Funders Oral Health Policy Group

Thank you to everyone who joined us last week for another informative convening! Below you will find notes from the discussion. You can also view a recording of the meeting here.

If you haven't yet, please take a minute to fill out the evaluation for the October Webinar. We value your feedback!

Thank you to our guest speakers **Eliot Fishman** of Families USA, and **Colin Reusch** and **Kasey Wilson** of Community Catalyst!

October Webinar Notes

WAIVERS AND RELATED MEDICAID INNOVATIONS

- Social determinants of health and health equity are the top issues for states when thinking about changing Medicaid care delivery and changing Medicaid financing.
- A growing number of states are trying to think about the integration of different parts of the healthcare system and the integration of the healthcare system with human services delivery and community-based organizations.
- No Wrong Door approach is needed to get people linked to the support they need across medical systems. Integrate care delivery and integrate financing across different healthcare sectors.
- Need to bring in social services into policy agendas to link healthcare delivery to social services and human services delivery in community development.
- When integrating care delivery and financing across different health care sectors, there are several important questions to consider:
- *What can Medicaid pay for?* There are limits on what Medicaid can pay for when it comes to non-healthcare items. Assuming that Medicaid is not going to become an all-purpose social services funding stream.
- *How do you set up an administrative infrastructure so that the different funding streams and different kinds of agencies can plan how they are going to work together?* How does one plan at the community level or the regional level for these different systems to work together? Especially in a medium or a large state, mandating that from the state capitol for the entire state at one time would get very unmanageable, even more so if you try to do that on a national level.
- *What sort of funding upfront do community-based organizations need so that they can fully participate in that process and then on an ongoing basis operationally?* What do non-healthcare providers need to be able to successfully engage with the healthcare system? What kind of investments do they need to be able to stand up robust community-based preventive interventions on social drivers of poor health? And where does that money come from?
- Common factors for states that have made successful changes with Medicaid Waivers include requesting a lot of federal money and integrating different sectors of healthcare delivery and different human services. States used a large amount of federal money to set up a regional table that pulled in Medicaid managed care, physical health, behavioral health, oral health, and significant community involvement. They then used significant amounts of that federal funding to make

investments in information technology, acting as a grant-making foundation with providers to get them engaged in this work.

- Oregon has a coordinated care system that evolved from a provider-based, managed care organization to a hybrid care system that is more involved with the National Medicaid managed care industry. A serious commitment to a regional level planning, accountability for measured outcomes, and real work to keep different both social services sectors in different parts of the health care system engaged in this regional planning process.
- Washington state did not want to drop the existing Medicaid managed care structure and instead created a parallel infrastructure - accountable communities of health- that planned around social determinants of health and integrating physical, behavioral, and oral health financing.
- Washington's model is important because many other states have existing manage care plans and this model would them allow them to create the infrastructure to do planning around coordination and to make decisions with managed care plans at the table.
- Minnesota, Massachusetts, and Rhode Island are a few of the states with Medicaid accountable care organizations. In Minnesota, providers do not become insurance companies and instead, there is some level of financial incentive around the cost and the number of patients. Minnesota is doing this without a Medicaid section 1115 demonstration waiver and without a big Medicaid waiver investment of federal dollars, using instead Medicaid state plan changes (which are typically faster).
- Trump administration has generally been unwilling to make Medicaid waiver investments and it is unclear if we would see Medicaid investments like those in Oregon and Washington under a Biden administration. Minnesota model could be more of a realistic scenario for states for now.
- North Carolina is implementing Medicaid managed care for the first time. Stretching what Medicaid can pay for by using Medicaid dollars to pay for more in the way of social supports for health.
- A regional approach makes a lot of sense unless you are in a very small state. Opportunities to highlight oral health as one of the priorities that states should be thinking about and the interaction between overall health and social determinants of health. Most states have concluded that they will not be able to change care delivery in this way unless investments are made to bring in providers who have not interacted with the healthcare system before.

- Discussions about states making new investments or doing anything innovative are currently stalled. Medicaid budgets are forecasted to do poorly in the upcoming lame-duck period and cuts are likely. Maintenance effort to keep states from making cuts to adult dental. Best case scenario: CMS puts out guidance around a phased approach to maintenance of effort.
- Telehealth will probably remain a significant part of the Medicaid program after the pandemic.

DEVELOPING AN ADVOCACY AGENDA

Oral Health Equity Policy Tool

- Community Catalyst is developing a resource guide, that is intended to help organizations, coalitions, and funders think through policy and advocacy agendas with an eye towards what makes for equitable policy and how to ensure that communities are engaged in that process. Unique in that it considers who is at the table and whether a given policy is crafted in a way that will address inequities or disparities. Intended to help answer questions like 'what makes for good and effective successful Oral Health Policy at the state level?'
- The tool is designed to be used either by a trained facilitator who guides a group through the process or by individual organizations who work through it on their own, with a policy or set of policies for which they're considering advocating. It asks:
    - What is the problem you are trying to solve?
    - What information or data do you have to inform that?
    - How do we know that this policy is going to have that intended impact?

    - Are we simply assuming that this policy is crafted in a way that will address disparities or equity?
    - Do we have some real knowledge or evidence that that might happen?
    - How do we know that this is the thing that affected or impacted communities need or want?
- After using this tool, test organizations have concluded that a policy may fit well within their agenda and is approaching a degree of equity, but there are a lot of holes to be filled in and the best way to do that is to bring community organizations and community members to the planning table.
- Cohorts of statewide oral health policy organizations are testing the tool internally and will provide additional feedback on how it can be deployed in the field. Community Catalyst intends to use the research to inform its technical assistance to state and local organizations moving forward.

Oral Health Equity Field Scan/Report

- Two-pronged approach: a quantitative survey to capture performance and a qualitative interview with those stakeholders, including oral health advocates and community and grassroots organizations.
- Community Catalyst intends to develop a report by the end of the year that will highlight some of those findings and bring it back to the advocacy and funder communities to help them think through how they can plan for and incentivize, more effective, collaborative, and inclusive oral health advocacy.
- Currently in the analysis phase with research partners to identify trends, pull out key information across cohorts, and look at the perspectives from the different groups on some of the same issues and questions around how oral health advocacy is playing out at the state level and what is holding it back.
- Early findings from this work include:
    - Flexible funding can bring people to oral health advocacy. Organizations prefer flexibility within grants as it allows them to work on the healthcare issues, they know are most important to the communities they serve and work in and oral health often emerges as an urgent need. Being invested and skilled in community engagement and having funding that allows the flexibility for them to work on the issues that they hear about when they are engaging communities is a powerful combination for organizations.
- During the pandemic, flexible funding has allowed organizations to be nimble in their work and shift advocacy priorities in real-time to help the

communities hit hardest by COVID-19 including black, indigenous, people of color, low-income communities, and people with disabilities.
    - The oral health advocacy field, both in terms of the more traditional oral health advocates, as well as funders, is starting to embrace the importance of community engagement and of approaching this work through a broader health equity lens as sort of a guiding value for the field. Overarching commitment to these practices as being integral for the work and becoming stitched into the fabric of the oral health advocacy community and what we collectively value.
- A natural relationship between community engagement and investment in oral health work. Community members come to the table already understanding how difficult it can be to access dental care. Observed groups who came to oral health, not through oral health funding, but because they recognize that need in their community and built a pathway to advocacy outside of the traditional framework.
- Unlike policymakers, community members do not need education to understand that oral health is important. Not only should people have a say in the policies that affect their health but there's real value in increasing the number of people who understand and care about oral health.
- The field scan and accompanying report are intended to inform the field of things that we ought to be thinking about as we approach this work in different ways and in more inclusive ways. Both are intended to highlight the gaps when it comes to who is at the table and how advocacy is collectively driven at the state level.
- Instead of thinking about how to attract and pull diverse voices to us and being disappointed when only a few people show up to the table, start going out into the community. Consider how to get invitations to come to someone else's table.
- When working on the policy equity tool, received feedback from the community organization cohort that the data presented in the survey was often bad and did not represent them and therefore did not accurately represent the problem. We should consider a new best practice of including qualitative and informal data that is gathered from members of affected communities.
- Community Catalyst is in the process of finalizing and designing a public product. AFL will let members know when it is available and how they can engage with these resources.

MEMBER MEETING

2020 Accomplishments

- Thank you to the 2020 Steering Committee: Connie Halverson, Suzanne Heckenlaible, Mike Monopoli, and Stacy Warren!
- Mike Monopoli was inducted as a Fellow in the American College of Dentistry! Congratulations!
- Check out the FOHPG webpage, which we designed to disseminate key information: https://www.afl.enterprises/funders-oral-health-policy-group
- Adapted 2020 Workplan to switch from in-person to virtual meetings
- Developed, planned, and facilitated 7 member webinars and 6 steering committee meetings
- Supported member inquiries, operations (including dues collection), and communications
- Solicited and supported the development of articles related to FOHPG member activities and initiatives for broader dissemination

2020 Member Survey Results

- Members are very interested in conversations about strategy and networking. Mixed interest setting a Slack group or another way to continue the conversation.
- Members are very interested in programming dedicated to health equity.
- AFL will vary the hours of the webinars for 2021.

Membership Report

- 18 members paid dues this year. Lost two member groups this year.
- No meeting expenses for 2020. $45,000 carryover funds from 2020 to 2021.

Steering Committee Member Election

- No nominations for the 2021 Steering Committee. 2020 Steering Committee has committed to staying on for another year although Suzanne would like to find her replacement.

Priorities for 2021

- 2021 programming will focus on one issue for the year: health equity.
- 2021 meeting format: three member webinars and one in-person meeting in the fall (if conditions allow).
- Member dues reduction from $4,000 to $2,000 .
- Steering Committee welcomes member feedback on webinar length and format, determining the best use of members' time and engagement. Building the framework for networking outside of FOHPG meetings around shared interests and goals.
- Signed commitment requested from members by November 30 to be a part of this focus on oral health equity.

Please help us:

- Recruit new members – we will share a membership announcement. This is a good opportunity to reach out to organizations that may not have been able to afford the fees or been able to travel.
- Distribute an RFP for a health equity programming consultant/facilitator
- We are still looking for new Steering Committee members, please let us know if you would like to serve! Help us guide the FOHPG agenda for 2021.

FOHPG NOVEMBER WEBINAR:

POST-ELECTION INSIGHTS FROM POLICY EXPERTS & IMPLICATIONS FOR ORAL HEALTH

Tuesday, November 17, 1 pm PST/2 pm MST/3 pm CST/4 pm EST

Join us on **November 17** for a panel discussion with Sarah Vidrine from NC Child, William Hoagland from Bipartisan Policy Center, and Mayra Alvarez from The Children's Partnership!

Click here to register today!

INTERESTING READS

- Why telemedicine may actually be making healthcare more human
- Learning and Unlearning: Centering Equity in Our Evaluation Practice

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ENTERPRISES
DESIGNING SOLUTIONS

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