

**Oral Health System: Pandemic Response Working Group**  
**Virtual Meeting**  
**June 16, 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.*

<b>Name</b>	<b>Organization</b>
Vanetta Abdellatif, MPH	President and CEO, Arcora Foundation
Eme Augustini	Executive Director, National Association of Dental Plans
Ann Battrell, MDSH	Chief Executive Officer, American 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
Terri Dolan, DDS, MPH	President-Elect, Santa Fe Group
Ifetayo Johnson, MA	Executive Director, Oral Health Progress and Equity Network
Steve Kess, MBA	VP, Global Professional Relations, Henry Schein
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
Mike Monopoli, DMD, MPH, MS	VP, Grants Strategy, CareQuest Institute for Oral Health
Colin Reusch	Senior Advisor, Oral Health Policy, Dental Access Project Community Catalyst
RADM Tim Ricks, DMD, MPH, FICD	Chief Professional Officer, USPHS, OHCC, IHS
Emmett Scott	Association of Dental Service Organizations
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

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

<b>Name</b>	<b>Organization</b>
Pamela Alston, DDS	President, National Dental Association
Stacy Bohlen	CEO, National Indian Health Board
Latisha Canty, RDH, MS	President-Elect, National Dental Hygienist Association
Edwin A. del Valle-Sepulveda, DMD, JD	President, Hispanic Dental Association
Susan Flores	Senior Policy Coordinator, California Pan-Ethnic Health Network
Chelsea Fosse, DMD, MPH	Senior Health Policy Analyst, American Dental Association Health Policy Institute

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
LaVette Henderson	Executive Director, National Dental Association
Alan Morgan, MPA	Chief Executive Officer, National Rural Health Association
Diane Oakes, MSW, MPH	Chief Mission Officer, Delta Dental of Washington
Tonia Socha-Mower, MBA, EdD	Executive Director, American Association of Dental Boards
Marko Vujicic, PhD	Chief Economist and VP, American Dental Association
Brett Weber	Public Health Policy & Programs Manager, National Indian Health Board
Vicki Young, PhD	COO, South Carolina PHCA and member of National Association of Community Health Clinics
Robert Zena, DMD	President, American Association of Dental Boards

**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
- 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
- (Not present) 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**

*Myechia Minter-Jordan opened the meeting by welcoming everyone and thanking them for being here today. Highlights of her comments:*

- There is clearly still work to do in other parts of the United States and in the world. I continue to think of countries that do not have access to the vaccine that we have had, and the fact that COVID continues to ravage those countries.
- We are very fortunate and blessed to be in the place we are now although there is much work to do. The Delta variant is top of mind - we must continue to remain vigilant. That said, we are at a turning point and even if there is a surge it will be different and many of the most vulnerable will be protected by vaccines.
- There is still lots of work to do in communities of color in terms of vaccine hesitancy and I am encouraged by the recognition of that and that there will be some resources allocated in that way. And yet there is still a lot of work we can do in these spaces, in our own individual roles.
- The risks of dental care from the virus have largely been avoided. Dental professionals have played an incredible role in mass vaccination settings and some practice settings.
- There is still much to do to fully integrate oral health professionals into the overarching health care workforce in terms of our availability to respond and to be included in the planning for what may be future pandemics.
- We've made progress toward the integration of oral health professionals in an active role to access to vaccinations, especially focused on those vaccines that have oral health implications.
- Issues that remain for us include registration as vaccinators, procurement of vaccines, storage issues, reporting, and reimbursement.
- We will continue to monitor those issues as a PRW and refine our understanding of the infection control and OSHA issues moving forward.
- I am personally very excited to see what this group may take on in the coming months. It's incredible to think about how we all came together, in this moment of crisis and how we have maintained the level of engagement that we have. We've been deep in the work, leveraging our individual and collective strengths. We've established ourselves as a cross sector laboratory of ideas and we've built relationships as the foundation for further learning and collaboration. And for me that's inspirational. To know this group exists and is united in our approach to how we think about lifting up the oral health care profession, depending on it to provide good, comprehensive oral health care in an equitable way, and stepping up in this time of the pandemic...these are all things we should be incredibly proud of. I am excited and energized by this group and hope everyone else is as well.

*Pat Finnerty also welcomed everyone and especially new member Emmet Scott of the Association of Dental Service Organization who introduced himself. Pat also mentioned another new member, Brett Weber of the National Indian Health Board.*

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

*Pat Finnerty 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 purpose of today's meeting** is to continue collectively monitoring the impact of COVID-19 in the country and on the field, to understand the role of dental teams in vaccine rollout and developments in billing for vaccine administration, and to learn more about the status of the Surgeon General's Report and the progress of the Working Teams.

## **C. Desired Outcomes**

*Pat reviewed the desired outcomes.*

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

- An opportunity to welcome new participants
- An update on the Biden Administration, including the Budget and the COVID Health Equity Task Force
- An update on COVID-19: vaccine rollout, boosters, the role of dental teams in vaccine distribution, and billing codes
- An update on the Surgeon General's report and next steps
- An update on the Working Teams
- Agreement on next steps

### **III. Biden Administration Updates**

*Marcia Brand and Dora Hughes presented.*

#### **A. Highlights of the President's Budget (PB)**

- Strengthening Public Health Infrastructure and Meeting Crisis-Related Needs
  - Improves Readiness for Future Public Health Crises - \$8.7B to CDC
  - Expands Access to Mental Healthcare - \$1.6B for Community Health Services Block Grant
  - Invests in Efforts to End Gender-Based Violence
  - Promotes Health Equity for American Indians and Alaska Natives
  - Addresses Racial Disparities in Health Care
  - Reduces Maternal Mortality Rate and Ends Race-Based Disparities in Maternal Mortality
  
- Defeating Other Diseases and Epidemics
  - Launches Advanced Research Projects Agency for Health (ARPA-H) - \$6.5B to drive transformational innovation in health research and speed application and implementation of breakthroughs
  - Makes a Major Investment to Help End the Opioid Epidemic - \$10.7B
  - Combats the Gun Violence Public Health Epidemic
  - Commits to Ending the HIV/AIDS Epidemic – accelerate and strengthen efforts to end the HIV/AIDS epidemic

#### **Additional Priorities Outlined in the PB 2022**

- Expands Access to Affordable, High Quality Early Child Care and Learning
- Enables Older Americans and People with Disabilities to Live Independently in Their Communities
- Addresses Racial Inequity in the Child Welfare System
- Supports Survivors of Domestic and Gender-based Violence
- Supports Research to Understand Disparate Health Impacts of Climate Change
- Restores America's Promise to Refugees
- Expands Access to Family Planning Healthcare Services
- Protects Rural Healthcare Access and Expands the Pipeline of Rural Healthcare Providers
- Increases Funding for Civil Rights Enforcement

#### **The PB 2022 and Oral Health Programs**

- CDC Budget Request
  - FY 2022 Request is \$19.5 million, level with 2021 enacted.
  - Would continue to support 20 states and one territory.
  - Build on successes from prior state awards and pilot project to test collaboration models between state chronic disease prevention and oral health programs.

- Continue to conduct research, analysis, and translation of national and state data on oral disease burden, dental care service uses, preventive services, and cost-effectiveness.
- Performance Measures for Long Term Objective: Prevent oral health diseases and promote effective interventions that support optimal oral health:
  - Measure 4.7.1 - Increase the proportion of the people served by community water systems who receive optimally fluoridated water
- HRSA
  - Oral Health Training Programs - \$40,673,000 (level funding)
    - Includes Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene and Dental Faculty Loan Repayment - \$26,675,000; State Oral Health Workforce Improvement Grants - \$13,998,000
  - Maternal and Child Health Block Grant - \$822.7 million is \$110 million over FY 21 enacted
    - SPRANS Oral Health Set-Aside - \$5,250 Million, level funding
    - Integrating oral health into the MIECHV (home visiting) program
  - Ryan White Part F –Dental Programs - \$13,122,000, level funding
  - Health Centers – Continue to work to increase and enhance access to integrated oral health services, priority area, increase the number of dental patients served (from more than 6.7 million in 2019)
- Total [estimated spend on Medicare benefits](#) – Estimated \$995.7 billion
  - Oral health spend \$1.930 billion in 2019 per NHE
- Total [Medicaid medical assistance benefits](#) – \$563.7 billion
  - Oral health spending \$13.719 billion in 2019 per NHE
- CMS highlights performance measure MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs
  - States’ efforts over the past decade have resulted in improved access to dental care for children covered in Medicaid/Medicaid Expansion/CHIP programs.
  - CMS continues to work closely with other stakeholders, including the Dental Quality Alliance, and to host regular Oral Health Technical Advisory Group calls with state Medicaid and CHIP Programs.

**B. Where is the Congress in the 2022 Appropriations Process?**

- House – Hoping to have a bill in July
- Senate – Shooting for early Fall

The process is behind, which is not unusual for a transition year.



### **C. White House COVID Task Force Fourth Meeting May 28**

- Presentations/Updates are [available on-line](#) and quite detailed
- Report from the Task Force on Discrimination and Xenophobia, recommendations
  - Mandate data collection, harmonization, and integrity
  - Expand services in marginalized communities
  - Engage communities
  - Increase Awareness and Access to Services
- Subcommittee Reports – Problem Statements and Recommendations
  - Healthcare Access and Quality
  - Communications and Collaborations
  - Data, Analytics and Research
  - Structural Drivers of Health Inequities and Xenophobia Subcommittee

The next meeting is on June 25 and we look forward to reporting back. We'll be watching for next steps re: implementation across these various areas.

### **D. Biden Administration Appointments and Nominees**

- **Biden Administration HHS Appointments**
  - CMS Administrator Chiquita Brooks-LaSure
  - CMS Principal Deputy Administrator- Jon Blum
  - CMS Chief of Staff- Erin Richardson

The Medicare director will be announced in early July; have not heard about timing for the Medicaid director.

- **Biden Administration HHS Nominee**
  - Assistant Secretary for Preparedness and Response (ASPR) Nominee Dawn O'Connell – hearing just held. Former experience:
    - Senior Counselor for COVID-19 response
    - Director of the Coalition for Epidemic Preparedness and Innovation
    - Senior Counselor to Secretary Sylvia Burwell
    - Deputy Chief of Staff to Secretary Sebelius

### **E. References**

- American Council on Education. A brief guide to the federal budget and appropriations process. 2019.
- National PTA. The federal appropriations and budget process.
- American Dental Education Association. Final tips for building relationships and communicating with members of Congress.
- President's 2022 Budget Request, Congressional Justifications for CDC, HRSA, CMS

## F. Questions and Additional Updates

- What about funding for a dental benefit in Medicare? Is it showing up anywhere??
  - *(Colin Reusch responded)* It's not in the numbers but there is conversation. Efforts are ongoing to make it happen. Regarding the prospects of this happening, it's in Congress' hands.... Impossible to know how likely it is.
- A high priority item is improving the pipeline of rural health care providers. Is there a specific action plan for this?
  - *(Marica Brand responded)* There is language in the CJ about investments in the National Health Service Corps and there is ongoing investment in the federal Office of Rural Health policy, and there is investment also in HRSA's other workforce programs and the loan forgiveness and loan repayment programs and many of them come with the requirement that you serve an underserved community. I can see what more I can find out.
- The CDC Division of Oral Health has level funding in the PB 2022 budget, which allows for funding "just" 20 states. Do you see this changing in the future? It's a situation of have's and have not's. What's the hope in this regard?
  - *(Marcia Brand responded)* This is the President's budget. These are budget targets and to fund those priorities resources sometimes have to be redirected. The way to address this is through the appropriations process and to let the folks know who are involved that 20 states and one territory does not get us to where need to be related to improving oral health in this country...*more...* OPEN has made it a priority to engage the Appropriations Committees around this. Now is the time and we encourage all those folks who are advocates for CDC's oral health division to do that now. This is the time.
  - *(Christine Wood responded)*. A legislator is circulating a "dear colleague" letter to ask for an increase. I don't know what kind of traction her letter is getting. *Chris later chatted:* Rep. Lucy McBath (D-GA) has agreed to lead the CDC Dear Colleague letter.
  - *(Manuel Cordera)* With regard to the pipeline, can we request that minorities be targeted where there is most need to address the inequities, we have been so painfully aware of during the pandemic. How can we treat dentistry with such a lack of respect? If oral health is essential to systemic health, they are not doing much for systemic health, and they need to be told this in plain language. I hope this can be discussed and we can write another letter in this regard.
- I see a lot of dollars being put into research. Is there a way to connect oral health into those research dollars?
  - *(Marcia Brand responded)* The NIH and NIDCR...we need to ensure that these and other programs examine access to oral health care and oral health outcomes as a part of what they do, what they are evaluating. E.g., community health centers see 6.7 million patients – what are they evaluating around oral health outcomes and care integration? We need to continue to advocate for the inclusion of oral health in the evaluation of all service delivery and workforce programs.

#### **IV. COVID 19 Updates**

##### **A. Opening Remarks**

*Mike Monopoli presented.*

- Over 600,000 people have died from COVID, and CDC believes that is an undercount.
- The vaccination schedule has changed – 52.8% of the US population have had one dose, 41.4% are fully vaccinated; however, there is uneven acceptance and availability of the vaccines. The Northeast, Mid-Atlantic, and West Coasts are at over 70% range for full vaccinations. Illinois, Michigan, and Colorado as well. There are still some areas of the country where the rates are really low, and the Delta variant is growing in the US – it's about 10% of new cases – it's an issue we need to watch carefully as it could potentially create a rebound as we go into the fall.
- At the G7 conference, President Biden pledged to donate half a billion doses for the world and the European countries matched that. Still, lots of work to go in terms of the world being in a place where we can stop the pandemic.
- The PREP Act still in effect – dentists' ability to vaccinate remains unchanged; however, we are at an inflection point in a lot of states as emergency orders are rescinded. The ability of dentists to administer vaccines is tied to those emergency orders so we need to look at this state-by-state. The ability of dental hygienists to be vaccinators is built around those emergency regulations so it's going to be even more complicated now around the ability of hygienists to be vaccinators as we go forward. *Mike offered an example from Massachusetts as an example of the unique complications that exist from state-to-state.*
- We're moving away from mass vaccination as an approach and more towards targeted approaches that specifically impact the issue of equitable access to care and trusted messengers. There is still a role for oral health providers to be part of that targeted approach. We still need volunteers, and we need to continue to make sure that's happening. And with the targeted approach, community health centers will have more of an important role in that outreach and we can work to support that.
- We need to continue to work toward structural inclusion of oral health professionals as vaccine administrators, further integrating oral health care into overall health care. We had a good start to doing this before the pandemic and the pandemic has helped to move that along, but we still have a number of areas – layers of the onion to peel – to make sure we continue to institutionalize this.
- The most difficult area of this is around payment – we have the codes for reimbursement for providing vaccines, but the work now is to have the services actually reimbursed. And we should consider if we want to do a collective action around this.

*Mike invited Eme Augustini of the National Association of Dental Plans to speak to this issue.*

- I can share some anecdotal information re implementation of codes that were adopted in March and became available for use based on regulatory approvals.
- Carriers worked to ensure inclusion of new codes on a claim did not remove a claim from auto-adjudication so that payment on other codes that were included would not be overly delayed. Carriers were also working to compile and submit information to

regulators about how to use the codes to receive approval, regardless of coverage decisions, and were working on systems and IT changes.

- In a usual cycle, this would be done between March-April and January of the next year when the code becomes effective. In this case, carriers are working on a rush basis.
- I think – depending on their business mix – that carriers are at various points in the process just now.
- I checked in with a handful and learned that the number of claims that include the codes is incredibly small. That is, the number of instances in which a dentist is administering the vaccine in the office, documenting that on a claim, and submitting that. This is all anecdotal, but it is seemingly consistent with the ADA's and Policy Institute's survey data (4% of dentists are administering the vaccine and most of those are at health sites, not in the office).
- I don't have data on dentists who are submitting to medical plans – e.g., oral surgeons who submit on the CPT. This could be a blind spot
- Medicaid could be a different story
- Overall, the numbers are very low – but it could be too early to tell or discern a pattern
- Carriers cannot discuss together their intent to cover or not cover or how much with one another due to antitrust policies.

*Ann Battrell shared HPI Data that aligns with this:*

In both April and May, about 38% of the dental hygienist panel resided in states that authorized hygienists to administer the COVID-19 vaccine. In May, 6.4% of dental hygienists who had the authority to administer the vaccines were doing so (down from 9.8% in April). These numbers are consistent with what we are seeing on the dental practice side where vaccine administration by dentists in states where its authorized has also been low.

*Laurie shared the billing codes in the chat:*

- D1701 Pfizer-BioNTech COVID-19 vaccine administration – first dose.
- D1702 Pfizer-BioNTech COVID-19 vaccine administration – second dose.
- D1703 Moderna COVID-19 vaccine administration – first dose.
- D1704 Moderna COVID-19 vaccine administration – second dose
- D1705 AstraZeneca COVID-19 vaccine administration – first dose.
- D1706 AstraZeneca COVID-19 vaccine administration – second dose.
- D1707 Janssen (Johnson & Johnson) COVID-19 vaccine administration.
- D0606 Molecular testing for a public health related pathogen, including coronavirus.
- Examples of CPT codes: Pfizer: 91300. First dose: 0001A, second dose: 0002A. Moderna: 91301. First dose, add: 0011A, second dose: 0012A.

## B. Questions and Additional Updates

- *(Steve Kess)* NYU International program had a conference on Friday. Marko Vujicic did a presentation on dentistry related to COVID and indicated that a lot of the issues reported about the private sector dental community did not materialize. Retirements did not take place to the degree folks were concerned about. Teledentistry that spiked to 15% use in early phase COVID (March-May 2020) is back down to less than 1% use. He gave the impression that 89% of dental patient volume is back in place – in some places a bit higher or lower (e.g., urban with people not commuting to their jobs so not getting oral health care in urban settings as they did before). He indicated that dentistry is back to pre-COVID levels and the focus of the profession seems to be consistent with pre-COVID behavior. For the last 15 months there was a lot of dialogue about the expansion of oral health into primary care and the integration and interoperability of oral health and medical records for better patient care and outcomes - lots of conversation in groups like this and the Santa Fe group – but the early tea leaf readings are not indicating tangible progress as relates specifically to oral health or Dr. Cordero’s issue of minority populations and certainly nothing on disabilities specifically and nothing on the expansion of resources for oral health even though there is a coalition of 150 organizations now who are actively having dialogue with CMS and others about the benefits of oral health. It’s frustrating because of all the great intention, including Tim’s program which has 107 or 108 members to it. But it does not appear that with all these efforts we have been able to change the landscape in any tangible way right now. The question for me and others is oral health is just not given the visibility, credibility, and recognition that it deserves because of the significant difference it makes when you have good oral health and when you might be suffering from a noncommunicable disease. That data is here and it’s been validated and paid for by the private sector for the last decade and the government hasn’t yet come around to realize that there are 20m people suffering with a noncommunicable disease who could get an oral health benefit and it wouldn’t cost the government any real money. It would be a great test to validate the importance of oral health to health care from both the triple aim.... There was a study by three academics from NY State looking at NY State Medicare data ([Dental Services and Health Outcomes in the New York State Medicaid Program](#)) and it reinforced the same triple aim outcome of reducing costs and improving quality of life through a dental benefit. They wrote letters to senators and others. What do we need to do? What do the oral health advocacy groups like those on this call need to do to let the public know that they are not being totally well-served? It’s systemic within oral health and health care and we’re just not getting the visibility and respect we deserve.
- *(Admiral Ricks)* I understand what Steve is saying but at the same time the PREP act authorized us to give the vaccination yet only 3% of dentists took advantage of that. And many who did were in health facilities. I can see why other health care professionals don’t respect us because even when given the opportunity – and even the dental hygienists – only 9% or now 6% integrate primary care with oral health, we’re not taking advantage of it. Where is the problem with the messaging? Is it us not getting the dentists and hygienists on board down at the local practice level? Where is the

problem? Until we break down the silo ourselves, other people will be quite comfortable with that silo. It's a rhetorical question.

- *(Steve Kess)* But it's a valid response because the truth is we met the enemy and it's us.
- *(Mike Monopoli)* That percentage underestimates the number of dentists who volunteered at mass vaccination sites. The way they collected the data did not parse that out. I do agree – it's frustrating that there is movement back to where we were before which seems to be a usual occurrence, but there are also some differences now that we need to focus on as we continue to do our work and having the connections that have been made during COVID – within this group and other groups – it's a helpful sign. It really doubles down on the importance of having the Surgeon General's Report, which is the next thing on our agenda.
- *(Eme Augustini)* The ADA survey included some answers as to why dentists were not engaging with vaccinations. Some roadblocks were indicated: liability was a concern, process training requirements were not included, and time constraints. The data indicates utilization of benefits is very high – back to pre-COVID levels or even higher – which is indicative of folks re-engaging with care...at least those who have a dental benefit...so the whole dental team is participating in an aspect of a public health effort here, which is getting patients re-engaged with their care and handling what is probably the unfortunate advancement of some dental conditions that happened during this time.
- *(Mike Monopoli)* We did a survey as well and while numbers were low, almost half of those who responded said they'd be interested in administering vaccines if the barriers were lessened.
- *(Admiral Ricks)* The PREP Act did address liability, so this was an easy one. When we talk about point of care testing by oral health professionals, think about the resistance to that. We couldn't get vaccinations out the door when there was a push by dentists and dental hygienists and then they don't do it. How are we going to get them to do depression screenings, cholesterol screenings, blood pressure screenings, and more - it's an uphill battle, and we're all saying the same thing, but we don't have a path forward right now.
- *(Ann Battrell)* I often think about this problem. We all have it. Even as regulatory advancements are made, it does not guarantee a change in the behavior of providers. A lot of that is driven back to self-identity. As a clinician and a provider, do I really feel I have the capability, the willingness, and the competencies to go do something different. In the hygiene community we talk all the time about when there are scope changes, or settings changes, and we work so hard to get those in place, and then we wonder where everyone went! There's a huge gap in getting people to change their identities first and then change their behaviors...about being willing to participate.

#### *From the Chat*

- *(Christine Wood)* Yes, look at how few dental therapists there are in the states that allow it!
- *(Ann Battrell)* Exactly, Chris Wood. It takes real leadership and willingness of everyone within the system to "change" and many are change adverse on an individual level.

## **V. Surgeon General's Report**

### **A. Opening Remarks**

*Mike Monopoli opened.*

We have been anticipating a Surgeon General's Report as a twenty-year update on oral health in America and progress that has been made since 2000. The report was due to come out in 2020 but it did not happen because of everything that was happening with the administration and the world. We now know the Surgeon General's Report is not going to be released as a Surgeon General's Report, but rather will come out as an NIDCR report (*see below*). The word is that the Surgeon General does not have the capacity to put the report out, and NIDCR has prepared the report for the Surgeon General and will put it out as an NIDCR report in the fall of 2021. The further delay is because it still has to go through the clearance process.

*Mike shared a short message from the Director of the National Institute of Dental and Craniofacial Research (NIDCR), Dr. Rena N. D'Souza.*

NIDCR can take this approach, however it raises some issues and disappointment around the impact of the report given our previous discussion. As the worst impacts of COVID subside and things shift to a new normal, we have new opportunities. One way to rally folks around a common discourse around those opportunities would have been a Surgeon General Report on Oral Health, which has value to the oral health community in general and was something we all worked hard to create.

*Admiral Ricks spoke to the importance of the Surgeon General's Report.*

The failure of this to be released by the Office of the Surgeon General is the greatest disappointment of my entire career. I have been deeply involved in this report since it was commissioned. I was on the steering committee starting back in March 2018.

There have been 64 or 65 Surgeon General Reports since 1964...the first was on smoking and health and we all know what impact that had as far as linking smoking to cancer. And there have been reports that included Community Health and Economic Prosperity and last year there was a report on smoking cessation. There have been about 33 reports on tobacco, but there has been only one on oral health and that was in 2000. I think most of us here know this – there have been three or four decades of research linking oral disease to systemic disease. And that report elevated the conversation beyond dental research. The push to medical/dental integration began with the 2000 report, illustrating the importance of a Surgeon General's Report.

There have been about 400 people involved in this new report – either in writing or reviewing, including some of you. And it took all of us by surprise to learn that this report – which was ready for a final clearance process and had the full backing of the previous administration – to learn on May 26 from Dr. DeSouza that NIDCR would release it themselves, rather than the Surgeon General.

Many of you have reach out by phone and email to share your concerns about this. I had nothing to do with it. Technically, Dr. DeSouza did not either. The reports are written by other agencies, like CDC and NIH; NIDCR wrote this one. The staff of the Office of the Surgeon General conveyed the decision to Dr. DeSouza. There were no specific reasons given that I know of. It's good it will be released by NIDCR as the messaging will not be completely lost.

Two years ago, right before the pandemic, I spoke at a World Health Organization and Pan American Health Organization meeting...and at least 15 different countries from around the world asked me about the Surgeon General's Report. Because a lot of these small countries use what comes from the U.S. Office of the Surgeon General to prioritize health or oral health in their countries. So this does not just have an impact on the U.S.; it has an impact around the globe. An agency report – and there have been numerous oral health reports have been very valuable – but those are not at the level of a Surgeon General's Report.

*(Mike Monopoli)* We have a duty to advocate that this is not the best course, while also being careful not to undermine NIDCR or Dr. DeSouza. As we heard earlier, NIDCR's strength will be important. The way this decision was made without a public process and without looking at aspects of the Report that could be improved and have this Administration take it on as something that is valuable to them...we need to point this out. We've started talking with stakeholders and specifically the Santa Fe Group about a possible response.

*(Steve Kess)* We are equally disappointed as everyone else with respect to this being lost in the transition to the new administration. What was created in one administration will not see the light of day in the other. It is not going to be what it was supposed to be. The reason for this is what has been pointed out. The Office of the Surgeon General gave visibility and authenticity to the report that will be lost when it's presented in whole or in part by others. We've made some inquiries and coordinated and collaborated with other organizations to see how we might reach into the Department of Health and Human Services to see if there is an appropriate way to revisit the decision, consider other options that would have greater visibility, fanfare, and credibility...perhaps through a collaboration among organizations. There is a national summit in March that Santa Fe is planning on key issues. It could focus on this report as a theme. Santa Fe will not be presenting; rather we will host a national dialogue over two days with different sectors, including community groups with a focus on health equity. We are disappointed. We're at a crossroads in a way. There are 19 of us in Santa Fe and one thought is that when we look at major gains made – e.g., in the LGBTQ community, AIDS research – these are unpopular issues with society but activists within these communities banded together and made more visible noise than perhaps the oral health community is willing or able to do. There was 100% support by individuals involved. Within the oral health world there is lots of fragmentation and there are organizations that you can or cannot count on depending on the issue and what the approach will be to change policy or focus. It's an extraordinarily difficult time for oral health because there was a great opportunity. Many feel that the COVID experience was such a huge disruptor that it gave them a chance to make changes that it would otherwise have taken years to make, but from a policy or advocacy



perspective we have not made the sustainable gains for oral health on behalf of the public's receiving of oral health that we had hoped to make and that is disappointing.

*(Mike Monopoli)* We have an opportunity to advocate and to bring our groups together and we're thinking about how and when to do that – we have some time, although not a lot – and we want to get from this group a sense of if this is a place we can think about taking collective action.

## **B. Discussion**

*What are your thoughts on ways to influence NIDCR not to release the report themselves, but in a way that retains support for NIDCR leadership?*

- Part of my concern related to this is that as NIDCR takes the report, none of us knows what's in it. I was a reviewer on the report and at the last juncture, it was still a bit of a mess. So part of the concern is, "what's in it?!" I like this question; however, we should all be cautious about the content as it comes into the hands of NIDCR. Will there be another opportunity for communities of interest to weigh in before anything comes out?
- If it were a Surgeon General's Report, the general public would not have an opportunity to review it. NIDCR made an effort to have external reviewers. I reviewed it as well and agree there were a lot of problems and a lot of comments were made but we did not see the adjudication of that. Generally, agencies release reports without public comment. It's Dr. DeSouza's decision but the precedent is without public comment.
- Do we know who made the decision?
- As Assistant Surgeon General, I do not have a definite answer, just suspicions.
- Some of us have heard that the decision came out of the Surgeon General's office to NIDCR.
- Several organizations are collaborating and coordinating around influence we might exert around options and provide some alternatives for NIDCR to consider. This effort is underway. The intent is to turn this lemon of a situation into lemonade for everyone's benefit because this was an anticipated boost to the oral health issue and by it not being released we're all set back in our ability to create more visibility and focus on what was or wasn't included in that report. The challenge is that short of the new Surgeon General releasing a report created by a prior Surgeon General from a previous Administration, which is highly unlikely, the best we can hope for is a collective effort and short of that to figure out a way to work with NIDCR to optimize the content and the visibility and impact of the findings through some collaborative, collective presentation of that information for maximum impact.

*Pat asked for a show of hands regarding a collective action in the form of a letter from this group.*

- It's ok but I think we need to consider all of this before we decide
- Congressional engagement is another option – encourage them to reach out to the Surgeon General's office about the importance of the report coming from the Surgeon

General. And perhaps seek their input on what the sequencing of these efforts should be.

- Amplifying consumer voice is also important in this situation. Perhaps it's not just organizations that need to speak out. We can send one letter, but it's one letter. Perhaps we want to activate our collective networks to make their voices heard. But we need to be clear on the messaging first.
- The AIDS crisis was a strong and loud response to reverse this. The longer this goes on, the less likely this is to be reversed. I know we're all working our channels. If there is a collective action, it needs to happen quickly. And consider a significant media push or public engagement, independent of who releases the report, that can be leveraged if/when the report is released.

*What are your thoughts on persuading the new Surgeon General to put oral health on his agenda, including taking ownership of this report?*

- My understanding is that the [Surgeon General is bringing back the chief officer of design and innovation](#) to facilitate new ways of communicating and facilitating dialogue. To the point of leveraging the office to host dialogue and conversation and innovative thinking in response to any oral health report that is released, this might be an interesting request to make of the Surgeon General's office, given that it is a platform in which the Surgeon General is very interested. My understanding is that this will be someone from IDEO.org
- There are a number of parallel efforts going with respect to oral health. Oral health is very fragmented and there are many stakeholders with different agendas. Santa Fe and other members of this group are attempting a number of approaches that will run the course by our next meeting. Perhaps at that time we can think about a public/private project – we have the dates in March on March 7-8-9 and a place in Virginia – to create a national dialogue. The idea of the design process could be a subject. We're looking to go back to the idea of the ADA meeting\* many years ago with 12 stakeholder groups with 12 representatives each at 12 tables. It was the US National Oral Health Coalition that emerged and eventually became OPEN. We have more pieces in place now; no need to replicate it. But we can brainstorm some ideas around practice, scope, and how to engage the new administration.

*\* Note: This was the 2009 Access to Care Summit:*

[https://www.ada.org/~media/ADA/Public%20Programs/Files/access\\_dental\\_care\\_summit.pdf?la=en](https://www.ada.org/~media/ADA/Public%20Programs/Files/access_dental_care_summit.pdf?la=en)

- Do we know when the next Surgeon General Report will come out?
- No there is nothing that's been said
- Maybe we ought to start working on it now so that it is his next report. OPEN has some national meetings coming up and this is a great place to have this conversation

*From the Chat:*

- *(Christine Wood)* Yes, we should do a collective letter

- *(Laurie Norris)* Does anyone in this group know our new Surgeon General, Vivek Murthy, personally?
- *(Ann Battrell)* Support but we need to utilize our federal lobbying efforts to request a meeting with the Office of the SG
- *(Eme Augustini)* Agree. A call from Senate or House health leader(s) could be meaningful
- *(Timothy Ricks)*: FYI: It is my understanding that Surgeon General Murthy, in his first term as Surgeon General, did inherit a report that was already being written, and this report - The SG's Report on Alcohol, Drugs, and Health - was published in 2016. Many of the Surgeon General reports do cross over Administrations, from what I've been told. However, there have also been reports that have died during Administration transitions.
- *(Kristin LaRoche)* If anyone wants to strategize offline about engaging with congressional offices on this let me know klaroche@carequest.org
- *(Colin Reusch)* Re: Surgeon General's report, might be worth some outreach to Mike Simpson's office.

## **VII. Closing**

*Pat closed the meeting by thanking everyone and sharing that the next meeting is July 21, 4-5:30 pm ET. We will take off the month of August and reconvene in September.*

## **VIII. Appendix: Working Team Update**

*Due to a lack of time, this update was shared out via email after the meeting.*

### **A. Dental Benefits in Medicaid & Medicare**

This team is focusing its learning and discussion on a research paper being prepared jointly by Families USA, Community Catalyst and the Health Policy Institute, crunching the data around how to make a business case to States on why they should cover dental care for adults enrolled in Medicaid. This team is also keeping an eye on activity in Washington DC around adding a dental benefit to Medicare, in case there might be an emerging opportunity for all of us to make a collective statement in support at a critical moment.

### **B. Integrated Care**

This team has identified two next steps to pursue: First, to gather information from several experts in the field - Patty Braun, Professor of Pediatrics, Family Medicine, Public Health and Dental Medicine at the University of Colorado, the InterProfessional Education Council (IPEC), and key leaders in HRSA's Bureau of Primary Health Care. All of these folks are doing leading edge working in the field of integrated care. And second – as a possible “collective action” for the entire PRW – they are considering developing a letter to the federal Office of the National Coordinator advocating that ONC prioritize efforts to create interoperability between medical

records and dental records. Stay tuned – you will be hearing more about this at our July meeting.

### **C. Data & Research**

This team has reaffirmed its view that it is a priority to gain a better understanding of what data is already being collected on oral health and health equity. At their recent meeting ASTDD introduced the group to John O’Malley’s data initiative, the National Oral Health Data Portal. It is a centralized repository for multiple oral health datasets. A next step for this team is to take a closer look at, and to potentially update, a different effort - a 2015 broad survey of the field that compiled a list of oral health data sets and metrics. Stacey Auger and ASTDD have graciously agreed to undertake this closer look, including identifying which of these datasets have information on race and ethnicity, and other equity related data. Once the team has this baseline information, they will turn their attention to the questions of how might this information be used, and what additional information would we like to have.

### **D. Messaging & Communications**

This team has aligned around “who” needs to be communicated to and “what” messages they need to hear. Of the three possible audiences for messaging – policymakers, providers, and the public – the team feels that the public is the least aware, and is also the audience which has the most potential to help move the needle on change. The “what” – the primary content of the messages to the public – should be to help them better understand and appreciate the critical connection between oral health and overall health – in other words the integration piece. The message should also address the need for equitable and accessible oral health care and the need to identify and eradicate the bias and racism embedded in the oral health system.