



COVID-19 IN TEXAS

An Opportunity to
Improve the Oral Health
System in Texas

October 13, 2020
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Why is good oral health important during COVID-19 response and recovery?

In 2000, the Surgeon General's Report on Oral Health made clear that oral health is part of overall health and well-being. In addition to dental caries being the most common chronic disease in our children, our oral cavity serves as the entry point to our digestive and respiratory tracts. Studies suggest that oral bacteria and the inflammation associated with a severe form of gum disease known as periodontitis play a role in various other diseases and conditions, including endocarditis, cardiovascular disease, diabetes premature birth and pneumonia. All of these conditions are most common comorbidities in populations experiencing higher prevalence and mortality rates due to COVID-19.

Background

In April 2020, approximately a month into our fight against COVID-19, unemployment claims data revealed that dental offices were among the highest groups affected in Texas, as well as the country. As the state reopens, our oral health system has shown courage, bouncing back to address the growing burden of oral health needs. A weekly survey administered by the American Dental Association's Health Policy Institute revealed that 59% of the state's dentists are still experiencing a lower volume of patients than pre-COVID levels compared to 52% nationally.¹ These reduced patient volumes directly impact the financial health of dental care settings and could lead to potential permanent practice closures. While early, this may be an indication of the long-term negative impact the pandemic may have on our state's oral health infrastructure and capacity.

Furthermore, decades of scientific research and studies have documented the direct impact of poor oral health on overall health, particularly chronic diseases such as diabetes and cardiovascular diseases.² This is an important factor in our ongoing response to the pandemic as the aforementioned chronic conditions have emerged as most common co-morbidities in groups experiencing high mortality rates during this pandemic. Bacteria present in patients with severe COVID-19 are associated with the oral cavity, and improved oral hygiene may reduce the risk of complications. Although COVID-19 has a viral origin, it is suspected that in severe forms of the infection, bacteria plays a part, increasing the chance of complications such as pneumonia, acute respiratory distress syndrome, sepsis, septic shock and death.³

These aforementioned factors coupled with inequitable challenges faced by communities of color and at-risk communities necessitate a unifying call-to-action to identify and address the systemic barriers that make our oral health system vulnerable and address the continued neglect of oral health as a vital component of overall health and well-being.

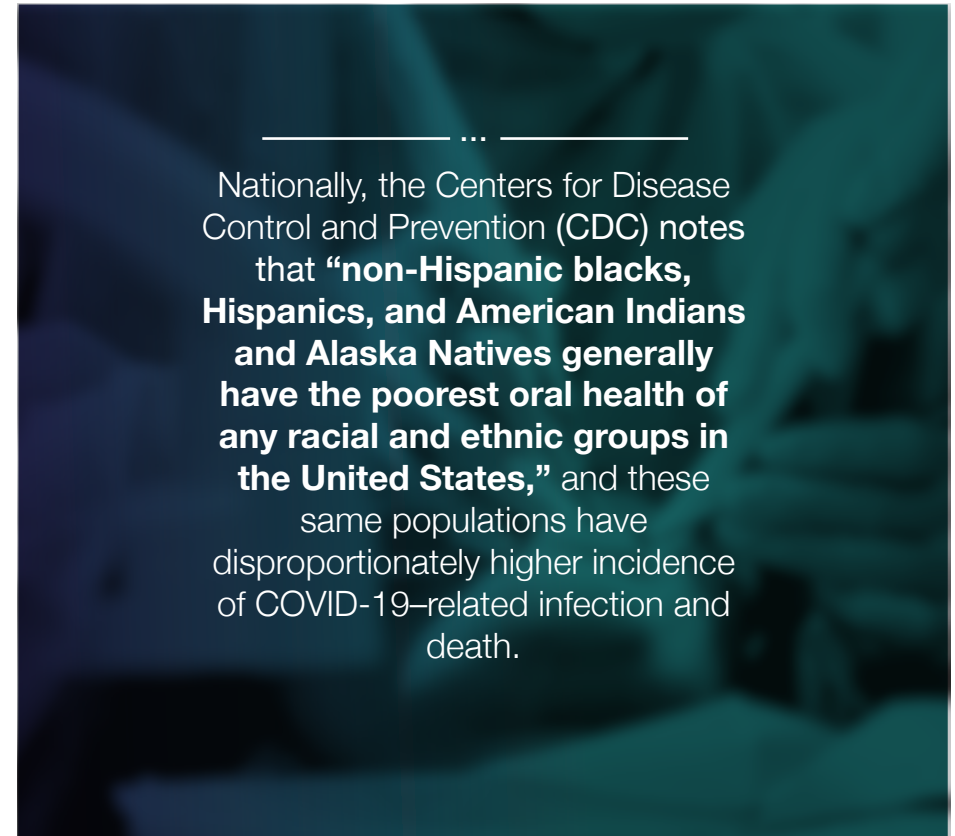
Objective

With a health equity lens, through this brief, we seek to identify and uncover the impact of COVID-19 on the oral health needs, capacity, and infrastructure in Texas, highlight best-practices, and offer systems-focused recommendations to mitigate the immediate and long-term impacts of the pandemic. In doing so, we hope to turn this pandemic into an opportunity to reinvigorate the oral health system in Texas.

Key Findings

1. Worsening inequitable oral health burden – As discussed earlier, populations at higher risk for major chronic diseases and COVID-19 are similar to those at higher risk for developing oral diseases. Common risk factors include stress, poor diet, alcohol and tobacco use, substance use, behavioral health issues, domestic violence, and poverty. The ongoing pandemic has exacerbated these factors and other social determinants of health that lead to both worsening chronic disease burden and poor oral health outcomes.⁴

Prior to the pandemic, Texas ranked in the bottom one-third of states for overall oral health outcomes and capacity. Particularly, the needs had been most concentrated in the state's Hispanic, low-income, and rural communities.⁵ For example, a third grader of Hispanic background enrolled in free or reduced lunch program and living in the panhandle region was more likely to experience untreated tooth decay and less likely to receive sealant or other treatment.⁶ Nationally, the Centers for Disease Control and Prevention (CDC) notes that “non-Hispanic blacks, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any racial and ethnic groups in the United States,” and these same populations have disproportionately higher incidence of COVID-19–related infection and death.^{7, 8} Given the pandemic's well-known disproportionate impact on the state's Hispanic population, these disparities are only projected to worsen existing oral health inequities in Texas.⁹

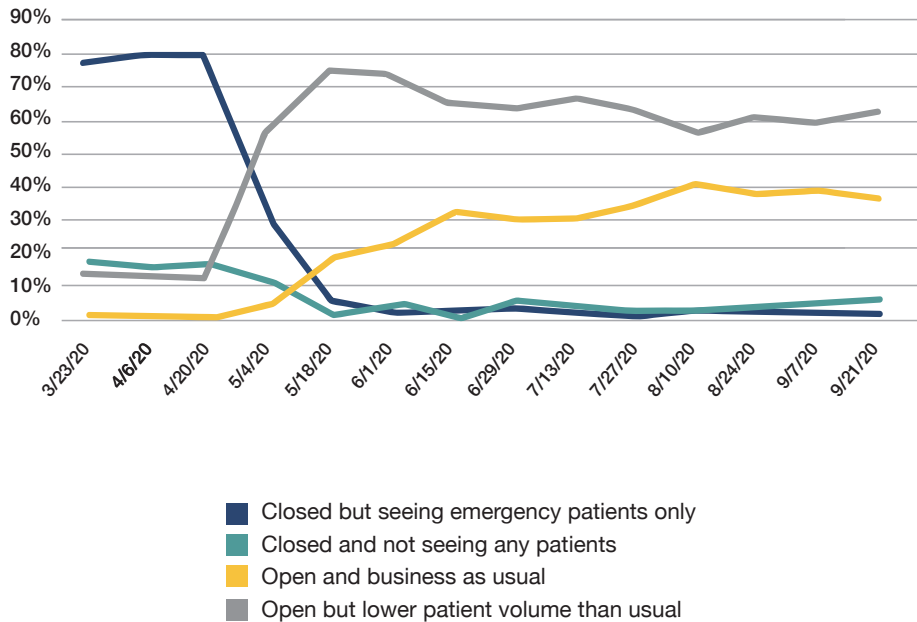


2. Growing need to strengthen and sustain the state's oral health infrastructure, especially the safety net – On March 16, 2020, the American Dental Association (ADA), recommended that dental practices postpone elective procedures until April 6, 2020, and provide emergency-only dental services to help keep patients from burdening hospital emergency departments.¹⁰ Because of the rise of infections, this recommendation was updated on April 20, 2020, and similar to ADA, the Texas Dental Association advised offices to remain closed to all but urgent and emergency procedures. Between the week of March 23 and April 2020, an ADA Health Policy Institute (ADA

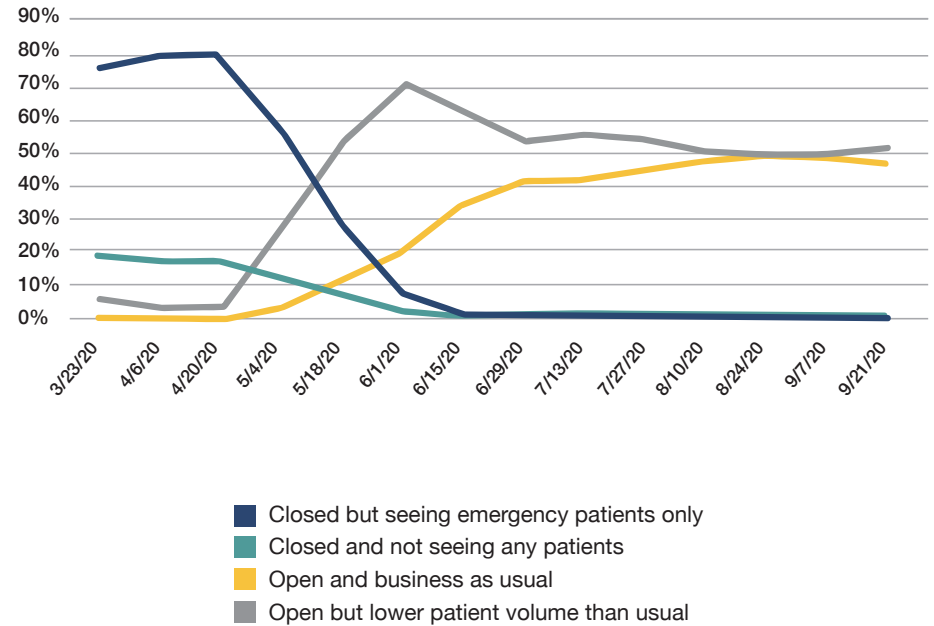
HPI) survey indicated that both nationally and in Texas approximately 76% of dental offices surveyed were closed but seeing emergency patients only, 17.5% were completely closed, and the remaining were open but seeing a very limited number of patients. These closures immediately resulted in job losses. However, following the executive order issued by Governor Abbott allowing dentists to return to full practice on May 1, 2020, most of the large sized and group practices

have returned to normalcy while, unequal impact has been observed in more independently-owned and small practices. During the week of September 21, 2020, 70% of dental practices in Texas with less than three staff members were still experiencing lower than usual patient volume compared to 56.6% of practices with four or more staff members.¹

Status of Texas Dental Practices During COVID-19



Status of US Dental Practices During COVID-19

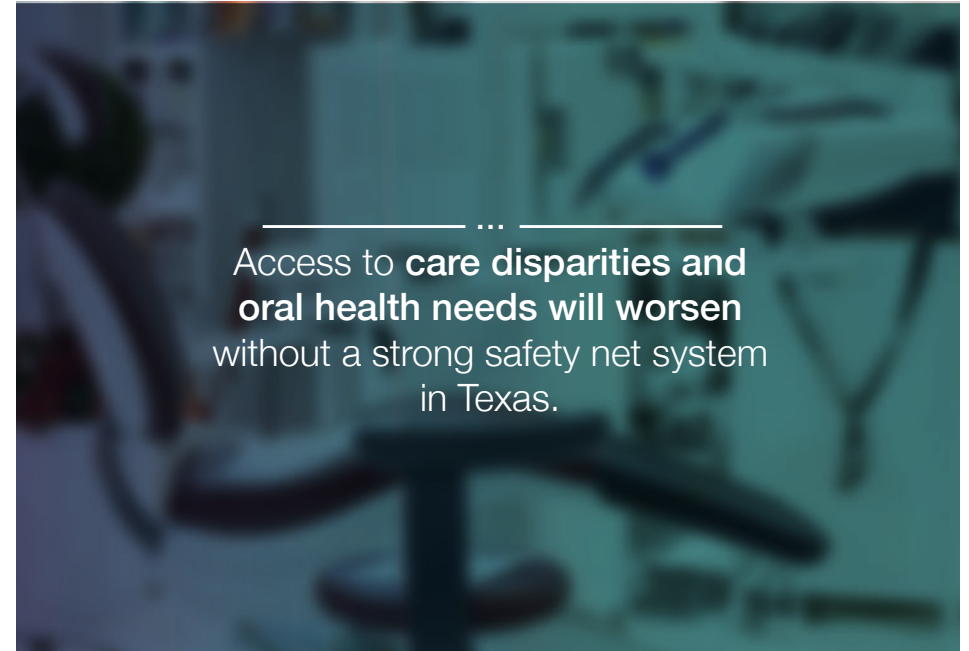


Source: American Dental Association Health Policy Institute's COVID-19 Economic Impact Survey Results. Retrieved from: <https://www.ada.org/en/science-research/health-policy-institute/covid-19-dentists-economic-impact/survey-results>

In addition to the negative economic impact of practice closures, an increased need for personal protective equipment (PPE), lack of widespread COVID-19 testing, and the use of instruments and equipment that generate aerosols containing oral and respiratory fluids further complicate recovery efforts.¹¹ Moreover, a recent analysis by ADA HPI estimates that dental care spending will decrease by 66% in 2020 and 32% in 2021.¹² Thus, it is evident that the economic impact of the pandemic will have long-term consequences; however, it is too early to predict the pandemic's long-term impact on the state's oral health infrastructure.

Why is this concerning for our safety net system? Given Texas's well documented challenges with access to oral health care in the state's rural and border communities, decades of documented evidence on the lower prevalence of sealant placements in low-income children, a weaker oral health safety net system compounded by lower Medicaid reimbursement rates and school closures, ensuring support to sustain the state's dental safety-net infrastructure will thus remain critical to serving at-risk populations during and after the pandemic.¹³ This capacity is needed now more than ever, as delayed and postponed treatment increases the need for more extensive and urgent care. Failing to protect this infrastructure will result in an increased number of emergency department visits and in severe cases inpatient hospitalizations for preventable dental conditions producing significantly higher downstream costs and adverse patient outcomes. Moreover, as experienced in recent years, delayed access to oral health care could also lead to preventable deaths.¹⁴

Given these challenges and growing evidence of the state's fast growing uninsured and underinsured population, it is imperative that Texas consider expanding adult dental benefits under Medicaid as well as review and revise its reimbursement rates which would result in more dentists accepting and serving Medicaid patients. Research in Texas and across the country has clearly documented the cost-effectiveness of a public dental benefit coverage.¹⁴ It is clear, access to care disparities and oral health needs will worsen without a strong safety net system in Texas.



Lastly, while the swift, pandemic-led adaptations to teledentistry were welcomed nationally, Texas currently does not have any allowances that permit teledentistry.¹⁵ However, Governor Abbott's recent support for telehealth services and ensuring payment parity for these services during the pandemic offers an opportunity to address systemic barriers that have inhibited its use in Texas. As additional national data emerges evaluating the efficacy of teledentistry services and more specific to telehealth/telemedicine services in Texas, future review and revision of current laws on teledentistry in Texas should be considered especially in terms of its role in providing patient education and engagement. Teledentistry can be used for education, consultation, and triage, allowing providers to advise patients whether their dental concerns constitute a need for urgent or emergency care, whether a condition could be temporarily alleviated at home, or whether treatment could be postponed. Given the pandemic-related stay-at-home orders and as dental offices are closed or operate at reduced capacity, communication and information via teledentistry can help lessen the burden of patients seeking dental care at overwhelmed emergency departments and urgent dental care settings.¹⁶

3. Opportunity and need to grow the role of oral health professionals in improving overall health and health equity –

In spite of the unique challenges faced by the state's oral health system, the role of many dental professionals in adapting and redeploying their skills and resources to support and/or deliver frontline health services during the pandemic should be recognized and appreciated. We have observed local and state public health departments' oral health teams being redeployed and supporting their respective agency's pandemic response efforts across the entire nation. Similar stories have emerged in our federally qualified health centers and other safety net settings. The scale and pace of this integration of dental teams into the wider health and public health system has been remarkable. Dentists, dental hygienists, and dental assistants have all had a substantial effect in supporting health service delivery during this pandemic and have developed new skills and clinical knowledge in the process. Rather than being isolated and separated from mainstream health care, this crisis has clearly shown the value of dental personnel in the healthcare team.¹⁷


This is especially important given the growing recognition of the link between oral health and overall health and oral health as a health equity issue.¹⁸ Over the last decade and following the passage of the Affordable Care Act, there has been increased support for prevention first and patient-centered care delivery models. Fundamental to the success of these new primary care delivery models and the myriad of individual and community needs they address are required coordinated, high-performing teams of diverse healthcare professionals.¹⁹ Available research suggests interest and willingness to practice the patient centered health home – dental home (PCHH-DH) model; however, the speed of adoptions hasn't been at scale. With the pandemic still continuing to impact the health and social determinants of health of our most vulnerable communities, oral health professionals have an important role to play in our state and community-wide responses to the pandemic, both in the immediate and long-term perspective. This is especially important for those serving the state's vulnerable populations, and the crisis has made the challenges and opportunities for oral health care in the United States increasingly evident.²⁰ During

this period, oral health care providers and advocates must clearly communicate the importance of oral health to overall health, indicate the steps being taken to ensure patient and provider safety, and promote prevention. This may include, but not be limited to, social determinates of health screening and navigation, collaboration with primary care and behavioral health providers in the safety net setting, and COVID-19 education and awareness. Concurrently, local, state, and national efforts must be led to ensure an oral health focus in policy considerations, continued research, monitoring, surveillance, and other aspects of health.

Recommendations

Any effort to address our most critical oral health needs and challenges will clearly require long-term, coordinated, and multi-faceted efforts. However, we will miss this opportunity if we fail to reimagine and rethink the way we perceive, seek, receive, deliver, measure, and achieve good oral health. To that end, we seek to offer a high-level, systems oriented framework that places the person and community at the center and will necessitate action across all components of our oral health, public health, and health ecosystem.




 **Prioritizing oral health equity** – A growing body of evidence and the pandemic’s impact on our most at-risk communities have made it obvious that factors preventing people from seeing the dentist, ultimately leading to poor oral health problems, are, by and large, the same ones that limitations to physical health care: access to transportation, access to healthy foods, language barriers, and other social determinants of health.²¹ Moreover, the recent turn of events has led to a growing recognition and urgency for a call to address racism and shed an important light on the need to identify and address these root cause barriers fueling oral health and health inequities.²²


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As mentioned earlier, there are many ways that health systems can work to understand and address the social determinants of health. Oral health providers and communities have the opportunity to do the same. Community-based oral health programs such as the ones led by the St. David’s Foundation in Central Texas and Center for Children’s Health led by the Cook Children’s Health in North Texas are good examples of effective programs in Texas. That said, more work needs to be done to develop and evaluate effective and scalable strategies and interventions for systems wide impact. In doing so, efforts should be made to ensure outcome and impact evaluation takes place on all levels — individual, organizational, and community.

Moreover, we must try not to reinvent the wheel, but proactively collaborate with health systems, public health agencies, and community based organizations. A national learning collaborative led by the Center for Health Care Strategies confirmed the need and critical importance of mobilizing community resources to build partnerships to overcoming inequalities in social determinates of health. These partners should have deep roots in the community and relationships with residents that produce invaluable perspectives to understanding and planning to address needs. It is important to build trust in these relationships.²³ It is imperative that any and all response and transformation efforts prioritize oral health equity as an end outcome.

 **Improving access and health outcomes through a health team approach** – Health care reform, overwhelming oral health needs, and growing associations between oral and systemic wellness confirm the need for a whole health approach across all forms of oral health delivery. Moreover, the pandemic’s impact on access to physical health and behavioral health services, financial challenges, and other contributing factors highlight the need for such an approach. From a positive viewpoint, the pandemic provides an ideal opportunity to demonstrate the value of a coordinated, co-located, and inter-professional approach. For example, oral health for older adult patients is vital for function, comfort, and communication and is a critical component of overall health. However, optimal oral health outcomes are often dependent on effective interprofessional collaboration between and among health care providers, in conjunction with patient family members and caregivers.²⁴

Treatment and management of oral disease often require coordination of care beyond the delivery of preventive and restorative treatments at the dental clinic. Identifying and addressing transportation issues, care navigation, and collaboration with other multidisciplinary team members are also necessary. Vital to success is ensuring a person and community-centered system design that facilitates structured yet seamless access to desired and required care.



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While previous person-centered care models within dentistry demonstrated limited success in part to having only a defined role for providers in clinical settings, emerging models and evidence highlight the essential role of the care designer within the broader system to create optimal environments, and enablers for providers to practice this approach in the most meaningful and effective ways.²⁵ In doing so, we could successfully position oral health as an integral and necessary part of the primary care system and leverage existing primary care transformation efforts to enable health system transformation. Moreover, a recent publication by ADA HPI offers important takeaways for the role oral health professionals could play in addressing primary care shortage issues and chronic disease management.²⁶

However, issues around data collection and data sharing fueled in large part by interoperability issues of electronic medical and dental records, lack of comprehensive care coordination resources, and concurrent shifts in payment models need to be addressed.²⁵ To that end, we must leverage national efforts and resources such as the ones led by ADA HPI, National Interprofessional Initiative on Oral Health, and DentaQuest Partnership for Oral Health Advancement to facilitate this transformation.




Ensuring sustainability and growth through increased adoption and shift to a value-based care delivery model—

Oral health service delivery has remained relatively insulated from payment upheavals in the broader health care system. The prevailing value-based payment (VBP) models and Alternative Payment Models (APM) in health care are largely absent in oral health care.²⁷ However, ensuing shifts in care delivery reform and the growing recognition of the important role of oral health in overall health and care delivery validate the need for increased adoption and implementation of these new payment models in oral health care financing. Moreover, as result of the pandemic's negative financial impact on the state and country's primary care infrastructure have led to growing calls for the need to ensure a system-wide shift to prospective payment mechanism. For example, the Texas Academy of Family Physicians recently released a Marshall Plan for primary care in Texas that clearly supports the need for such an approach and offers a five-step approach to implementation.²⁸ By doing so, we are improving the ability of our state's primary care and oral health system, especially the safety net, to mitigate the negative impact of diminished revenue during health emergencies and events such as the COVID-19 pandemic.

To that end, it is important to recognize that prior to the pandemic, the state's Medicaid program had widely been recognized and credited for advancing some of these shifts in oral health care delivery through two programs in administering its benefits. First, is the dental P4P program. By design and intent, this program is a redistributive model; a DMO could lose up to 1.5% of its capitation based on whether it's worsening in performance across agreed upon measures. Another approach is through increased value-based contracting both with our state's MCOs (managed care organizations) and standalone DMOs. As a result, the state's contract with these organizations include performance targets for the percentage of dollars paid to providers that should be governed by a VBP construct. In 2018, the state had established an overall target of 25% of provider payments to be governed by a VBP construct for contracted DMO's. This target of 25% has a subset of 2% of these dollars set aside for risk purchasing.²⁹ The positive impact of these approaches on lowering costs and improving outcomes have been discussed both at the state and national level thus justifying wide-scale adoption.^{30, 31}


Given its proactive role in advancing efforts in this space, Texas has an important opportunity to be at the forefront of these innovations and advancements. In doing so, we must also leverage concurrent efforts such as the one led by TAFP and nationally by Primary Care Collaborative to achieve broader health systems-wide impact.

 **Strengthening our infrastructure through policy and systems reform** – By design and intent, the Affordable Care Act improves access to and the affordability of a wide range of health care services. While dental care for children is part of the law’s essential health benefits and state Medicaid programs must cover it, Texas remains one of the last few states to not provide an adult dental benefit. As a result of the growing percentage of uninsured Texans, an even higher number of Texans will face greater financial barriers to receiving oral care that lead to unmet oral health needs. A study published in Health Affairs in 2016, revealed that irrespective of age, income level, and type of insurance, more people reported financial barriers to receiving dental care compared to any other type of health care.³² As health advocates and state leaders explore and pursue solutions, including Medicaid expansion, an adult dental benefit must be included as a key priority. To that end, since 2018, Texas Health Institute has released a series of reports and analyses that reflect the high downstream costs and negative impact on Texas lives and economy because of the lack of an adult dental benefit.¹⁴ In other words, both state and national level research have proven the cost-effectiveness of an adult dental benefit. In fact, an adult dental benefit has proven itself as one of the most effective, low-cost, high-impact policy interventions that demonstrates the role of smart public policy in reducing costs, improving access and outcomes, and improved overall quality of life.

Additionally, as mentioned earlier, concurrent review of our Medicaid reimbursement rates, ensuring best-practice approaches in increasing the number of dentists serving Medicaid beneficiaries, periodic review and revision of state policy actions addressing workforce demand and supply need to be pursued concurrently to realize true change. Lastly, the state must ensure continuity of annual evaluation of the state’s incentive structure with contracted dental plans and ongoing modifications to motivate, recognize, and reward dental contractors for superior performance.³⁰

In summary, the complex and inter-dependent nature of the issues that our oral health system faces will require multiple policy and systems change strategies that are aligned, coordinated, and concurrent in their design, implementation, evaluation, and ongoing modifications.



 **Advancing innovation through increased data availability and optimal utilization in decision making, resource allocation, and outcomes measurement** – Any type of system transformation effort is an evolving process and not a point-in-time activity. Fundamental to ensuring the transformation is producing desired outcomes and impact is the need for ongoing evaluation and improvement. However, lack of oral health data availability at all geographic levels and population groups remains the biggest barrier for ensuring successful and sustainable transformation. Even in the process to develop this brief, the lack of data on population level oral health needs and issues during COVID-19, both in Texas as well as nationally, was one of our biggest barriers. Clearly, more investments and intentional efforts need to be pursued to increase data availability for broader oral health awareness as a health and equity issue, measure the health, economic, and equity impact of the pandemic and similar health emergencies on oral health needs, track the progress and efficacy of policy interventions such as an adult dental benefit and teledentistry, and to facilitate care delivery and payment reform efforts.

Conclusion

This issue brief highlights only a few elements of the complex dynamics of the oral health needs and system in Texas during and after COVID-19. Texas Health Institute will continue to monitor these issues and engage with oral health providers, patients, leaders, payers, funders, and advocates to find ways to improve oral health equity and more effective systems.

About Texas Health Institute

Texas Health Institute (THI) is a non-profit, non-partisan public health institute with a mission to advance the health of all. Since 1964, THI has served as a trusted, leading voice on public health and healthcare issues in Texas and the nation. THI's expertise, strategies, and nimble approach makes them an integral and essential partner in driving systems change efforts. THI works across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life.

Recommended Citation

Sanghavi A, Jones C. (2020). "COVID-19 in Texas: An Opportunity to Improve the Oral Health System in Texas" Texas Health Institute. <https://www.texashealthinstitute.org/>.

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