Funders Oral Health Policy Group

Thank you for attending the September FOHPG webinar!

Thank you to everyone who joined us for another engaging and motivating 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 September Webinar. We value your feedback!

Thank you Michael Monopoli for leading the discussion and for bringing our guest speaker, Dr. Robert Weyant!

September Webinar Notes

DENTAQUEST PARTNERSHIP FOR ORAL HEALTH ADVANCEMENT OVERVIEW

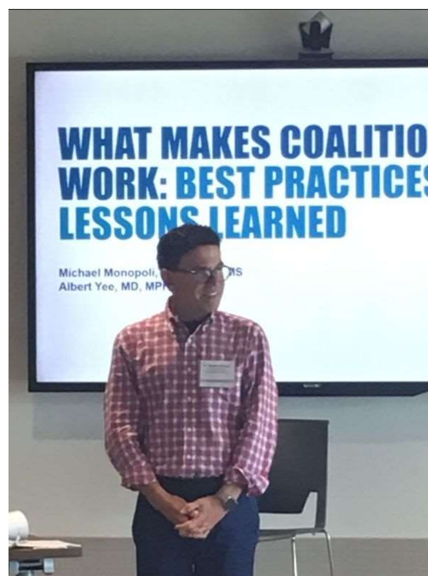
- It became very clear quickly that policies, issues, and underlying systemic racism led to inequities in COVID-19 rates in the population. Decided that a COVID-19 response was part of their response to build equity.
- Made numerous donations to community response funds, concentrated on response funds that focused on populations that were most in need, e.g. the Native American Community Response Fund.
- 2021 grant strategy will include a focus on equity and a focus on continuing to monitor and donate to the populations most affected by COVID-19.
- Rather than focusing on programs, focus on changing systems. Working with state-based advocacy or community organizations on disparities and other areas that produce inequities in oral health.
- Grant with Community Catalyst: One part of the grant is to go upstream to look at the State in terms of inequity and power. The other part is to deliver coaching and tailor technical assistance to grantees. To develop learning resources and opportunities for their connection with the open network. To build around issues such as oral health literacy for partners and to build capacity for advocacy approaches.
- One of the desired outcomes is to elevate community voice by seeking out and engaging community-based organizations. To give communities the tools to advocate and to help the groups most impacted by oral health inequities.
- Grantees Include:
    - **Virginia Commonwealth University:** Grant supports the University to engage with community-based stakeholders around access to oral health. Works specifically on outreach, education, and bringing people together to maximize their ability to access healthcare in the most effective way.
    - **Native American Connections**: Improving the lives of individuals and families through Native American culturally appropriate behavioral health, affordable housing, and community development services. Looks at the experiences of Native Americans in oral health and policy advocacy related to work force. Extension of Medicaid benefits.
    - **AltaMed Health Services**: Community driven oral health provider in Southern California. Formed California Oral Health Progress and Equity Network (CA-OPEN) out of the national Oral Health Progress and Equity Network to advocate for specific programs that support health in CA. When Governor Newsome proposed a $14 billion budget cut in May of 2020 that included cutting the adult Medicaid

dental program, CA-OPEN created an advocacy campaign to push back. Newsome refiled budget and included adult dental benefits. Shows importance of broad-based community voice that has access and partnerships across the state.

- **Arkansas Medical, Dental and Pharmaceutical Organization Inc. (AMDPA) –** An African American organization of doctors, dentists and pharmacists that works to engage the community to address health disparities in underserved populations. Grant supports the association to develop a community driven oral health plan that addresses disparities, connects communities, and promotes systems change around people's access to medications. Plan includes addressing the role of pharmacists in oral health instruction.

Identifying Non-traditional Grantees

- DentaQuest Partnership reached out to their current grantees and partners in specific areas and states and asked them for recommendations for organizations that may be interested in doing work in oral health. Then made calls to CEOs of organizations asking "Are you interested in rural health? If so, would you want funding from us?" Also asked organizations who else they should call. Started with 20 grantees and ended up doubling that number.



A CALL TO ACTION TO IMPROVE ORAL HEALTH CARE IN THE UNITED STATES

Surgeon General's Report on Oral Health

- Last report came out 20 years ago. Followed up with a Call to Action.
- Opportunity now to bring Oral Health into the view of the nation. Lever for motiving policymakers, the report is expected in January or February 2021.
- The burden of oral disease on school performance, job performance, economic prosperity, and military readiness as a selling point to resonate with policy makers. If you do not have good oral health at the population level it impacts economic productivity and the ability for communities to thrive.
- Report clearly indicates that policy changes across the system are needed to reduce inequities and increase access.

Lancet Commission on Global Oral Health

- In June of 2019, published two articles: one on the scope of oral health problems globally and one on potential remedies globally.
  - Articles identified social determinants. Noted that 3.5 billion people in the world have dental disease and lack access to care. Almost every nation in the world puts oral health as a 2nd tier behind any other kind of medical care. U.S. compares with low- and middle-income countries in terms of how much we pay attention through our policy and financing of oral health.
  - Policy approach recommendations: improve dental coverage financing, improve oral health promotion and dissemination of info outside the dental office.

National Academy of Medicine Committee Aimed at Improving Primary Health Care

- Report looks at medicine, financing medicine, and provider burnout but also discusses medical/dental integration. Medical/dental integration is going to be a slow, long process that requires changes in healthcare, dentistry, and financing for healthcare and dentistry. Predicts a 10-year window to see this reach maturity.

- Examples of obstacles to medical/dental integration:
    - There is no motivation for big medical software vendors to add dental to their medical record systems. It is too small a market for them and without that change, it makes referrals a challenge.
    - Co-location is going to take time and structure change. 80% of dental care is delivered in the cottage industry of small offices randomly distributed around the country. Whereas medicine is aggregating and moving into large group practices, dentistry is staying way outside of that.

Medical/Dental Integration

- Dentistry does not own oral health. Oral health can occur anywhere in the system; we need to elevate it across the board. That includes housing policy, food policy, etc. Oral health needs to be broadly distributed through the healthcare system, through the education system. Get CMS to start to bring oral health in the conversation.
- No one is accountable for oral health. Dental is treated as a commodity.
- The separation between oral health and general health is artificial. Oral health is health.
- Social determinants play a huge role in oral health outcomes. Commercial determinates also playing a big role. Ex: big sugar is behaving like big tobacco was, marketing sugars in a way that hurts health.
- Access to oral health care is a structural issue in the way dental care is financed and the way we deliver care. 40% of the people in the US do not get the care they need.
- Finance reform is necessary for medical/dental integration. Pay people to do things differently. We need to figure out how to align dental and medical appointments. Medicare is an issue as many physicians do not understand that Medicaid does not work the same way in dental as it does it medical, or that Medicare does not include dental. Aligning healthcare payments in a way that allows medical/dental referral is essential.
- Besides Medicaid, other financing organizations do not have an incentive to pay for dental. We need to move away from fee for service. Universal healthcare or making Medicare universal could be a solution.
- Advocate for States Boards to be representative of their populations.
- Advocate for Accountable Care Organizations to bring oral health into their contracts and bundle dental into their plans. Incentivize the cross-referral process because all providers share in the benefits.

- Opportunity for workforce redesign. Opportunities to move dental care out of dental offices and into alternative venues where care can be delivered to people that traditionally can't access it, or to people that don't want to take time off from work to receive care.
- For 10 years, Maine has been funding the From the First Tooth program which trains pediatricians to do oral health assessments during well-child visits.
- Change restricted practice acts so hygienists can work at the top of their scope of practice, and/or add new workforce members such as therapists. Also, adding dental training to other areas of medicine.
- Teledentistry could work well in emergency departments. Have a dentist on call to the ED to consult with doctors and set-up appropriate referrals instead of EDs mistreating dental cases by prescribing antibiotics or opioids.

Fixing Dental Education

- Dental education is where we need to start to get behavior change from health care providers. Examples of change at the education level that have shown change in equity and implicit bias: happens by virtue of dental school accreditation.
- To fix dental education, we need to create a dental delivery system that delivers better outcomes. Bring the evidence-based practice skill set to students so they have the skills to apply this knowledge in community settings. Get care into the communities that need it.
- Dental education costs could potentially be reduced by having students spend more time working in the community (e.g. spending a month working on an Indian reservation or at a FQHC) and reducing full-time dental school faculty by bringing in lecturers to teach intensives.
- Opportunities for funders:
    - Fund the expansion of community-based clinical education programs at dental schools (e.g. Robert Wood Johnson Foundation Dental Pipeline Program).
    - Develop a speaker’s bureau. Have a list of speakers to come in and share their experiences.
    - Fund curriculum changes. Minnesota distributes over $1 million in state funding each budget period for "Clinical Dental Education Innovations." E.g. Hennepin Healthcare, a county-based hospital system that hosts dental residents.
    - Effective implementation. Find a program that is successful in another state and partner with a grantee to implement it in your

state.

FOHPG OCTOBER WEBINAR:

FOUNDATIONS AS AGENTS OF POLICY CHANGE

Thursday, October 15, 1 pm PST/2 pm MST/3 pm CST/4 pm EST

Join us on **October 15** for a member discussion and presentation by **Eliot Fishman,** Senior Policy Director at Families USA,and **Colin Reusch**, Senior Advisor on Oral Health Policy at Community Catalyst!

Click here to register today!

INTERESTING READS

- School Closures Cut a Critical Line to Dental Care for Poor Students
- An Open Letter: Can Telehealth be Saved from Systemic Racism?
- Covid Causes Vast Drop in Critical Early Child Care for Poor

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