How Will Dentistry Respond to the Coronavirus Disease 2019 (COVID-19) Pandemic?

Lisa Simon, DMD

On March 27, the US Centers for Disease Control and Prevention recommended postponing all nonemergent dental services nationwide as part of the coronavirus disease 2019 (COVID-19) mitigation efforts, matching guidelines already released by the American Dental Association, state dental societies, and departments of public health. By early April, 95% of dental practices were fully shuttered or open only for emergency care.

Changes to Dental Care During the COVID-19 Pandemic

Unfortunately, oral health problems will arise even when dental practices are closed. Without access to preventive or palliative dental care, pain caused by dental abscesses or periodontal infections may become more prevalent. Such dental emergencies compose more than 1.5% of all annual emergency department visits. Decayed teeth that have been repaired with a simple filling may deteriorate, requiring more costly treatment (that is less likely to be covered by dental insurance) when practices reopen.

In response to the COVID-19 pandemic, new federal policy allows dentists and other health care professionals to use off-the-shelf software, such as smartphone video chatting applications, to conduct telehealth visits to screen patients for dental problems. However, American Dental Association billing guidance lists only 6 Current Dental Terminology codes that can be billed through telehealth and not all may be reimbursed by insurers. Such codes encompass only diagnostic services, representing a fraction of most dentists' care. Before the COVID-19 pandemic, only California had enacted legislation reimbursing dentists for the use of teledentistry, which facilitated procedural treatment by dental hygienists with remote supervision.

Lasting Consequences of COVID-19 on Dental Care

Most dentists are small business owners who operate independently or with a few partner dentists. The prolonged closure of dental practices is causing financial strain similar to what many other small businesses are experiencing during the pandemic. As of April 20, 45% of dentists reported that they were not paying any of their staff. Although dental practices are eligible for small business loans provided by the federal Coronavirus Aid, Relief, and Economic Security Act, staff furloughs, limited access to protective equipment, and social distancing will likely impede dental care even after practice restrictions are lifted.

The average dentist is aged 50 years and operates in a solo practice, and 40% of dentists are over 55. If shutdowns persist, many older dentists may retire rather than resume practice after a prolonged and costly gap in operations. As dentists in rural areas tend to be older, such practice closures could compound existing geographic disparities in access to dentists, making oral health care even less accessible for rural residents.

While representing only a minority of all dental practices, the number of practices with more than 10 employee dentists as well as the number of practices contracting with dental service organizations to streamline business operations, have been rapidly expanding. Massive financial
losses during the pandemic may hasten the consolidation of dental practices under models that can better weather financial uncertainty.

In 2018, 6.4 million US residents received dental care from a federally qualified health center (FQHC). Because more than 90% of patients in FQHCs earn less than 200% of the federal poverty line and 22% lack health insurance, FQHC dental clinics are a critical access point for vulnerable communities with the highest risk of unmet oral health needs. With FQHC dental programs already operating on limited margins, responses to COVID-19 have included redeploying dental staff to frontline COVID-19 testing or triage roles or being forced to furlough them.

The broader economic consequences of COVID-19 may also affect dental access. During budget shortfalls, dental benefits are often among the first services cut from state Medicaid budgets. In the 2008 recession, 19 states removed or limited adult dental services from their Medicaid programs. (Medicaid programs are mandated to offer a pediatric dental benefit.) Loss of dental coverage for patients with low incomes resulted in lower dental utilization and higher rates of emergency department utilization for dental problems. FQHCs are often highly dependent on Medicaid reimbursement, so reduced Medicaid coverage for dental care decreases their funding to provide dental services.

Opportunities to Improve Dental Delivery With COVID-19

Not all change may be negative. As patients become accustomed to the convenience and accessibility of telehealth, it will likely take stronger root in dentistry as well. Current teledentistry codes enable evaluation and triage of acute dental problems without an in-person visit. With increasing smartphone camera quality, clinicians can use televists to garner additional diagnostic information. Although telehealth cannot substitute for procedural intervention for most dental disease, the growth of teledentistry may benefit patients who face barriers to conventional dental care, including patients in rural areas, nursing homes or other residential facilities, and those with mobility or transportation limitations.

The COVID-19 pandemic may also hasten the adoption of interoperable electronic health records in dental care. Currently, most dental health records are not integrated with medical records, representing a potential safety risk and barrier to coordination of care. As COVID-19 testing capabilities expand, dental offices may become a convenient site for walk-in testing, a move encouraged by the American Dental Association. During the H1N1 epidemic, dentists were authorized to administer influenza vaccines, which could also occur once a COVID-19 vaccine is developed. Such expansions in dentists’ scope of practice would require enhanced information sharing between medical and dental providers.

Lastly, modifications to the dental workforce may occur. Changes to nurse practitioner and physician assistant scope of practice that eliminate the need for physician supervision in states hit hard by the pandemic may have lasting implications for team-based medical care after COVID-19. Similarly, opportunities may increase for midlevel dental professionals known as dental therapists. They complete at least 3 years of academic training and provide a limited scope of treatment, such as fillings and treatment for periodontal disease, in collaboration with a dentist. Dental therapists have been found to reduce overall dental costs and expand access in rural and tribal areas. A total of 13 states have passed dental therapy legislation, but expansion of the model has been slow, largely because of opposition from organized dentistry. Based on state practice laws, the specific scope of practice and the extent of supervision ranges from remote supervision and the ability to extract teeth among dental therapists practicing in remote areas of Alaska to the need for direct supervision and an additional degree in dental hygiene to practice in Maine. In a recovering economy, the lower cost of dental therapists may foster their adoption or more independent scope of practice.

Historically separated from medicine, dentistry has been largely insulated from many changes in health care delivery. At this point, dentistry has been deeply affected by COVID-19 but only
indirectly involved in the response to it. Nonetheless, dental care will likely emerge from the pandemic as altered as the rest of public life in the US.

**REFERENCES**

1. US Centers for Disease Control and Prevention. CDC guidance for providing dental care during COVID-19. Published April 20, 2020. Accessed May 13, 2020. https://www.cdc.gov/oralhealth/infectioncontrol/statement-COVID.html

2. Carey M. HPI poll examines impact of COVID-19 on dental practices. ADA News. Published April 1, 2020. Accessed April 8, 2020. https://www.ada.org/en/publications/ada-news/2020-archive/april/hpi-poll-examines-impact-of-covid-19-on-dental-practices

3. Allareddy V, Rampa S, Lee MK, Allareddy V, Nalliah RP. Hospital-based emergency department visits involving dental conditions: profile and predictors of poor outcomes and resource utilization. *J Am Dent Assoc*. 2014;145(4):331-337. doi:10.14219/jada.2014.7

4. US Department of Health and Human Services. OCR announces notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. Published March 20, 2020. Accessed April 8, 2020. https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

5. American Dental Association. COVID-19 coding and billing interim guidance. Updated May 11, 2020. Accessed May 13, 2020. https://success.ada.org/-/media/CPS/Files/COVID/ADA_COVID_Coding_and_Billing_Guidance.pdf

6. Health Resources and Services Administration. 2018 National Health Center Data. Accessed May 8, 2020. https://bphc.hrsa.gov/uds/datacenter.aspx

7. Neely M, Jones JA, Rich S, Gutierrez LS, Mehra P. Effects of cuts in Medicaid on dental-related visits and costs at a safety-net hospital. *Am J Public Health*. 2014;104(6):e13-e16. doi:10.2105/AJPH.2014.301903

8. Simon L, Obadan-Udoh E, Yansane A-I, et al. Improving oral-systemic healthcare through the interoperability of electronic medical and dental records: an exploratory study. *Appl Clin Inform*. 2019;10(3):367-376. doi:10.1055/s-0039-1688832

9. Koppelmann J, Vitzthum K, Simon L. Expanding where dental therapists can practice could increase Americans' access to cost-efficient care. *Health Aff (Millwood)*. 2016;35(12):2200-2206. doi:10.1377/hlthaff.2016.0844