COVID-19 and Oral Health Care: Implications for Provider and Public Health Literacy

[Captioner standing by]

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>> DR. LAWRENCE SMITH: Good afternoon, everyone.

Thank you for joining us.

My name is Lawrence Smith.

I am the executive vice president and physician in chief at Northwell health and dean of the Donald and Barbara Zucker school of medicine at Hofstra, Northwell.

I also chair the roundtable on health literacy, a project of the national academies of sciences, engineers, and medicine.

I would like to welcome you all to today's webinar of "COVID-19 and Oral Healthcare: Implications For Provider and Public Health Literacy".

Which is hosted by the roundtable.

This webinar will explore approaches to increase the literacy of providers in safer practices in clinical dental care during the COVID-19 pandemic.

The roundtable comprises health literacy experts from healthcare, pharma, community-based organizations, and other fields.

We typically host two to three workshops per year, convening to share promising and best practices and cutting-edge research in health literacy around a specific topic or issue.

Recently, the roundtable has held workshops on integrating and oral and healthcare through practices and developing health literacy skills in youth.

This June we convened a webinar on health literacy strategies for reducing disparities among communities of color.

Later this month, whether he host a webinar on addressing health misinformation through health literacy practices using COVID as a case study.

Some housekeeping: This webinar is being recorded and will be archived at the roundtable website, nationalacademies.org/health literacy RT.

I would now like to introduce the moderator of this webinar.

We are incredibly fortunate to have Dr. Nicole Holland moderate this discussion.

Dr. Holland is an assistant professor and director of health communication, education, and promotion at Tufts University School of Dental Medicine.

She developed a Tufts dental school health literacy intensive, a curriculum for health literacy in dental education.

Her research intersects interests between the intersection of health literacy, language access, and oral health as well as the impact of oral health messaging in the media.

Dr. Holland is co chair of the American dental association's national advisory committee on health literacy in dentistry and she serves on the national Academies of science, engineering, and medicine's roundtable on health literacy.

She is the diplomate of the American board of orofacial pain.

She completed her doctorate of dental surgery at New York university college of dentistry, master of science in health communication at Tufts University school of medicine and oro facial pain and temporomandiburar disorders fellowship at Massachusetts general hospital and Harvard school of dental medicine.

I turn now to Dr. Holland who will provide some opening remarks and introduce our speakers.

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>> DR. NICOLE HOLLAND: Thank you, Dr. Smith for the introduction and thank you to the roundtable members and project staff for organizing this webinar on such an important topic today.

We know that many of our roundtable members and their colleagues are pivoting their usual health literacy work to focus on addressing COVID-19.

Today, we wanted to highlight some of the work being done in the oral health community, and lessons that may be beneficial to the general healthcare field.

We are grateful so many of you are here today to join us in this conversation.

COVID-19 has posed significant challenges to the field of oral health.

Emergence of this disease has brought about unprecedented changes, not only in the way we practice but as a society how we navigate the healthcare system.

This pandemic major has created an abundance of new and rapidly evolving data, along with recommendations from scientists, healthcare organizations, and regulatory bodies at local, national, and international levels.

The dental profession is inherently and particularly at high-risk due to the respiratory nature of virus transmission, in combination with the prevalence of aerosol generating dental procedures and the close proximity with which many forms of dental treatment occur.

While unique occupational characteristics and regional regulations must be considered in all our respective professions, our hope is that this example of a COVID-19 response by oral health leader as put forth in today's webinar can demonstrate how fundamental health literacy principles can positively impact the ways in which effective and equitable healthcare and services are communicated, accessed, and practiced.

With this in mind, the objectives for today's webinar are to highlight the efforts to increase health literacy on the safe practice of clinical dental care in the era of COVID-19, through a collaboration between the California State Department of Public Health and the California Dental Association.

To explore the implications of CDC and other regulatory bodies' recommendations on oral healthcare delivery.

To highlight the use of health literacy principles to develop clear and concise resources for providers, and to discuss the impact of COVID-19 on oral health equity and public health literacy.

So without further ado, I'd like to welcome and introduce our esteemed panelists.

Our first speaker will be Dr. Jay Kumar.

He has served as the state dental director in the center for health communities at the California department of public health.

Previously, Dr. Kumar was the director of the Bureau of Dental Health at the New York State Department of Health, where he served in several positions, including

director of Oral Health Surveillance and Research and director of the New York State Dental Public Health Residency.

He also served as an associate professor at the University of Albany School of Public Health and was a dentist in private practice from 1980 to 2008.

He is a current diplomate and former president of the American board of dental public health.

He earned a doctor of dentistry degree from Bangalore University and master of public health degree from the Johns Hopkins University Bloomberg School of Public Health.

Following Dr. Kumar is Dr. Lindsey Robinson, a pediatric dentist and has maintained a dental practice in Grass Valley, California since 1996.

She received her certificate in pediatric dentistry from the University of Florida and dental degree from the University of Southern California. Dr. Robinson is a past president of the California Society of Pediatric Dentistry and the California Dental Association (CDA), and served as chair of the CDA Foundation.

She was a member of the American Dental Association Council on Access, Prevention, and Interprofessional Relations for six years and, during her tenure, served as chair for 2 years. Dr. Robinson has served as on the National Academies of Sciences, Engineering, and Medicine Roundtable on Health Literacy as an oral health representative since 2013.

She has been a guest editor for several issues of the CDA journal on a variety of topics including oral health literacy, peri-natal oral health and medical integration.

She's also a past member of the ADA Board of Trustees.

Last little bit of housekeeping, I would like to, before we start the presentations, I just want to ask all the audience members if you did not have a chance to submit questions in the Q and A for the registration page, upon signing up for the webinar, then please submit a Q and A box at the bottom. Screen.

With that, I will ask Dr. Kumar to begin his presentation.

Thank you.

>> DR. JAYANTH KUMAR: Thank you, Dr. Holland.

Thank you, Dr. Smith for inviting me to participate in this roundtable.

We are working with Dr. Robinson, the California Dental Association and UCSF Technical Assistance Center on another project to enhance the team's communication with patients using health literacy principles.

Basic literacy and health literacy are fundamental in putting sound public health guidance into practice and helping providers and consumers follow those recommendations.

In this context, it is those procedures and protocols that are adopted on a national, state, and local level that can make it easier for providers and consumers to understand and apply information and services that are connected to their health.

Today, I'll talk about some key aspects of the California Department of Public Health guidance document for resuming dental care.

I'll not be able to discuss the guidelines in great details, but I will instead, I'll use a health literacy lens to view these guidelines.

COVID is adversely impacting oral health.

In 2018, California published its 10-year oral health plan, a key objective in our plan is to increase annual dental visits, it's aligned with one of the Healthy People 2020 Leading Health Indicators and this is to address profound oral health and disparities that exist today.

A strategy is to enhance dental teams communication staff at capacity, we are working with University of Berkeley School of Public Health's action team to develop a toolkit and training resources for using health literacy principles in dental offices.

This COVID pandemic will set us back in achieving oral health equity.

Most dental offices will not be able to function at full capacity.

School based programs will not be operational for a long time.

Many dental offices, especially those providing care to underserved populations will find it difficult to manage the economic burden.

In California, because it's such a big state, there is wide geographic variation in the prevalence of COVID-19.

The county orders vary.

And dental offices have to comply with these local orders.

Dental offices know how to comply with blood borne pathogen standards, there's a requirement that all licensees take continuing education courses on infection control every two years here in California.

But this virus requires transmission-based precautions in addition to standard precautions.

So there are new recommendations and standards that dental offices have to comply with.

Finally, it's important to partner with professional organizations to disseminate the guidance and provide resources.

So, California took aggressive action early on in March and issued the statewide stay-home order.

We did not envision that in March 2020 we would be communicating the message to providers and the public to postpone dental visits.

Initially, the message given was that dental settings are not equipped to provide routine dental care during this time of the pandemic because of the high risk of disease transmission, shortage of PPE, and too many unknowns about this virus.

Our goal then was to focus on managing dental emergencies and to prevent referrals to hospital emergency departments.

This curve had bent and flattened in California by May, so we issued the guidance to reopen, we wanted to send the message that dentistry can provide a safe environment for patients to seek dental care.

It requires the dental healthcare personnel comprehend the recommendations, standards, and regulations and implement them

The goal was to create a safe environment for providing dental care and protect dental healthcare personnel.

It required making several changes in the office protocol and procedures.

To bring back the patients dental offices should communicate to the patients about the steps they are taking to create the safe environment.

Here we are in July, the number of cases and hospitalizations have gone up in California.

We have a modified stay home order in place in many counties.

But dentistry being part of the essential healthcare, it's still open.

There are differences across the state in the prevalence of COVID as well as testing rates, containment capabilities, and hospital capacity.

There is variation in local orders depending on community conditions.

So in May, for example, San Francisco required testing of all dental patients undergoing aerosol generating procedures whereas other counties required screening for symptoms.

Now, San Francisco is strongly recommending testing but not requiring it.

In Los Angeles, aerosol-generating procedures are to be avoided to the extent possible.

So, I'm illustrating here the need for clear communication which is later in scheduling patient appointment, training staff to respond to inquiries and when treatment procedures are modified.

We recognize the importance of providing information in an actionable way.

When this information is coming from agencies, different agencies and sources in the form of recommendations, standards, regulations, it helps the provider with all these resources are and recommendations are in one place.

We try to pull together all the requirements and we try to avoid inconsistencies.

There are several new gadgets like extra oral suction, [Indiscernible] ultraviolet radiation, and dentists need to know what's the minimum certificate required to meet the standards, especially when the science is not clear.

We try to communicate this in our guidance by using the terms "must" and "should".

Generally, when dentists hear the word that this is a recommendation, the perception is that this is optional.

In this case, the CDC recommendations are in the Cal/OSHA standards, referenced in the state dental board regulations.

California employers are required to establish and implement an injury and illness prevention program to protect employees from workplace hazards, including infectious diseases.

Adopting changes to their IIPP is mandatory since COVID-19 is widespread in the community.

Employers must implement infection control measures, including applicable and relevant recommendations from the centers for Disease Control and Prevention and follow Cal OSHA standards.

The CDPH guidance emphasizes the dental offices pay particular attention to local orders and local conditions.

Dentists should access this information about local orders and COVID statistics on the regular basis, understand it, and take this community conditions in to considerations when they provide care.

For example, the time for procedures and the precautions depend on some extent to what the community conditions are.

Another consideration is the supplies.

Dentists must ensure they have adequate PPE supplies.

The recommendation is to have at least two-week supply.

Dental offices should also make facemasks and cloth coverings available to all patients and require their use while in the office.

In the NIOSH hierarchy of steps to minimize risk, the most effective step is screening to rule out COVID-19 status.

We recommended a symptom-based strategy, the person who is screening is usually a front-desk person in a dental office who needs to be trained properly to ask the right questions.

We recommended testing this strategy only for symptomatic patients who needed to be seen for emergency conditions.

There are many challenges and barriers for using a testing based strategy in a dental setting.

Visual signs for respect to hygiene, hand hygiene and etiquette are important.

Dental offices have to make some modifications including erecting barriers, especially when some practices are based on the open-day concept.

Safe physical distance should be maintained all the time and ensure there is good ventilation and the air movement, make sure it's from clean area to less clean.

This requires consultation with an HVAC professional.

And dental offices also should consider air filtration unit and the use of ultraviolet radiation.

Staff should be trained including job or past specific duties on preventing transmission, this includes appropriate use of PPE, respiratory production cleaning and disinfections.

Staff should be monitored on a daily basis for symptoms and contact.

Dental healthcare personnel are considered at very high risk because we deal with aerosols.

Even when we are providing preventive services, we use hand faces, water syringe, they are used to inherent to the air dissolve transmissible standard.

This is a new standard.

In addition, they have to enhance engineering controls, what controls and PPE use in addition to implementing cleaning protocols.

CDC has provided excellent guidance, very detailed regarding all these aspects.

And I would refer you to look at those guidance materials.

The risk associated with aerosols generated in the dental setting is based on old science, so we need more research in this area.

We don't know how well these gadgets used in dentistry work and we have some excellent equipment to capture aerosols in dental settings.

Next slide, please.

We recommended the dental offices prioritize care when this table or was implemented, many patients were in the middle of treatment but the goal here is to take care of these patients and take care of potential emergencies first.

We included preventive care as well because we believe these can be safely provided with minimal aerosol generating procedures and prevent future emergencies.

We have the guidance for providing preventive procedures using hand scaling, tube brush cleaning, fluid application, and CY.

So what did we learn?

This was a consensus document.

We didn't have the time to conduct surveys, focus groups, and key performed interviews.

So one thing we learned is that dentists look for clarity.

Mostly they'll tell me, what am I supposed to do?

We try to bring together all the guidance requirements in one place, the conditions are such that we have to give options.

Say for example the N95 respirators.

It's not available in all sizes in quantities.

The dental office is one, pre-pretesting is a challenge.

Surgical masks are not easy to find.

So we have some options and we have described that in the guidance document.

Engaging in the dental community in this process was very helpful in providing the clarity.

And the options, identifying required resources and tools.

So there are many challenges and barriers, for example if an accurate graphic point of care saliva test is available for all dental offices and it costs less than $10, say, then substantially reduces the risk of exposure.

But it's not available.

Patients require multiple appointments and therefore require testing multiple times.

These tests are not covered by dental benefit plans and most likely will not be covered by health plans.

Finally, our guidance documents are text heavy.

It would be easier for dental team members to comply with recommendations and understand them if incorporated in images and graphics in resources.

Thank you very much.

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>> DR. NICOLE HOLLAND: Thank you, Dr. Kumar for your very informative information.

I would now like to turn it over to our next presenter, Dr. Robinson.

>> DR. LINDSEY ROBINSON: Thank you very much.

Excuse me.

Thank you so much to Dr. Smith, our Chair, roundtable Chair and our wonderful roundtable staff for bringing this webinar in to fruition.

And it really was a pleasure working with Dr. Holland and Dr. Kumar on our collective presentations.

Before I begin, I just wanted to make a mention of the California Dental Association 150 new logo.

We are celebrating 150 years of existence, we began in 1870.

23 dentists in California came together to form the organization and now in 2020, we have 27,000 members.

Which is pretty incredible growth.

One out of every seven ADA members is actually a member of CDA.

So, here we are.

As we all know too well, this country is grappling with an unprecedented public health crisis which is up ended all segments of society and change the way people go about their daily lives and it has put tremendous strain on the healthcare system.

And as part of that system, it includes the delivery of oral healthcare.

And so the goal of my portion of this is to give you a peek in to the work that we did at CDA to translate all of that text-heavy and the complicated guidance and requirements coming from the regulatory bodies, translate it in to documents and resources in a manner that our rank and file dentists could understand and use easily.

So, before I dive in to that element, I just wanted to give folks an idea of what dental practice is like.

And many of you may understand that.

But dental practice is really, we practice outside the broader healthcare system.

We're generally small business owners and so are our group practice.

We're employers of staff.

And so we do not have a hospital system or a healthcare system to provide us with the guidance and the delivery of, and the PPE necessary to be able to deliver oral healthcare.

So it's upon us, it's upon the dentists and the employer to make sure that all the PPE is sufficient to cover services and that there's enough funding coming in to the office to make sure that we can pay all of our staff and cover all the expenses that we need.

We also are required to comply with all CDC infection control standards, Cal/OSHA standards, and California Dental Board requirement.

Next slide, please.

So, to both Dr. Kumar and Dr. Holland talked about the risk of dental practice, the provision of oral healthcare.

And that's because hygienists, assistants, and dentists practice very close to patients.

That close proximity is risky as well as the exposure to dental aerosols.

And we'll talk quite a bit more about dental aerosols in a moment.

But compared to other occupations, there is really -- we are the highest risk of all different, of any, of the workplaces.

So let's go to the next slide, please.

So I wanted to start by providing you some information on the ADA develop resources.

The ADA early on in the pandemic began by creating an ADA COVID-19 advisory task force and the folks who actually worked on this return to work interim guidance toolkit were, took health literacy training the previous summer.

So the ADA has invested quite a bit of resources and funding in to supporting efforts around health literacy and dentistry.

One of those is training their staff on health literacy best principles.

And so that guided them in developing this toolkit for dentists to reopen.

The other piece on the other side is the, it's brand new.

It came out just a few days and it's a communication tool for dentists to help their patients understand what it's going to look like going back to practice.

And going back to the dental office for care.

So about the same time, CDA created their own clinical care work group.

And I was part of that work group.

And the goal was to actually, to use the ADA documents as a foundation but knowing dentists wanted clarity and concise and clear information and how to understand, how to comply with all these new regulations, we want it to be very granular in what we presented.

We also felt it was important to have a public private partnership, we were very fortunate to have Dr. Kumar as a co-chair of this work group.

And he was our voice in, at the state public health department and at Cal/OSHA to make sure they were releasing guidance in a timely manner and specific to dental practice.

We needed our own guidance because we're unique because of the dental aerosol issues.

So we had multiple stakeholders who were part of this group.

They included the President of the California Dental Hygiene Association, the president of the dental association, we had a dental director for federally qualified health center there as well, she was, she's also part of CDA leadership.

And we wanted to identify the existing evidence-base as a foundation for all of our recommendations.

We divided in to three groups, PPE, aerosol management, and protocols work group.

The protocols work group was tasked with taking all of the information from what we were learning about aerosol management, all of the evidence.

You taking all the guidance from CDC and OSHA and turning that in to resources that were easily digestible and based upon health literacy best principles.

We also have been using end user testing to inform improvements.

Now, these documents are pretty new.

But we learned early on from phone calls and e-mails from members that they were having difficulty sifting through on the website all of the resources.

There were so, such a rich amount of resources.

We conducted some testing to understand how to best reorder the website and to make it easier to navigate and find specific resources.

And then finally, we wanted to identify the gaps in knowledge, Dr. Kumar mentioned in his presentation about there's, there just isn't a lot we know around quantifying the mitigation of aerosol transmission when we use a combination of different environmental controls.

And they're, all of these new kind of fancy somewhat expensive devices being, that are out on the market now that are meant to mitigate the aerosols and we don't know.

We just have no idea how well they work. And so early on, digging through the evidence base, it was pretty clear that we needed more research.

On those devices.

Okay, next slide, please.

So this, to give you some idea of the resources, we wanted them to be simple, clear, and easy to follow. So you'll see flow charts, you'll see check lists amongst the training and the resources that we provided.

This is, this is particular, a piece, a regulatory reporting requirement.

If a patient reports symptoms within two days after a dental visit or if an employee reports symptoms or exposure to a COVID-positive person.

So this flow chart was actually updated yesterday because updated guidance and requirements came out from OSHA and CDC related to this.

So we were constantly needing to update resources based upon the latest guidance and as we know more about virus transmission and how, and spread.

So, the also, you can see that we used health literacy basics here, in flow chart.

White background with pops of color.

And again, the goal for us was to take all of that text heavy complicated information, coming out from the regulatory agencies and convert it in to a way that makes sense.

For our members to use.

Let's go to the next slide.

So this is a very important piece here.

This is, came out from the aerosol management group.

And I was actually part of that group.

First of all, we need to understand that we need to think about this in terms of zones.

Zone one is intraoral.

Zone two is three feet surrounding the oral cavity, zone three is the operatory and zone for is the general office setting.

So we put together just a huge amount of resources around looking at the evidence, understanding what kind of environmental controls are needed in each zone, and putting that in a larger document that is, accompanies this particular diagram.

So this, you can find on the website and also the document that demonstrates all the different mitigation efforts for each zone.

It also highlights the evidence, we put together a list of resources that came from the literature that you can search and look at.

And we also offer some information on untested but interesting types of infection control items like UVC lights, hypochlorous acid as a fogger, as a disinfectant, not approved by FDA, but they're important for research.

So, I wanted to share this with you.

This is an a chart that is helping dentists and PPE, based upon the degree they're exposed to aerosols.

I have the example of the bottom row, the highest risk.

Using a hand piece with water spray, using a scaler for hygiene.

It's another example.

And their PPE required is a fit-tested N95 mask with a caveat and this is CDC guidance here when N95s are in short supply which has been the case, that level three mask with a face shield over is okay to use.

Also, a face shield just in general, gloves, of course, a gown.

Head, and shoe covers as well.

So, when N95 masks are in short supply, this is a photograph of my office.

There were a few of us who got together from the COVID-19 work group and put together a little subgroup on masks, looking to masks.

And one of the alternatives to N95, respirators are reusable as elastomerics, I wanted them for my office, because I couldn't find enough N95, I bought them from a

medical working supply company, they were readily available and they're pretty easily fit-tested.

They're reusable, they're disinfectable.

They're a lot of pluses.

They're just kind of bulky.

And they have exhalation valve in the front, you have to not contaminate the patient.

The patient's exhalations.

That's what we did.

We're also looking at power aired purifying respirators as an alternative.

If you can imagine, a hygienist in a tight-fitting mask for eight hours constantly, that would get pretty difficult to breathe through, very warm.

And so PAPRs are a viable alternative.

And CDA, a few of us at CDA working with the Michigan health association to test out a new PAPR device modified for dentistry, because we have loops to scan a light and they have to be able to fit over all of the loop material and our exhalation needs to be behind us, not in front of us.

And don't require testing, fit over, and they're reusable as well.

So next slide, please.

Okay.

So this document is a high level flow chart on screening and triage of patients.

Based upon COVID-19 risk.

And it's very easy to follow, again, it's a nice flow chart.

And it provides treatment options based upon the symptoms that patient brings in.

So if, there might be a case where if somebody is COVID symptomatic, you just work with a medical provider and just provide emergency care only.

Non urgent care can be delayed.

Sometimes it just, using minimally invasive care without using any kind of aerosol generating procedure is possible, you use of silver diamine fluoride, glass anomers, minimal transmission, along with those, no transmission with those.

So next slide, please.

This is the continuation of that document.

And I also wanted to give you the website statistics for these resources.

We launched on May 18 and through July 5th, we had a total of number of page views of just over 174,000.

We had unique users over 16,000 unique users.

So remember these resources are in front of the membership firewall and they're accessible to everybody.

So I think that's why we're having so many people log on and download this material, most of them are actually outside of California.

The top five resources were back to practice staff training and I'll show you that in just a minute.

The N95 respirator, mask information, patient screening form, respiratory protection program, and the employee screening form.

So we have a really wonderful package of, back to practice staff training.

And if you Google CDA back to practice, you'll see that, you'll see the page and there are five buckets, five categories of resources.

And so that makes it easier to search for specific types of resources that you're looking for, whether it be PPE or patient protocols, patient care.

Billing, that kind of thing.

And below that is the back-to-practice portal and if you go on there, you'll click on that, you'll get all the information and all the packages for training of staff you can also get CE using that material.

And again, it's entirely free to the oral health community.

There's no fee for that as well.

And it's a good day's worth of staff training and it gets granular.

As to how the work flow should be, the administrative controls that you need, the environmental controls that you need, screening of patients before they come to the office.

The questions that need to be asked, taking temperatures, making sure the staff is screened every single day.

All of the forms and documents are needed for doing all of that are included in the package material.

So next slide, please.

So, I understand that the public health literacy and the issue of oral health equity, there are two slides related to those.

But we could spend a whole webinar on the impact of this pandemic, on oral health equity and how it's really set us back quite a bit as Dr. Kumar was saying.

So public health literacy, which has been discussed a few times at the roundtable at our workshops, we've had Dr. Shillinger from CSF present on that, where he described the concept of public health literacy as multidimensional in nature.

Engaging many stakeholders like the public, lawmakers, policymakers, and not just clinicians and patients.

To address issues of public health, prevention, and upstream determinance of health to reduce disease and alleviate suffering.

And certainly in our case, public health leaders is needed to create a safe dental environment which is critical for patients seeking health services and providers who are presenting the care.

So as dentists, we need to make sure our staff is safe, our patients are safe in the provision of care for them.

So case in point: Is trying to get our public health officials to understand that we need the proper PPE.

There were not sufficient N95 masks on the market.

You couldn't buy them.

And fortunately for us, well, initially the State Department of Public Health in California agreed to give us 1 million N95 masks from the stockpile and so CDA paid to have them transported from the stockpile to a holding facility to distribute out to dentists in California.

The day after we took possession of them they, the state asked us to give them back.

And they showed up with their trucks to take them back.

And so we were back to square one.

Basically.

And so that's, it's been difficult.

We've had to, we've had to advocate for dentistry and for oral health providers to make sure they have proper PPE and that they, and that public health folks understand that we are part, part of the healthcare system.

We are, we need all -- our risk is higher than anybody else outside the hospital setting.

So we deserve and we need those types of supplies.

So, let's go ahead to the next slide.

Oral health equity in the era of COVID-19 and I don't know, Dr. Kumar mentioned this.

The impact on both dental clinics and dental offices who treat Medicaid patients has been very difficult.

Many of them are still closed.

Some of you may have seen that "Wall Street Journal" article that came out a few days ago that nearly 2,000 dental clinics that serve minorities and people of color are closed and not, temporarily closed, who knows when they'll be able to reopen.

And that primarily impacts people who are underserved and have been underserved in the past.

This is one giant step back from where we were before.

Certainly the effects on budgets, California's actually.

We've had to advocate to the governor that they maintained the dental and Medicaid benefits for adults.

And their reimbursement levels that came from prop 56 funds, tobacco tax funds.

Initially those were not in the governance budget and we were fortunate enough to have enough advocacy, power behind us to get those back in to the budget.

Also, the governor's new revised budget illuminated expansion of benefits for undocumented adults.

So no Medicaid, dental care for adults, and for undocumented and that, they're really a backbone of the economic engine of California.

So that's really unfortunate.

And then finally, compliance difficult with airborne transmission standards relative to the high disease burden of many Medicaid patients because they've had such problems with access in the past, they come to the dental office needing a lot of care that requires a lot of peridontal care, regenerative care, that generates a lot of aerosol, that's concerning.

Especially in a world where we don't have sufficient PPE to go around for everybody.

I just wanted to mention also the work that CDA that's done over the last decade around improving the oral health, not just for people who can afford to pay it, but for everybody in California.

And that really began with the creation of the access plan that came out about eight years ago.

And that plan guided CDA's efforts, advocacy efforts towards establishing a state office of oral health in California within the public health department.

Prior to that we really had none.

We had no doctor Kumar.

We had no epidemiologists.

We had very little advocacy at all inside the state department of oral health.

And so that access plan guided us, guided our efforts to make that happen.

And ultimately, it led to us being able to afford to hire or the state to be able to afford to hire Dr. Kumar and epidemiologists, programming officer to provide them with all that we need to make sure that we have a strong voice in state public health for the benefit of all Californians.

So the next slide, please.

With that, thank you.

I just wanted to mention that I am, have the opportunity to guess at another CDA journal, coming out next month.

There may be some of you who are viewing this who actually contributed as authors and I thank you very much for your effort and volunteering to do that.

I'm very excited about this coming out and so please look for it online in the next few weeks.

With that, I will say thank you very much for this opportunity.

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>> DR. NICOLE HOLLAND: Thank you, Dr. Robinson for an outstanding presentation, lots of resources that many are asking about in the Q and A.

So I just wanted to remind everyone that all of the CDA materials are open to the public, so certainly you can access all of those.

And then also, for those asking for the slides and the recording, it will be posted latest tomorrow.

The roundtable website on the national academies.org for the roundtable.

The slides should actually already be there.

If I'm correct, Alexis.

So both of them should already be there for you.

So everything will be made public, the CDA resources as well as the recording.

So, to get on to questions, there have been a lot that have come in, both before, during registration as well as currently through the presentations.

I'm going to start off the first question which addresses many of the questions that came through before.

Which is, and I will direct this to both Dr. Robinson and Dr. Kumar.

How are you systemically addressing health inequities in your work and what is the role of health literacy in this?

Dr. Robinson, you did address this at the end, so we'll go ahead and start with Dr. Kumar and of course, if you'd like to respond as well, feel free, please.

>> DR. JAYANTH KUMAR: Thank you for that excellent question.

From public health agency's perspective, we always look at assessment of the key functions.

So in this case, you know, identifying oral health disparities and the causes of it, identifying social inequities and access to the resources and opportunities, those are some of the things that we do routinely.

And also, to communicate the findings of these assessments in a simple, easy to understand way.

When using this assessment, we create policies and programs and then evaluation is also very key because we want to identify best practices promising practices and build evidence-based as well as we want to track progress with respect to some of these indicators.

And finally, planning the next steps using the information and communicating the findings to stakeholders and partners to reassess these strategies whether they're working or not and planning next steps.

Those are some of the approaches that we are using to address health inequities.

>> DR. LINDSEY ROBINSON: And I would just add that all of that requires funding.

Money!

And CDA has been really instrumental in making sure there's sufficient funding for activities like that.

And just as an example, there was a ballot measure a few years ago to increase the tobacco tax California, that was prop 56.

And that was a collaborative effort with many, many of California's dentists in order to get it on the ballot in the first place.

And that funding has allowed increased, an increase in reimbursement rates for not only dentists but for physicians as well in the Medicaid program.

And also to fund some health literacy activities for the state department of oral health.

>> DR. JAYANTH KUMAR: Yeah, I can expand, to answer the second part of the question, the role of health and literacy.

So on that side, we are working to address this.

We continue health literacy as an approach to address health inequities and we are addressing barriers in dental care settings is key.

It's important so we are developing a toolkit through, and training resources to achieve that.

But another part of it is extending this, the community settings.

I'll give an example.

In California we think by, we have a requirement kindergarten oral health assessment requirements so that, what that means is we'll be able to deliver healthy children to schools so they don't miss school days because of developing.

So we're encouraging all the grantees to focus on especially target the efforts to lower income schools.

And schools where there's lots of professional minority populations where there are lots of barriers, to make sure that all kindergarten children are assessed.

But it takes a lot of effort, help to see the related efforts because we have to communicate this to the school boards and get their approval, we have to communicate this to parents.

So, and we have to train champions in order to accomplish all these things.

So in all these efforts we're trying to incorporate health literacy principles.

Thank you.

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>> DR. NICOLE HOLLAND: Thank you.

Dr. Kumar, and Dr. Robinson.

If I can just follow up, there were a lot of questions that came in also through the registration page about school-based oral health programs.

So what do you see, Dr. Kumar, as the future of school-based oral health programs?

>> DR. JAYANTH KUMAR: We have some real challenges when it comes to, you know, we don't know.

There are a lot of uncertainties whether schools will open this way.

And when they reopen, convincing them to, you know, allow us to provide clinical services in schools is going to be a huge challenge.

And so, towards that effort, we are actually creating a protocol of how clinical preventive services can be providing, provided in schools without generating aerosols.

So, and we're also looking at what are some of the alternative ways.

For example, school linked the program may be in an approach that we can use in the future.

Where we can screen children, identify them because most of the schools are used to vision and hearing screenings, so this would be very similar to that and schools probably would be more minimal to allow dental professionals to do the referrals.

And an important piece of that is linking them to the source of care, tracking it to making sure that children see the needed services and establishing a dental forum for them.

That is the model that can be explored.

>> DR. LINDSEY ROBINSON: And if I could add to that last point you made, Dr. Kumar, about, you know, we have a, we have a a program that started in California, called the virtual Dental Home program from UOP and we've been pretty successful in linking hygienists out in the community and community settings such as day care facilities, Head Start facilities, linking them, collecting the data and sending all of that information to a dentist and having the dentist look at all the information and also the judgment of the hygienists onsite and providing some palliative care.

There's opportunity here to promote minimally invasive procedures like the application of silver diamine fluoride and anomers and I use that tool so much and they become such an important part of what I do, I just really think there's an, you know, you've got to look for all the little opportunities in the midst of this pandemic.

I think this might be one of them is to promote those types of efforts for kids.

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>> DR. NICOLE HOLLAND: We're going to switch gears and potentially, there's a lot of concern about reentering the dental setting from the public.

And several questions have come in.

So what would you say are the top one to three messages to convey to patients about getting dental care for themselves or family members in light of COVID-19?

How would you encourage providers to engage in this discussion?

>> DR. LINDSEY ROBINSON: Well, if I may just offer again the resources both the ADA just came out with that communication tool that's customizable, now it's brand new so there's been no end-user testing or out in the field.

But there is something there and it's got really nice info graphics and it provides patients with the information about what they will, what they should expect that the dentists should be doing and also CDA also has quite a bit of information.

They have some media, like, little resources that you can use that the dentists can use out in the community to broadcast out to the media.

And also, their own social media.

But it's, I think it's very important that dentists communicate effectively what it's gonna look like.

What it, and what they're doing in order to comply with all the requirements to make sure that patients are safe and their staff is safe.

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>> DR. NICOLE HOLLAND: Great.

Thank you.

Dr. Kumar, I have, we're almost out of time for questions but this one is also has come through, regarding provider literacy.

There have been a lot of different recommendations that have come out.

Essentially, who is the authority on this information?

Is it better to follow federal guidelines, better to follow state guidelines, how would you answer that question?

>> DR. JAYANTH KUMAR: So, I tried to answer that in one of my slides.

We have to comply with all those recommendations.

Because, you know, CDC, OSHA, state guidelines and local health department ordinances.

So they're all important and what we try to do is bring all of them together in one place.

So that's the best way I can answer that question.

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>> DR. NICOLE HOLLAND: Okay.

Thank you.

And my last question for Dr. Robinson, what are the plans to integrate the updates to science in the pandemic age of the communication processes and materials moving forward?

And has language access have these been thought to translate in to various languages?

>> DR. LINDSEY ROBINSON: So I did check back with CDA staffing and we have to recognize that these are brand-spanking new for the most part.

They're only in English now.

But we can certainly, especially Spanish would be the next language, I believe, totally makes sense.

Especially around patient communication because so many residents in California don't speak English, they speak other languages and primarily Spanish.

But I think that, especially around patient communication tools that it's, would be an important next step to do that.

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>> DR. NICOLE HOLLAND: Great.

Thank you.

And thank you both, again.

Very much Dr. Kumar, Dr. Robinson for your wisdom and expertise as it relates to where we are as a dental field.

And hopefully all those in healthcare can gleam lessons from what we learned today.

I do want to briefly summarize one of the main points I heard, communication obviously we need to think about tailoring the communication to who it is in our audience that we're talking to, whether it be patients, providers, the public health space, the regulatory bodies, a lot of this changing science we're really gonna have to be amenable in how we deal with this.

And then also the need for research.

There's a lot of need out there.

We briefly discussed funding, certainly hopefully we can put some pressure on some funding bodies to have the research come from this.

So thank you both.

I will now turn it back to Dr. Smith so we can go ahead and conclude this session.

And thank you to the audience members for tuning in as well.

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>> DR. LAWRENCE SMITH: Thank you again, to our speakers, moderator, and the audience for a wonderful discussion.

Thanks also to the National Academy staff for facilitating this webinar.

As a reminder, this webinar has been recorded and will be posted on the roundtable web page with slides within a week or so.

Please sign up for the roundtable listserv for updates about future webinars and workshops.

Take care, everyone.

And thank you.

[End of webinar]