Oral Health System: Pandemic Response Working Group
Virtual Meeting
May 19, 2021
4:00-5:30 pm ET

Group Memory

Convenor:
Michael Monopoli, Vice President, Grants Strategy
CareQuest Institute for Oral Health

Facilitator:
Patrick Finnerty, Strategic Advisor
CareQuest Institute for Oral Health

Content Manager:
Sara Oaklander, Interaction Institute for Social Change

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I. Participants

A. Pandemic Response Workgroup

The following Pandemic Response Workgroup participants were present at the meeting.

Name	Organization
Ann Battrell, MDSH	Chief Executive Officer, American Dental Hygienist Association
Latisha Canty, RDH, MS	President-Elect, National Dental Hygienist Association
Gregory Chavez	Chief Executive Officer, Dental Trade Alliance
Manuel A. Cordero, DDS, CPH, MAGD	Executive Director & Chief Executive Officer, Hispanic Dental Association
Susan Flores	Senior Policy Coordinator, California Pan-Ethnic Health Network
Mitch Goldman, JD, MBA	Executive Committee, Association of Dental Services Organizations, and CEO, Mid-Atlantic Dental Partners
Jane Grover, DDS, MPH	Director, Council on Advocacy for Access and Prevention, American Dental Association
Hazel Harper, DDS, MPH	Past President, National Dental Association
Ifetayo Johnson, MA	Executive Director, Oral Health Progress and Equity Network
Steve Kess, MBA	VP, Global Professional Relations, Henry Schein
Mike Monopoli, DMD, MPH, MS	VP, Grants Strategy, CareQuest Institute for Oral Health
Alan Morgan, MPA	Chief Executive Officer, National Rural Health Association
Colin Reusch	Senior Advisor, Oral Health Policy, Dental Access Project Community Catalyst
RADM Tim Ricks, DMD, MPH, FICD	Chief Professional Officer, USPHS, OHCC, IHS
Tonia Socha-Mower, MBA, EdD	Executive Director, American Association of Dental Boards
Emily Stewart	Executive Director, Community Catalyst
Barbie Vartanian	Executive Director, Project Accessible Oral Health
Christine Wood	Executive Director, Association of State and Territorial Dental Directors
Robert Zena, DMD	President, American Association of Dental Boards

The following Pandemic Response Workgroup participants were unable to attend today's meeting.

Name	Organization
Vanetta Abdellatif, MPH	President and CEO, Arcora Foundation
Pamela Alston, DDS	President, National Dental Association
Eme Augustini	Executive Director, National Association of Dental Plans
Stacy Bohlen	CEO, National Indian Health Board
Edwin A. del Valle-Sepulveda, DMD, JD	President, Hispanic Dental Association

Terri Dolan, DDS, MPH	President-Elect, Santa Fe Group
Chelsea Fosse, DMD, MPH	Senior Health Policy Analyst, American Dental Association Health Policy Institute
LaVette Henderson	Executive Director, National Dental Association
Casey Long	Public Health Project Associate, National Indian Health Board
Sarah Miller, MPA	Director of Philanthropy and Foundation Operations, Dental Trade Alliance
Myechia Minter-Jordan, MD, MBA	President and CEO, CareQuest Institute for Oral Health
Diane Oakes, MSW, MPH	Chief Mission Officer, Delta Dental of Washington
Emmet Scott	President, The Association of Dental Support Organizations (ADSO)
Marko Vujicic, PhD	Chief Economist and VP, American Dental Association
Vicki Young, PhD	COO, South Carolina PHCA and member of National Association of Community Health Clinics

B. Strategic Advisors and Staff

- Marcia Brand, PhD, former Deputy Administrator, Health Resources and Services Administration
- Hannah Cardosi, Administrative Coordinator, CareQuest Institute for Oral Health
- *(Not in attendance)* Brenda Cocuzzo, Executive Assistant, CareQuest Institute for Oral Health
- Patrick Finnerty, former Medicaid Director for the Commonwealth of Virginia
- Dora Hughes, MD, MPH, Associate Research Professor, GWU Milken Institute School of Public Health and former Counselor for Science and Public Health, Department of Health and Human Services
- Marianne Hughes, former Executive Director, Interaction Institute for Social Change
- Kristin LaRoche, Vice President, Public Relations, CareQuest Institute for Oral Health
- Laurie Norris, JD, former Senior Policy Advisor for Oral Health, Centers for Medicare & Medicaid Services
- Bianca Rogers, PRW Working Teams Coordinator and Medicare Policy Advisor, CareQuest Institute for Oral Health
- Al Yee, MD, MPH, Senior Advisor to Community Catalyst Dental Access Project and leader in health care, public health, and philanthropy

II. Start-Ups

A. Welcome

Mike Monopoli opened the meeting.
A lot has happened since we last met, which always seems to be the case. The role that vaccinating people has had in turning the pandemic around is becoming much more evident. More things are opening up and there are changes in the ways we are interacting, and these are positive signs as we go forward. The world, however, is experiencing much inequity – there is a crisis in India and much work to do around the world to address those inequities and promote equitable access to vaccination as we go forward.

Here in the U.S., as we start to see a vision of a post-COVID time, it will be more important than ever to focus on systems that promote equitable health, and the role of oral health in that equity, and the role of us working together to achieve a more just health system . And also the continued role of oral health professionals – both dentists and hygienists – in their role as vaccinators is still going to be important as we focus more on specific communities in specific areas. Hopefully dentists and hygienists can also play a role if boosters are needed in the future.

Also increasingly evident is that a lot of routine screenings and routine health care has been delayed because of COVID and we as health professionals have a role in helping people to catch up with routine care and screenings and their general health altogether. Our group really has an opportunity now to be central to that vision and to provide the thought leadership that will continue our role as essential health providers focused on whole person care. I'm really excited about the possibilities as we go forward and envision a more equitable health care system in which we play an important role through screening for general health issues, improved access through teledentistry, and continued integration of oral health and health care.

B. Purpose of the Effort in 2021 and of Today's Meeting

Pat Finnerty also welcomed everyone and reviewed the purpose of the effort as well as today's meeting.

Our overall purpose is to contribute our collective voice and influence toward making oral health more affordable and accessible to all. In 2021, we will:

- continue to monitor the impacts of COVID-19 on safety, infection control, and access
- learn more about the work already underway in each of the prioritized areas
- discuss and take action as opportunities arise

The purposes of today's meeting are to continue our work in collectively monitoring the impact of COVID-19 in the country and on the field, to deepen our understanding of the relationship between COVID-19 and Oral Health, to learn from some of our member organizations who are tackling vaccine hesitancy and inequitable access, and to give an update from each of the Working Teams

C. Desired Outcomes

Pat reviewed the desired outcomes.

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

- An update on the Biden Administration
- An update on COVID-19: Vaccine rollout including the role of dental hygienists, states opening up, and issues concerning the virus variants
- A deepened understanding of the relationship between COVID and Oral Health and next steps
- A shared understanding of how some of our PRW colleague organizations are tackling vaccine hesitancy and inequitable access and ideas for how all of our organizations can play a role
- An update from each of the Working Teams
- Agreement on next steps

III. Biden Administration and COVID-19 Updates

Marcia Brand and Dora Hughes presented.

A. Biden Administration Announces $1 Billion for Rural COVID-19 Response

- HHS announced the availability of nearly $1 billion to strengthen COVID-19 response efforts and increase vaccinations in rural communities.
- HRSA will implement the Rural Health Clinic COVID-19 Testing and Mitigation Program and provide $460 million to more than 4,600 rural clinics across the country.
- In addition, HRSA will implement the Rural Health Clinic Vaccine Confidence Program, making nearly $100 million available in grants to eligible RHCs to address health equity gaps by offering support and resources to medically underserved communities where COVID-19 vaccine uptake lags in comparison to more populated areas.

B. American Rescue Plan Funding to Support Emergency Home Visiting Assistance for Families Affected by the COVID-19 Pandemic

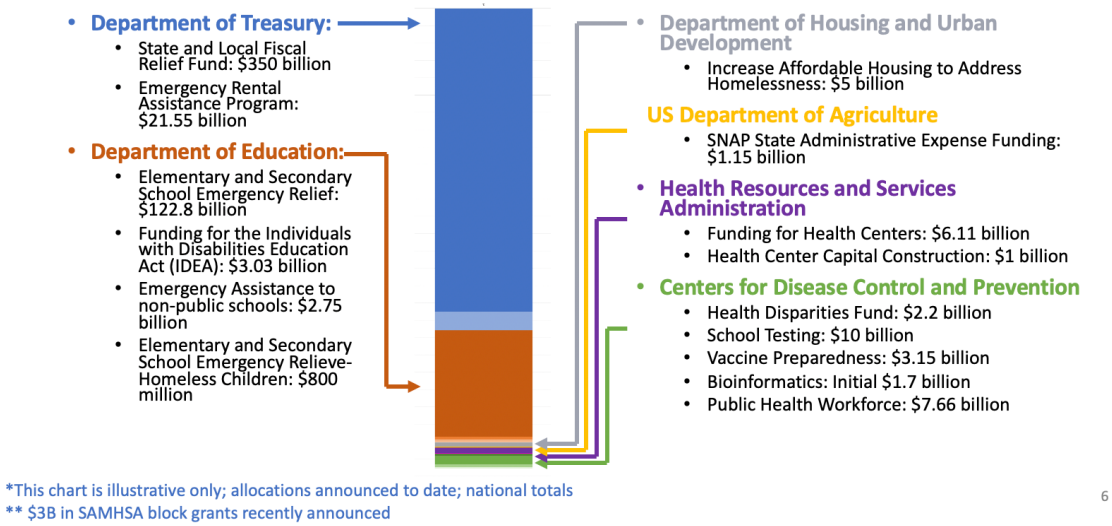
- HHS will award $40 million in emergency home visiting funds to states, territories, the District of Columbia through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program.
- The MIECHV program supports the delivery and coordination of comprehensive, high quality, voluntary evidence-based home visiting services to children and families living in communities at risk for poor maternal and child health outcomes. In FY 2020, three quarters of the families participating had household incomes at or below 100 percent of the FPL, 78% of adults and children relied on Medicaid or the CHIP program.
- Funds can be used to provide services and emergency supplies; families can be provided with technology to participate in virtual home visits; funds can be used to train home visitors on emergency preparedness and response planning for families.

C. Community-based COVID-19 Workforce

- HHS announced a new $250 million investment in a community-based workforce designed to "serve as trusted voices sharing information about vaccines, increase COVID-19 vaccine confidence, and address any barriers to vaccination for individuals living in vulnerable and medically underserved communities."
- Will share more on this as it is learned.

D. American Rescue Plan Act: Highlights of funds going to states and localities

There are tremendous amounts of funding going out to states and cities and other localities.



We're working to understand the timing of the expenditures and additional details. We will learn more each month and share those details. There may be opportunities within these funding streams to address the needs of our constituents.

E. Biden Administration HHS Nominees

<u>Confirmed</u>

Deputy Secretary Andrea Palm

- Former Secretary of Health (WI)
- Former senior HHS official in the Obama Administration

<u>Discharged from Committee, Pending Floor Vote</u>

CMS Administrator Designate Chiquita Brooks-LaSure

- Former CMS official
- Former OMB official
- Former Ways and Means Staff

F. CDC Update

- John Auerbach, former president of Trust for America's Health, will return to CDC as the Director of Intergovernmental and Strategic Affairs.
- Ann Schuchat, Deputy Director, will retire after 33 years.
- Nancy Messonier, Director of the National Center for Immunization and Respiratory Diseases, has joined the Skoll Foundation.

And there is further discussion in the news of CDC reorganization.

G. Health Equity Task Force Meeting

- Next meeting: May 28
    - Purpose is to consider interim recommendations specific to discrimination and xenophobia
- Past meeting: April 30
    - Focused on mental and behavioral health

Yesterday was the first day that there was not a single COVID death in the United States. This may be an indication that there is hope for the post-COVID future.

IV. COVID 19 Updates

A. Opening Remarks

Mike Monopoli presented.

There has been a dramatic downturn in COVID cases. 83% of people over 65 have been vaccinated to date. 50% of adults have had at least one vaccination and we're on track for 70% of adults to be fully vaccinated by July 4. And teens recently started to be vaccinated, as well, so there is a lot of positive news. Hospitalizations are down, and severe disease is down.

But it's still not completely even. We still have much to do to advance the number of vaccinations and now is the time to refocus our efforts to address equitable availability of vaccines and to make sure their issues of trust are addressed. The Johnson & Johnson vaccine, which was most applicable to dental offices because of its single dose and storage needs, hit a headwind in terms of clotting issues that were created in some parts of the population leading to some lack of trust with that vaccine, but I think it will still end up being the best vaccine for office settings. And potentially AstraZeneca, as well, if and when it's approved for emergency use.

We've been working across multiple components of oral health to develop and incorporate vaccine training into dental professional curricula so that we can create opportunities for dentists and hygienists to participate in vaccinations well into the future, and especially to be relevant for vaccinations that have such an impact on oral health, specifically HPV vaccine, flu vaccine, and others that could be applicable. So hopefully this will be one outcome of COVID

that will continue – to create that link in interprofessional care that has oral health professionals where they need to be in terms of promoting oral health and health in general. We're still going to see the need for community-based volunteerism but in a different and more focused way.

We are starting to see emergent evidence of the relationship of COVID and oral health and health outcomes and we'll talk a little bit about that today as well.

Ann Battrell presented on the work of ADHA to promote the role of dental hygienists in COVID vaccination. Highlights of her comments:

- Thank you for attaching the draft letter to today's agenda. I've already heard from a couple of you expressing support.
- The letter was also shared during the Public-Private Partner Dental Coordination Group meeting under the direction of Dr. Tim Ricks. There is some overlap there – we're getting some good traction there with an overall group advocacy effort and appreciate the support of the CareQuest Institute.
- We have 19 states now that authorize dental hygienists to be considered as vaccinators.
- Reports from hygienists who have gone through the training and are providing the vaccine tell us that there is a very high satisfaction rate to be part of this collective effort to make a difference in the United States.
- Anything you all can do to support this effort is greatly appreciated.
- Please let Mike know of your group's willingness to sign on to the letter by May 24th. Our primary way to solicit sign-ons for the letter are the PRW and the Public-Private Dental Coordination Group.

B. Questions and Additional Updates

Steve Kess:

- Two senior scholars of the Santa Fe Group – Diane Rico and Tim Ricks - published a white paper on COVID that is getting a lot of recognition.
- We're all beginning to chant the same tune, which is great to see as hopefully with harmony in voice we will get some collaboration in action. This is my hope.
- Our third webinar from Santa Fe was on upscaling and expanding health system integration of oral health and overall health….will be available on the Santa Fe website in two weeks. The first two programs are posted there now for you to watch at no charge and at your leisure.

Jane Grover:

- ADA had a webinar today with Laura Noonan addressing vaccine hesitancy and health literacy. It went the full 90 minutes with over 300 registrants. Happy to share the recording with this group.

Alan Morgan:

- (From the Chat) A lot of great news regarding COVID! However, Mid-June 2020 was when rural COVID cases began tracking higher than urban per-population. I'm waiting until June 15th to declare we are done with COVID. Vaccine rates are still trailing rural vs. urban: https://www.usatoday.com/story/news/health/2021/05/18/vaccine-rates-rural-us-lag-behind-urban-areas-cdc-analysis-finds/5143975001/
- There is an ongoing concern from the rural perspective. The CDC released a report showing vaccine rates lower in rural areas. This comes on the heels of our report showing that vaccine rates among hospital staff are very troubling nationwide. We actually shared that, and it was released by the Politico White House reporter and that day the RHC funds were magically released so we're all very happy about that.
- June 3 will be a key date. We're working with the US Ad Council, CDC, HRSA, and the COVID collaborative to develop rural-specific messaging which surprisingly isn't out there yet. It is our intention to get it out to more than 250 rural organizations to help communities talk about how we can keep our communities safe instead of how it is now which is a lot of confusing messaging from the CDC. We want to change the discussion to how we can keep our businesses open, safeguard our fragile health care system, how do we as community take the lead to keep ourselves safe.
- In seeing the data from rural counties in Alaska and New Mexico in particular have seen some unsettling increases in COVID cases over the last two weeks. Coming up on Memorial Day weekend was when the rates in rural areas started going up. So there is a concern that we don't forget about these rural communities that are not getting vaccinated at the same rates and just might end up being reservoirs for COVID as we move forward.

From the Chat:

- (Colin Reusch) Have seen some great examples of this kind of messaging in Virginia and West Virginia in recent months.
- (Alan Morgan) I have not, would love to see state specific rural messaging.
- (Timothy Ricks) It may be obvious, but HRSA has a Rural Health Information Hub - https://www.hrsa.gov/library/rural-health-information-hub-rhi-hub

V. COVID 19 and Oral Health

A. Opening Remarks

Mike Monopoli shared what we are learning about the relationship between COVID-19 and oral health as a starting place for further discussion. Highlights of Mike's remarks included:

- There is emerging evidence that the systemic inflammatory response that creates the relationship of periodontal disease with cardiovascular disease and diabetes is evident in COVID. It's becoming clearer that periodontal disease is associated with more severe

COVID response and potentially poorer outcomes. This is something we will continue to monitor and bring back to the group as may be warranted.

- Oral disease and having more virulent oral organisms have for a long time been associated with more severe ventilator-associated pneumonia. And with non-ventilator pneumonia, lying in bed and being static for a long period of time can create the same issues with oral organisms.
- The relationship of Alzheimer's with severe virulent oral organisms continues to be evident.
- The seriousness of all these factors during COVID is heightened and we will continue to monitor the role that oral organisms – especially periodontal disease and other oral diseases – have in the systemic response.
- There is growing evidence that the oral cavity specifically is a site for COVID infection. Salivary glands are a place that COVID viral particles can attach, and that saliva can be a vector in transporting COVID.
- The evidence is not clear now about aerosolization. The aerosols that are produced in oral health treatment are a combination of saliva and also the water we use to create thermal protection for teeth. The relative impact of that re risk of COVID spread is not completely clear but we will continue to monitor and bring this back to the group.
- Better oral health continues to be associated with better outcomes with COVID and multiple diseases so it will be an important topic for us to continue to discuss.

B. Discussion

Pat Finnerty referenced the recent article in the New York Times and lifted up that the point was made that it goes both ways: The impact your current oral health can have on COVID and how COVID can impact your oral health.

- (Ife) This gives us an opportunity when talking about Medicaid and Medicare – to never let a good crisis go to waste. This is a time when we can show the importance of oral health to overall health in ways we've not been able to previously. We should take the opportunity to put this in front of Congress and other groups as we talk about the expansion of coverage. And take this back to grassroots as a reason why we promote grassroots organizations being involved in oral health care.
- (Jane) I totally agree, and it is state-specific and a call to action that any state legislature can determine that adult oral health coverage is optional in Medicaid. We can lean in on this conversation seriously. If adults do not get oral health services – and some state legislators devote only 2-3% of their budget to oral health care – this is the time to call it out in that it impacts overall health, but you will save money in the long run, and bottom line it is just the right thing to do. Let's put some teeth in the health equity conversation.
- (Steve Kess) Ira Lampster – former dean at Columbia - published a paper on oral health and Medicare – and a second paper coming this fall. Even with impact variables filtered out, it's clear that good oral health improves quality of life, reduces health care costs, and accomplishes the triple aim more than ever. Those looking to defend this are

looking for a long-term longitudinal study. I'm not sure why because there wasn't one done for other diseases. But truth be told, third party payers of medical insurance are beginning to help lower risk factors for patients' primary health care status by sending patients for oral health treatment. There is a movement taking place. There are 157 signatures on a bill in front of CMS for a trial program for the noncommunicable disease audience for seniors to get a dental benefit which would save the government money and provide access to oral health care for 20 million adults. Liberty Partners is managing the effort. Visit the Santa Fe website to see the organizational signators and please join us. The ADA chose to pull out and wrote some damaging letters, but perhaps they will return with the restructuring there. It's been made into a political issue but it's really not. It's really health equity at its base. Please get active.

- (Colin) Take a look at the NYT piece – it does a great job summarizing the intersection of oral health, the effects of the pandemic and other areas of health and social inequity that have plagued our nation for decades. And how these things compound one another. In addition to framing oral health in the context of the pandemic and health, we can also be framing this in terms of economic recovery and how oral health plays into greater societal inequities – economic and costly chronic conditions that we already know the effects of, and that we know are unequally distributed.
- (Chris Wood) In addition to there being a public dental benefit – through Medicaid or Medicare - I keep hearing that companies are struggling to get people to come back to work. Maybe making the case to private industry that if they offer dental insurance, it could be an incentive to get people back to work. Come at it from both directions.
- (Ann Battrell) There is so much information here that is near and dear to our hearts. The messaging group has a job to do to synthesize this and create a uniform message and break through the health care related messaging that is out there today.
- (Hazel) I really appreciate this discussion. I am still practicing two days/week. As I open up lines of communication with colleagues, we see patients coming into the office with really deteriorated conditions in terms of their oral health due to their fear of coming in during the pandemic. We're just witnessing the tip of the iceberg – as more come back into care, I have to remind myself not to be judgmental, but what I am seeing is alarming. The long-term impact of COVID on oral health will have to include this data. Also very disturbing is that we don't have partners in caring for oral health patients. We know how debilitating it can be to be in a hospital facility and we don't talk about how no one is paying attention to the oral health care of patients in the hospital. Their teeth are not being brushed; they may not even be given toothbrushes. The bacterial flora in the mouth is exacerbating many conditions. We haven't talked about this but if we want to use this as an opportunity to educate and inform and accelerate medical/dental Integration, we need to talk about this. These patients deserve to have their mouths cleaned daily.
- (Manuel) This is all about messaging and we are not fully addressing it properly. It is the medical/oral health link that is going to get much worse. We are not doing enough at taking advantage of the situation that is the best time to explain to people how periodontal disease is at the basis of so many conditions that impact the whole body. This is an amazing moment of time to prove how necessary it is to have good oral

health. This message needs to be spread to the general public – the importance of maintaining good oral health at all times, including in the hospital. And the importance of dental insurance to bring patients back into the work environment is a phenomenal idea. This is good information we can advance.

From the Chat

- (M A Cordero, DDS, CPH) Please notice that there will be three different links to register for the Diverse Dental Society Summit, that way you can register with the organization you would like to support within the DDS.lDDS
    - Registration under SAID: http://www.thesaidonline.org/conferenceregistration
    - DDS registration at HDA: https://hda.memberclicks.net/dds-virtual-multicultural-oral-health-summit-2
    - DDS Registration under NDA: 2021 National Convention – National Dental Association (ndaonline.org)
- (Jane Grover) Has everyone seen the "Resolution in Support of Awareness and Importance of Oral Health Care" that was passed at the National Lieutenant Governors Association? It passed in March - I will send it to the group.

VI. COVID 19 and Vaccine Hesitancy and Inequitable Access

Pat set up this section by naming the three speakers.

They are our members who represent the voice of the community in our group. They were asked, *What have you seen as some/most of the root cause concerning vaccine hesitancy? What is your organization or community is doing to tackle vaccine hesitancy?*

Pat then opened the conversation by sharing these updates:

- In fact, in a recent Kaiser Family Foundation "COVID-19 Vaccine Monitor," one of the key findings was that Hispanic Adults are twice as likely as white adults to want a COVID-19 vaccine as soon as possible…which presents an opportunity for some targeted outreach to boost overall vaccination rates.
- That same report goes on to say that significant access barriers and information gaps exist for Hispanics, including concerns about potential costs, lost wages, and immigration-related issues.

A. Susan Flores, CPEHN

Regarding the statistic just shared about the Hispanic population and vaccines – they are twice as likely to want the vaccine as soon as possible – this is important because earlier in the year and late last year there was rhetoric that communities of color and particularly the Hispanic community didn't want to get vaccinated. There was rhetoric that this community was hesitant because they didn't trust the vaccine, but in fact we're now seeing that they want this vaccine but have no access to it. There were big venues for vaccination in many parts of the country –

here in LA it was Dodger Stadium – but what made it inaccessible were the 9-5 hours which don't work for many essential workers who are from communities of color, the locations require cars when many people of color don't have cars, and the sign-up platforms were all in English rather than threshold languages. It was just impossible.

One approach taken in California to address the inequity in vaccine distribution: In my neighborhood, one in five residents contracted the corona virus and just a short distance away it was one in fifteen. People in my neighborhood participated in surveys and were asked if we wanted the vaccine. The governor here in CA then announced that the vaccine would be targeted to the most vulnerable populations – those in the lowest quartile of the Healthy Places Index (HPI). The HPI measures community conditions like housing, transportation, and education, as well as other indicators of health and well-being. We worked on this effort at CPHEN to allot the vaccine to the 40% - the lowest quartile of the Healthy Place Index – and some communities received the vaccines before it was expanded to all adults. In my community we were all eligible to receive the vaccine just by living in this neighborhood.

B. Emily Stewart, Community Catalyst

One tool that the Kaiser Family Foundation puts out that is really valuable is the chart by race and state that shows the distinction between the impact of COVID disease and death and the rate of vaccination and there are really huge discrepancies in many states, particularly for Black and Latino people in this country who have borne the brunt of the disease in terms of infection and death. This data speaks to the access issue.

Community Catalyst has been in the early stages of launching a new program, grant-funded by the CDC, that is focused on working with 75 community-based organizations across the country that are led by or working with people of color to get information out to communities about the COVID-19 vaccinations and to build connections with trusted providers. The goal is to encourage and facilitate access to more providers in the community that people trust. Often from a public health standpoint, you might be looking at a map and see all the health care providers that are well-located. Seems like an easy solution, but even though a provider might be only five miles away, that provider might be one that Black and Brown communities have had negative experiences with.

In terms of the information access side and addressing access issues re: unique concerns that people might have…we are in the process of learning about this. A lot of people's concerns are community-based, dependent on family and friends, what they're hearing in the community. The most important thing to do is to resource community-based organizations and make sure they have the tools and resources to respond to those questions. A lot of this is about providing access to a provider - where to get the vaccine and help facilitating access once they know, including transportation and other access issues. That's part of what we're doing as well.

The second major focus is working with all of our partner organizations across the country to put a health equity lens onto the distribution of the American Rescue Plan Act funding. There is

a lot of confusion around how and when money will flow to states and localities. We are working to make sure our partners know which money is flowing through states and localities and what the purpose of that money is, and more about timeline. And making sure there are tools and resources to connect into policy processes to make sure the needs of communities are at the center of those discussions, including funding around workforce and vaccination access. And we're taking the opportunity to lift up the importance of oral health care and the role of oral health professionals in the vaccination process.

C. Dr. Hazel Harper, National Dental Association

Dr. Hazel Harper presented "COVID-19 Hesitancy: Historical, Social, and Political Implications"

Documented Distrust: Historical Perspective

Tuskegee Study, 1932-1972. Driver of documented distrust.

- Tracked 600 low-income AA men; 400 had syphilis
- Men lied to and provided "sham" treatments
- Needless infection of family members, suffering, death
- Exposed a "pathology of racism"
- President Clinton apology in 1992?

The descendants of those in the Tuskegee study are working to promote the vaccine.

Beyond Tuskegee

- 60s and 70s – Documented sterilization of thousands of Native American women without consent (a CA eugenics law forced or coerced thousands of sterilizations of Mexican women and men in the 20th century; 32 other states have had similar laws that were disproportionately applied to people of color.)
- Widespread experimental abuse of prison and military populations
- Experimental exploitation and abuse of frail elderly populations and disabled children
- Questions raised about the role of race in medical research priorities (ex. Sickle cell disease affects mostly AA, but for decades received less attention than other diseases)

AA Health – Current Research Findings

This all lays the foundation for distrust – among African Americans and others. Folks are working to counter this distrust that is justified from what has gone on in past years; however, we know it has to be overcome.

- Receive less care. Often receive worse care.
- Have worse health outcomes (Specifically; more limb amputations; and lower quality services for cancer, HIV, prenatal care and preventive care)
- Have increasing rates of maternal and infant mortality
- Receive less treatment for CV disease

Reasons for Disparities

- Less health coverage. Less preventive care.
- Cultural incompetency, communication barriers
- Racial stereotyping based on false beliefs (50% of medical students and residents believe falsely that Blacks have higher pain tolerance than whites)
- SDH
- Disparity built into the health system structured on the basis of race, ethnicity and class
- Biased clinical decision making
- Access barriers caused by shortages of racial and ethnic minority providers

Health Inequities Perpetuate Distrust

- Mainstream resistance to health system reform and policies (many white docs refused participation in Medicare and Medicaid)
- Lax enforcement of 1964 Civil Rights Act (Title 6)
- Dual track health and PH, PP health system strategic planning remain in place
- Racial and ethnic minorities confined to underfunded public health sector and government insurance
- Increasing inequities in training, licensure, and double-standard peer review of URM health providers (recruitment, matriculation support (financial, mentoring), some ineffective D&I administrators)
- Biased training curricula reinforces racial stereotypes and different treatment for different races

African Americans and Black Doctors

When treated by Black doctors, recent studies reveal:

- AA patients receive better care
- Have better health outcomes
- Receive more preventative services
- Have more trust

However, routine medical practice treats whites and blacks differently (ex. Racism often results in inappropriate care and less pain management contributing to needless suffering and perhaps death

COVID Vaccination Hesitancy: The Political Divide

- Influence of social media
- Misinformation fueled distrust in science
- Inconsistent messaging planted seeds of confusion
- Researchers reported political affiliation as the best predictor of vaccine hesitancy
- Recent poll - older Republicans less resistant than younger Republicans
- Partisan divide in vaccinations may actually grow wider as younger people become eligible for the vaccine nationwide.

References

- UNEQUAL TREATMENT. Confronting Racial and Ethnic Disparities in Health Care. IOM
- Elizabeth A Jacobs, MD, MPP,[1] Italia Rolle, RD, PhD,[2] Carol Estwing Ferrans, RN, PhD,[3] Eric E Whitaker, MD, MPH,[4] and Richard B Warnecke, PhD[5.] Understanding African Americans' Views of the Trustworthiness of Physicians *Journal of General Internal Medicine*
- Martha Hotstetter and Sarah Klein. Understanding and Ameliorating Medical Mistrust Among Black Americans. The Commonwealth Fund, January 14, 2021
- Danielle Ivory, Lauren Leatherby, and Robert Gebeloff. Least Vaccinated U.S. Counties Have Something in Common: Trump Voters. NY Times. April 17, 2021
- Christine Clark. Republicans Became More Vaccine Hesitant as the Coronavirus Pandemic Unfolded. UC San Diego News Center. April 28, 2021. (Researchers: Ariel Fridman and co-authors, Ayelet Gneezy, the Carol Lazier and Family Endowed Chair in Social Innovation and Impact at the Rady School and Rachel Gershon, assistant professor of marketing at the Rady School.)

D. Questions and Group Discussion

Pat shared that there is a webinar tomorrow relevant to this conversation.
A webinar is being offered tomorrow – Thursday, May 20 - at 11 AM eastern time discussing the findings of the Kaiser report on vaccine availability for Hispanics.
https://us02web.zoom.us/webinar/register/WN_0EgOQ-6dSA-iVaUvM5svwg?utm_campaign=KFF-2021-Events&utm_medium=email&_hsmi=127944120&_hsenc=p2ANqtz-9dbZa10oAFaetUPA15VAiJGcltRY2Ygj07BOrsVEw59ueFsH8GXVe_GijgvJSOJtMsWMWgVIiK1drBiEl1SxCnNlnnQQ&utm_content=127944120&utm_source=hs_email

Q. Have you looked at the role immigration and immigration laws have on hesitancy? Are there studies on this?
Susan – We've noticed here in California that there has been some hesitancy in seeking care when contracted COVID-19 – including accessing coverage under Medi-Cal that was extended to people with uncertain immigration status.
Public charge language had a chilling effect on immigrants. This rolled into vaccine hesitancy – uncertain about how to access without being tracked, especially with the two-dose vaccines. Many CBOs have done great outreach to these communities. Access remains the biggest issue, more than fear. Finding providers that will give the vaccine because their trusted providers do not necessarily have the vaccine.

Discussion Prompt: Are other participants taking action toward the equitable distribution of the vaccine?

- A couple of months ago, ASTDD wrote to all state dental directors and encouraged them to look at vaccine distribution plans and ensure it is targeted to groups most impacted by COVID.

- Henry Schein is a member of the federal FEMA supply bridge program and advocated for PPE and later for vaccine to be made available to community-based professionals. The program is still in discussion. The major distributors have mainly handled the bulk of vaccine distribution to medical infrastructure and pharmacies. Individual professionals including dentists are next in line. Will work to make sure the right folks are aware of the programs and can secure the vaccine for their programs.
- NDA did two things. Had a social media campaign asking dentists to show themselves getting vaccinated so it could be shared widely, and encouraged dentists to be prepared to deliver the vaccine and many partnered with local groups to make the vaccine more accessible – churches, especially – and dentists participated. Vaccine hesitancy is definitely overcome when they see trusted providers in trusted places working with the vaccine. Reaching out to fraternities and sororities as well.

Discussion Prompt: Are there ways providers and community groups can partner with each other in communicating about vaccine hesitancy and inequitable access?

- We had a successful event in San Diego but there was only one Spanish-speaking provider. She had a long line. She was interviewed and we shared it with our chapters to encourage more Spanish speaking volunteers. Most vaccine appointment platforms require English, a cell phone or computer, and more - so much facility with technology and more – it made it nearly impossible or impossible for many people.
- As a dentist I reside in MD but my practice is in DC where I am licensed. I wanted to volunteer to vaccinate at my church but to get a temp license to allow that was filled with obstacles.

Two Additional Discussion Prompts:

- Are there any structural barriers to dental teams participating fully in the vaccination effort?
- Is there anything the PRW can do as a group?

From the Chat:

- (Susan Flores) Very good episode on vaccine hesitancy in Tennessee on The Daily the other day: https://open.spotify.com/episode/5YA09lINwveWqgOy2llkfN?si=db572b76af2f4cc1
- (Ife Johnson) Also good to highlight the POC who are instrumental in vaccine development like Dr. Kizzmekia Corbett who helped design Moderna.
- (Ann Battrell) Would love to know what community is doing this well
- (Colin Reusch) Perhaps some useful resources on the data issue here: https://s3.amazonaws.com/cdhp/DQF+Summary+Report+on+OH+Measurement+Systems.pdf
- (Colin Reusch) https://www.astdd.org/docs/dqf-astdd-cdhp-measurement-brief.pdf
- (Barbie Vartanian) The disability community struggles tremendously with access and hesitancy. Caregivers are fearful due to ongoing overall vaccination concerns and the effect of. Also, locations are not equipped to deal with potential behaviors. Community

partnerships examples that are working...The Special Olympics has been successful in providing familiar settings and volunteers to support. Also, UOP has adopted a similar vaccination model using volunteers that are familiar with some of the potential fears and behaviors to support the individual. We must not forget this community in the equity discussions.

VII. Working Teams

Laurie Norris presented updates from each of the Working Teams.

A. Effective Messaging & Communications

Meeting: May 10, 5 attendees plus staff

Top Takeaways:

- The pandemic laid bare the intolerable inequities and inadequacies of the oral health system.
- The group aligned on the idea that the most important things we need to communicate at this time are:
    - the importance of oral health to overall health
    - the need for equitable and accessible oral health care
    - to identify and eradicate the bias and racism embedded in the oral health system
- We agreed that there are three audiences that we need to address: the public, policymakers, and providers.
- We asked ourselves the question: How can our team along with the PRW help amplify a unified message of equity and access?

Next Steps: To answer that question we will first research which organizations in the field are doing the best messaging on equity so that we can then discern what if anything is missing and then decide next steps.

B. Data and Research

Meeting: May 11, 2 attendees plus staff

Top Takeaways:

- There is significant interest in increasing collection of oral health data, particularly equity-related data, and making it widely accessible and actionable.
- The following are the agreed-upon aims for the group:
    - Increase awareness of available data sources by querying and mapping which groups are collecting data at the national and state levels
    - Identify and share information on funding resources to support enhanced data collection and strengthen the data infrastructure

- Ensure data resources include data on access, care and outcomes for diverse patient populations
- Identify opportunities to collaborate for purposes of maximizing efficiency, avoiding duplicate work and achieving synergies when possible
- Track and monitor COVID-related data initiatives that may have relevance for the Working Team and PRW

Next Steps: We will begin our work with the first three of these aims, over the next few months.

C. Oral Health Integration

Meeting: May 11, 4 attendees plus staff

Top Takeaways:

- There has been a lot of encouraging work in recent months to examine and promote oral health integration, including:
  - The recent release of the Primary Care Collaborative's report "Innovations in Oral Health and Primary Care Integration"
  - The Harvard School of Dental Medicine's "Resource Library for the Integration of Oral Health and Medicine"
- The group discussed opportunities to promote oral health integration, including:
  - Engaging consumers to create demand for a different approach to care delivery that includes oral health integration
  - Broadening the "interface" to include in care coordination other providers in addition to physicians and dentists (e.g., PAs, NPs, dental hygienists)
  - Taking a "population-based approach" to care integration, including a focus on kids, seniors, veterans, and rural populations.

Next Steps:

- Health centers already have co-located dental and primary care services. What have they learned about improved patient satisfaction and quality? We should engage HRSA's Bureau of Primary Health Care and see if leadership would be willing to have a call with us and talk about what they've been doing and opportunities to promote oral health integration.
- It will be important to review the Surgeon General's oral health report when it is released and see if there are policy opportunities identified to promote oral health integration.

D. Dental Benefits in Medicare & Medicaid

Meeting: May 10, 6 attendees plus staff

Top Takeaways:

- Congressional champions support adding a dental benefit to Medicare Part B this session, but the "pay for" is a challenge as it is competing for other priorities in the big infrastructure bill. Thus, it will be a steep climb to get this through Congress this session, especially as the White House does not seem on board with making it a priority.
- HPI, FUSA and CC are collaborating on an issue brief outlining the potential economic impacts of having an adult dental benefit in Medicaid in every state; this could help us persuade Congress to enact a mandate for adult dental in Medicaid. In the meantime, pregnant/post-partum people and former foster youth are "first up" in Congress's effort to add a Medicaid dental benefit by population group.
- At the state level, there has been lots of activity in the 2021 legislative sessions, with ~30 bills filed to extend Medicaid dental coverage to selected groups of adults. For example, HB 172 in Louisiana – adds comprehensive dental benefits for adults with developmental disabilities.

Next Steps: We will meet again in early June to consider possible advocacy strategies based on the issue brief looking at economic benefits from an adult dental benefit in Medicaid. We are pausing on Medicare action pending openings for strategic advocacy in Congress over next weeks or months.

Laurie concluded by saying that the next round of meetings will be announced and all are welcome to join any group meeting that is of interest.

VIII. In Closing

Pat closed the meeting by thanking everyone and sharing that the next meeting is June 16, 4-5:30 pm ET.