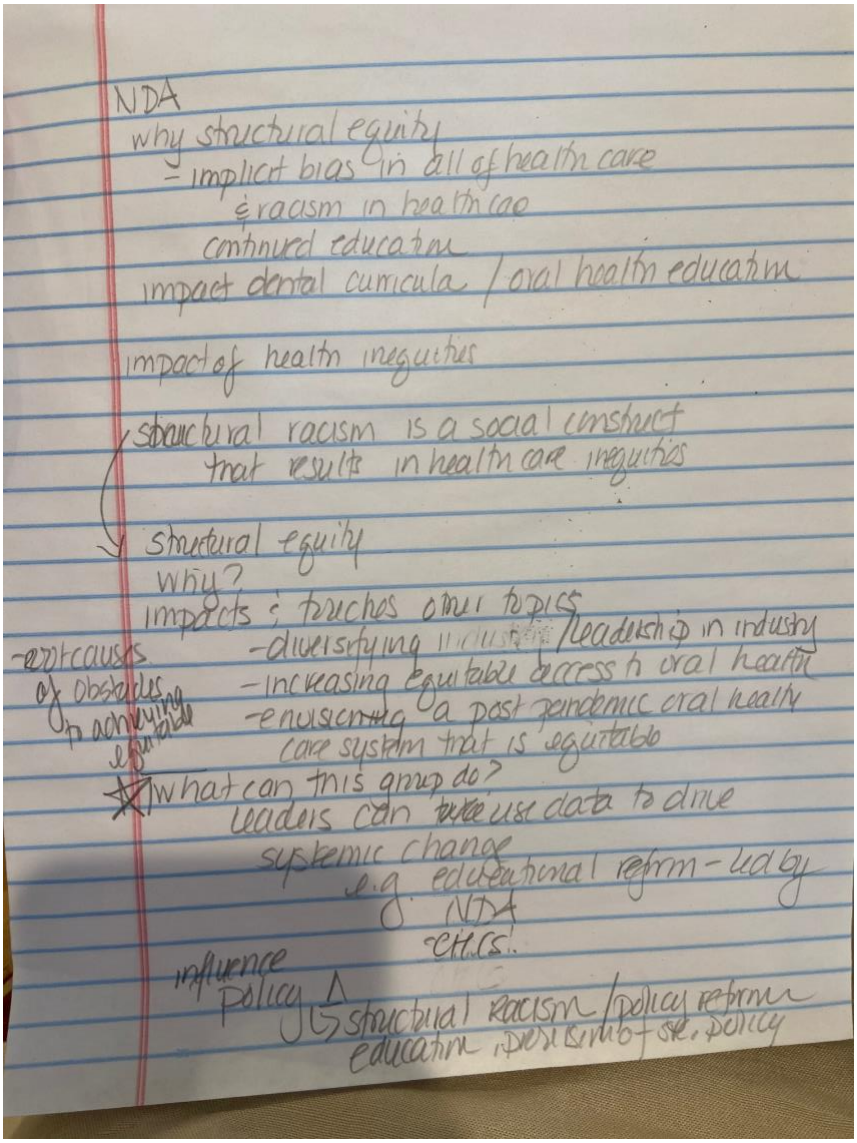
A. Closing Comments

(Mike Monopoli)
The discussions were clearly all amazing and the output very important. Feel free to share notes with Mike. We will take all of the information that you generated in your small groups and create a proposed sequence of topics and an order in which to tackle them. We will then come back to you with a process proposal for how to move forward, most effectively utilizing the opportunities of this group.

(Dr. Jordan) The level of engagement today speaks to why this group exists. The ability to bring your leadership to this group as you have done is incredible. Another benefit is the ability to network for feedback and input. There is great value in this. Please continue this high level of engagement, use ourselves as a resource, drive change as we already have done. The potential of this group is unmatched. I hope you are energized. I look forward to connecting with you all again soon.

V. Appendix: Breakout Group Notes

Breakout Group C- Addressing structural racism in the oral health system so that we move instead toward structural equity



Breakout Group I - Improve the availability of data and research by sub-populations to support better-informed policy decision-making

- Data serves as the starting point for making decisions on policy, programs, evaluation. Without having the data, you can't make the case to make any policy decisions, program decisions, evaluation… Everything should be data-driven…

- Challenges with data
    - Patient level, in practice, no uniform records, no diagnosis codes, claims being proprietary
    - Access to researchers, experts
    - Variability in collection on measures
    - Collecting representative data at the local, state, national level
    - Reporting it in a digestible format
    - Data sharing
    - Historically hasn't been collected or reported with an equity lens

- The need for consumer-based research, shift to outcomes research
    - Opportunities for public-private partnerships. The role of industry, at least in terms of patient preferences of products… How do those in dental public health make the case for collaborating for consumer-based research?
    - We rarely ask the communities what data they want about their community in terms of oral health

- Dental workforce data collection varies widely state to state… Need the ability to share data that is state-specific even if not uniformly collected by others, but could serve as motivation for other states to do the same

- ASTDD Oral Health Data Portal:
    - Brings data in from multiple sources so it's easily accessible. Users will be able to look at particular indicators at state level.
    - Hope is that researchers will be able to start identifying the factors that have the greatest impact on oral health status, outcomes. Availability of dentists, insurance coverage, Medicaid participating providers, benefits packages and covered services, cultural competency of providers. How do these impact oral health status? What factors make the biggest difference?
    - Access for the public, for policymakers, for researchers to access and manipulate the datasets