Northern Virginia Oral Health Forum

Presented by the Virginia Oral Health Coalition

With generous support from the Northern Virginia Health Foundation and Potomac Health Foundation

Thursday, January 26, 2017 | 9:30 a.m. – 2:00 p.m.

Sheraton Tysons Hotel | 8661 Leesburg Pike, Tysons, VA 22182

Meeting Facilitator: Kathy Greenier, Floricane, LLC

Proceedings

Meeting facilitator Kathy Greenier led introductions at tables.

Welcome

Susie Lee, Executive Director, Potomac Health Foundation & Pat Mathews, President & CEO at the Northern Virginia Health Foundation

Overview of the 2016 Virginia Oral Health Report Card

Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

- Click to download a copy of Sarah's presentation slides.

Data Walk Activity

- Kathy invited participants to break into groups of three and provided instructions for the Data Walk activity.
- Half of the groups viewed posters representing adult oral health data, and half of the groups reviewed posters representing children oral health data, then switched.
- Each group appointed a scribe to record their responses to a set of question prompts about the data as they viewed the posters.
- Click to download a handout of the charts that participants reviewed during the data walk.
- Click to download a detailed compilation of the participants' responses.
- Summary of participants' responses:
    - Overall
        - More granular regional and local data is needed, especially on barriers to care such as transportation, time, employment, language, immigration status, etc.
        - Demographics such as race/ethnicity, SES, gender, age, etc. should be consistently reported
        - Need to know all data characteristics – e.g., indicator description, time frame, sample size, sample weights, statistical power, and significance of within-/between-group differences

        - Inferences about causal relationships cannot be made based on the charts presented; they only show descriptive statistics, leaving a lot of possible interpretations. More complex analyses may be needed.
        - Helpful to know how the region compares to other regions, the state, and the nation
        - Several populations were missing or underrepresented; e.g., some racial/ethnic groups, individuals with special health care needs, etc.
    - Adult Oral Health Indicators
        - Many were surprised by specific data points, such as
            - the high number of older adults (65+) who had a dental visit (seemed to be contrary to the low % of adults who are actually covered)
            - the apparent correlation between low income and greater effects of dental pain
            - the limited race/ethnicity data for the adult indicators generally
        - Most agreed that the data gave only a cursory snapshot of the health inequities in Northern Virginia
            - Data specific to cultural perspectives of dental care was lacking
    - Children Oral Health Indicators
        - Again, many were surprised by specific data points, such as
            - low preventive service utilization among eligible children of all races/ethnicities and ages
            - differences by age among 3rd grade children in decay and sealant rates
            - the apparent disparities in 3rd grade sealant rates and prevalence of tooth decay when broken out by race/ethnicity, SES, and coverage status
        - Most agreed that the data gave only a cursory snapshot of the health inequities in Northern Virginia
            - Even children with Medicaid coverage have low utilization
            - Data specific to cultural perspectives of dental care was lacking
        - Many were curious about the timing of interventions and their effects on outcomes shown in the data, especially sealants and decay rates

Data Walk Debrief

Following the data walk, participants had a large group debrief, facilitated by Kathy Greenier.

"L" refers to Lauren Gray, VaOHC Program & Engagement Manager, and "A" refers to an attendee:

- Is there a way to work with the data to determine if the differences are statistically significant? I.e. are the differences meaningful?
    - L: Most of the survey data comes from VDH, and yes, it is possible to examine significant differences between groups and overall – but, when aggregated regionally, the samples for this data may be too small to test the statistical significance. If there are questions, please write them down and send them to the Coalition. Part of the reason we're here today is to figure out the questions and gaps to lift those up to state partners. With the Medicaid utilization data, we do not have the capacity to analyze statistical significance.
- Can you determine whether the outcomes are mediated/moderated by race vs. SES?
    - L: Challenge with national- or state-level surveys is that they're aggregated best and most precisely at the state level rather than regionally (limited for a representative sample within the region). It's still good to have the information, but going forward as we're working in the oral health and social determinants/health equity, we need to be defining the groups more clearly to determine if the differences we see really are along racial/ethnic lines or SES lines.
- Attendee: Additional demographic data would inform the strategies; e.g. If Spanish isn't first language, would have Spanish language materials
- With all of the charts, need more context – where does oral health fit in the state's strategic plan and as a priority?
    - Sarah: We have a state oral health plan, and the Coalition convenes population-focused, state-level workgroups. We also work to align the plan with other agency plans where they overlap. However, we don't know about all of the regional plans that exist, strategies, etc. - we don't know how they marry and it's a great strategic point to talk about today.
    - A: Alexandria strategic plan lists local health concerns – equally as important for the city where the state puts the health issues.
- Charts in jurisdiction didn't include Loudoun.
    - L: Particularly the adult data from BRFSS – it's from health planning region
- White/Hispanic isn't included
    - L: There wasn't a large enough sample size to be able to break it by every race; ones listed are the only ones large enough. Some of the data is weighted to reflect the size of the population. Show the demographic breakdown for the region in the future. Depends on the survey, but moving forward we will show what is weighted (like BRFSS).
- Who performs 3rd grade screening?
    - L: VDH has public health dental hygienists who perform open mouth surveys and clinical services all over the state. Is a representative sample.
- Why is there a difference in age in the 3rd grade?

    - L: Different reasons for age differences for each region. Children from other countries may be older. Statewide, % of 10 year olds is very small in terms of sample size.
- Is data 3rd graders who have gotten sealants in kindergarten or for the first time in 3rd grade? Can we tell when the intervention is happening?
    - L: We can look and see if they have notes about the timing of sealants.
    - Browder (VDH): Follows guidance from the CDC – statewide survey of schools, weighted, prevalence only – when and where they were done isn't gathered. Has to do with the likelihood that they'd have 6 year molars and practical matter of conducting the survey.
- Can someone from schools tell us when sealants are offered?
    - Most commonly kindergarten and first grade (5 or 6).
    - Browder (VDH): VDH is the bigger of all school programs, but more programs around the state. VDH sees kids for an assessment, can do fluoride varnish for younger children. If kids have molars in kindergarten, they would seal it. 10 hygienists in dental HPSAs categories, then schools are identified by free lunch participation, then principals give permission, then parents give permission.

Population Group Discussions

Raja'a Satouri (Fairfax County Health Department) introduced the afternoon activity, and Kathy gave the instructions. Meeting attendees assigned themselves to different groups by population category: adults, children, individuals with special health care needs, and older adults. Each group responded to a set of two question prompts. The responses are summarized below for each population group.

<u>Prompt 1</u>

Taking into account the regional snapshot you saw, the context of your work and experience, relevant health indicators, and the unique needs of your population:

1. **Identify one priority issue that, when addressed, will improve the system of health care and create enduring change for your population. E.g., "Increasing the sealant rate among Northern Virginia's Hispanic third grade children."**

2. **Frame that issue as an outcome statement; e.g., "By 2022, the sealant rate among Northern Virginia's Hispanic third grade children will improve by 5%."**

Adult group	By 2020 % of pregnant women receiving dental services increases by 5%.
Children group 1	Identified a few priorities: • Oral health education of children and parents • Every child should have a dental home and identified provider

	• School systems monitoring students' dental visits
Children group 2	1. PCPs are not checking dental screening on MCH 213 (VA School Entrance Health Form) – in Alexandria Public Schools (ACPS) <50% checked; educating health care professionals about importance of dental health. 2. By 2020 there will be a 20-30% increase in documentation of dental screening on kindergarten entrance physicals (MCH 213s), bringing attention to health care professionals, awareness, handouts.
Children group 3	1. To increase the number of children who have identified dental home by age 1. 2. By 2022, the number of 1-year old children who have an identified dental home will improve by 25%.
Individuals with special health care needs (ISHCN)	1. Barriers: • Transportation • Payment procedure • Accessibility • Dental providers limited education about ISHCN and bias • Lack of monetary resources • Inter-professional care coordination • Education for the population/advocates • Advocates may be too few and may not have broad enough expertise in what are the varying needs for ISHCN to collaborate • ISHCN may be afraid to identify themselves – need to feel empowered, dignified 2. By 2020, an inter-health professional curriculum on ISHCN will be established and taught at the college level (or professional school).
Older adults	1. Expand oral health data collection on older adults, especially those residing in long-term care (LTC) facilities. It must be noted that, even with the "aging in place" strategy, LTC and nursing home population is not declining; some can't live at home. There are likely major disparities by race/ethnicity, SES, etc. 2. By 2022, increase the rate of LTC residents accessing dental care by X% (need baseline data).

Prompt 2

Building on the priority you have been discussing, answer the following questions together:

3. **What is already happening in Northern Virginia to address this?**

4. **What is missing? If nothing is currently happening in this region, what examples elsewhere might inform our work?**

5. **Identify 1 or 2 high-level strategies that address the barriers surrounding the priority you identified. These strategies can build on existing efforts identified in question 3, or they can fill gaps addressed in question 4. E.g., "Change school district policy to facilitate expansion of sealant programs."**

Adult group	3. Case workers, home visitors, pharmacy, and health care navigators. 4. Several gaps: • Oral health integration – involvement and education of primary care and OB/GYN providers • Awareness about the relationship between oral health and overall health (oral health literacy), and the existence of the Medicaid dental benefit for pregnant women (and what it covers) • Navigation systems to access care (transportation, understanding social determinants, and access) • Coordinated charity care 5. Three strategies: • Strategy 1 – Provider education: o Address abandonment and legality (no waiver) o OBGYN education • Strategy 2 – Navigation: o DSS – include an oral health component in training o Use patient navigators – Community Dental Health Coordinator (CDHC) model promoted by American Dental Association. o Social workers/home visitors • Strategy 3 – Consumer education o Messaging and different tactics
Children group 1	Oral health education of children and parents • Dietary components – sugar intake • When to brush • 6 months old begin dental care Every child should have a dental home and identified provider • Dental professionals visit schools – what info do they share? • Could OB/GYNs play a role in increasing parents' awareness of the need for preventive dental care and healthy eating habits to prevent cavities? School systems monitoring students' dental care • Could require children to brush their teeth after lunch at school – maybe a targeted intervention for Head Start students • School health forms offer an opportunity to gather data about kids' connection to dentists
Children group 2	3. ACPS, Neighborhood Health mobile van

	4. Nothing is currently being done to educate health care providers (like pediatricians, etc.) to do dental screenings and refer as needed. 5. Eight main strategies: • Education of all health care providers • Ask National Association of School Nurses (NASN) to add oral health to chronic health conditions to collect data • Can MCH 213 be reviewed to include dental screenings? • Recommended training website- VDH could send out • WIC screening in • Food banks – toothbrush • Backpacks stuffed with toothbrushes, toothpaste, resources • Social media
Children group 3	3. Bright Smiles, Smiles for Children, family services, early childhood programs (Early Head Start & Head Start), pediatric dental offices taking Medicaid 4. Partnerships between PCPs and pediatric dentists, culturally relevant dental education, safety net programs – missing comp. list 5. Education: • Health care provider education – OB/GYN offices, PCPs, etc. • Education targeting patients at these offices
ISHCNs	3. What's happening: • There are professionals currently working with ISHCN that have expertise • Tufts is working on a special curriculum re: kids with ISHCN • Our response to those with ISHCN is currently reactive 4. What's not happening: • Various groups not working together • Lack of clarity around who makes existing curricula • Our response to ISHCNs is not proactive 5. A curriculum is not a plan, it's part of a plan. With that said, the top 2 strategies to implement this curriculum would be: • Make compassion a value in our society • Need a list of other curricular that's out there now
Older adults	3. Arlington data, treatment plans, some major issues known 4. Need to determine barriers, emergent needs, utilization, edentulism rates 5. Three main strategies: • Identify greater needs through qualitative data, include data broken out by race • Improve partnerships with community organizations • Utilize remote dental hygiene or other remote care models

Closing Remarks

Sarah (VaOHC) thanked attendees and reminded everyone that meeting materials (including handouts and powerpoints) will be shared after the meeting.

Sarah encouraged attendees to fill out a partnership form to get involved with the Northern Virginia Oral Health Steering Committee, and/or one of VaOHC's state-level workgroups.

Next Meeting – Northern Virginia Oral Health Steering Committee

Thursday, April 6, 12:30 pm – 2:30 pm
Northern Virginia Family Service
10455 White Granite Drive
Suite 100 – Oakton Training Room
Oakton, VA 22124