COMMONWEALTH OF MASSACHUSETTS

SPECIAL COMMISSION ON ORAL HEALTH MEETING

INTEGRATION SUBCOMMITTEE

Monday, January 6, 2025

Via Microsoft Teams

11:30 PM

General (Open Session) Meeting Minutes

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| Commission Members  Present: 9   1. Chair: Mary Foley​ 2. Jane Barrow​ 3. Helene Bednarsh​ 4. Katie Jahreis​ 5. Robert Lewando​ 6. Anthony Silva​ 7. Diana Vascones 8. Athanasios Zavras at 11:48 PM 9. Brian Swann at 12:05 PM |
| Commission Members  Not Present: 3   1. Anna Lubitz​ 2. Hugh Silk​ 3. Amina Khan​ |
|  |
| Staff Present:   1. Matthew Horan |

**I. Welcome**

**II. Call to Order | Determination of Quorum**

Time and call to order (11:36 AM by Mary Foley)

#Present: 7

1. Chair: Mary Foley​
2. Jane Barrow​
3. Helene Bednarsh​
4. Katie Jahreis​
5. Robert Lewando​
6. Anthony Silva​
7. Diana Vascones

# Absent: 5

1. Anna Lubitz​
2. Hugh Silk​
3. Amina Khan​
4. Athanasios Zavras
5. Brian Swann

# Recused: 0

# Abstained:0

**III. Approval of Agenda**

DISCUSSION

Review posted agenda, no changes

ACTION

Motion by Mary Foley to approve the agenda, seconded by Helene Bednarsh​, and unanimously approved by a roll call vote as follows:

#Approve: 7

1. Chair: Mary Foley​
2. Jane Barrow​
3. Helene Bednarsh​
4. Katie Jahreis​
5. Robert Lewando​
6. Anthony Silva​
7. Diana Vascones

# Absent: 5

1. Anna Lubitz​
2. Hugh Silk​
3. Amina Khan​
4. Athanasios Zavras
5. Brian Swann

#Recused: 0

#Abstained: 0

Document: Mary Foley shared “Integration Meeting AGENDA SLIDES 1.6.25”

Members who join late:

* Athanasios Zavras at 11:48 PM
* Brian Swann at 12:05 PM

**IV**. **Work on the Plan for Developing an Oral Health Needs Assessment**

DISCUSSION

* Slides shared by Mary Foley to help guide the conversation
* Group member introductions including their unique skills and passions for integration
* The concept of integration of oral health is broadly discussed:
  + Early work is limited to dentists taking blood pressure
  + Pediatricians using Fluoride varnish
  + Change efforts funded by federal partners focusing on clinical activities
  + A need for systems and infrastructure changes to support the providers making the changes in the field
    - A need for clinical incentives to drive change
  + The challenge of medical and dental systems not communicating
    - Software level, coding systems, outcomes, diagnostic codes
  + ICD (International Classification of Diseases) code use or a subset of codes suggested for use by dental providers
  + Clinical and non-clinical teams across the lifespan and workforce highlighted
  + Oral health plays a role in everything – what should we start with?
  + Working toward a dental benefit in Medicare – demonstrating a financial and health benefit through integration activities, coalition work, and data sets
  + Demonstration projects are crucial to success at the patient care level
  + Root causes include isolated dental training, need for more collaboration, dental is undervalued and often the first thing cut when facing financial challenges
* Integration sub-topics suggested by OOH (Office of Oral Health) discussed by the group
  + Integration of oral health across healthcare
  + Primary care partnerships
  + Emergency room diversion programs
  + In-patient oral care
  + Antibiotic stewardship
  + Behavioral health collaborations
  + Chronic disease collaborations
  + Point of care testing
  + Tobacco/nicotine cessation
  + Nutrition and pregnancy
  + Long-term care
* Other potential topics that may be missing in integration reviewed:
  + Infection control and exposure management in the sense of the health of the workforce was reviewed – a healthy workforce issue
  + Integration of non-clinical teams involved in care – social work, etc.
  + Common risk factor management – dental diseases have shared risk factors with diabetes, cardiovascular diseases, etc. with medical
* Most of the work has been focused on the provider level thus far
  + For improved health outcomes, there’s a need to shift toward integration at the health plan level, and state agencies
    - Dental wasn’t incorporated into the original ACO (Accountable Care Organization) model of care in MA
    - Dental remained a stand-alone payment system
    - Multiple state agencies with shared populations often work separately
      * Medicaid is now being directed to integrate community-based services within DPH
      * The need for state agencies and programs to become more integrated officially on an activity level
      * Population-level programs also need to be more formally linked and integrate (everyone who works with Medicaid DDS members for example)
      * The role of BORID (Board of Registration in Dentistry) was highlighted and other boards of licensure
  + Outside of public programs, the need to consider private programs (commercial plans) is highlighted
    - The concept of driving change via the profession or via the government
* A reconciliation and expansion of integration sub-topics included:
  + Public and private entities, finances
  + Improved branding of dentistry
  + Common risk factors (chronic disease)
  + Common resources
  + Integrated stakeholders, ACO
  + Programs to incentivize behaviors – providers, plans, infrastructure, education
  + Expanded infrastructure
* Where do we want to be at the end of the work? How do we get there?
* Group assigned to review the updated subtopics list and think about the data table related to each before the next meeting

**V. Adjourn**

DISCUSSION

None.

ACTION

Motion by Helene Bednarsh to adjourn the meeting, seconded by Athanasios Zavras, and unanimously approved by roll call vote as follows:

#Approve: 9

1. Chair: Mary Foley​
2. Jane Barrow​
3. Helene Bednarsh​
4. Katie Jahreis​
5. Robert Lewando​
6. Anthony Silva​
7. Diana Vascones
8. Athanasios Zavras
9. Brian Swann

# Absent: 3

1. Anna Lubitz​
2. Hugh Silk​
3. Amina Khan​

# Recused: 0

# Abstained: 0

*Let the record show the meeting adjourned at 1 PM.*