

Improving Dental Health for Texans

Key Lessons for Policy Advocates



This issue brief was produced by the Texas Interfaith Center for Public Policy (TICPP) and the Children’s Dental Health Project (CDHP). TICPP is an Austin-based organization that is part of an interfaith network bringing faith to bear on various issues through grassroots education and policy. CDHP is a policy institute in Washington D.C. that seeks policies that help children and families lead healthy, successful lives. Learn more about our organizations at www.interfaithimpact.org and www.cdhp.org.

Background

The messages used to seek policy change are one of many factors that shape the effectiveness of advocacy. To learn which messages are most likely to resonate with policymakers, the Children’s Dental Health Project (CDHP) commissioned in-depth interviews and a virtual focus group of policymakers and influencers from a variety of states. This research was concluded in February 2017. These two national research projects produced important insights. First, CDHP learned there are major knowledge gaps about oral health. Second, it appears that policymakers are largely unaware of the human and financial costs that dental disease imposes on families and taxpayers.

This year, CDHP sought to deepen its understanding by learning whether focus groups within particular states would produce similar or different insights. With the financial support of St. David’s Foundation and the Dental Trade Alliance Foundation, CDHP conducted focus groups in central Texas in June 2018, one each in Bastrop County and Williamson County. Bastrop County (BC) is mostly rural, and its largest municipality has fewer than 9,000 residents. Williamson County (WC) has a much larger population, and its suburban communities are rapidly expanding. WC has been one of the 10 fastest-growing counties in Texas.

Defining Terms

Policymakers: People at the local, state and federal levels who make or implement policy decisions that determine the laws, regulations or practices that affect the public’s health and well-being. These individuals include state legislators; Medicaid officials; city council members; county commissioners; members of Congress; and hospital or health systems administrators. Even school boards can be health policymakers because most of them approve budgets that decide what health services will be offered to students and how many schools will be staffed with nurses.

Influencers: Individuals who have greater leverage over policymakers than most Americans. For the purpose of these focus groups, we defined influencers as people having leverage from their professional or social reputation, and/or their willingness to interact with policymakers. Those interactions include learning about and advocating for an issue by sending emails to elected officials, signing petitions, or attending “town hall” meetings or other civic events.

Focus groups were convened to hear from “influencers” in each county. A questionnaire was used to recruit participants for each focus group. One of the questions sought to learn if individuals had been civically engaged within the previous 12 months—whether, for example, they had displayed a yard sign or bumper sticker in support of an issue or candidate; attended a community meeting to discuss a public issue; or written emails to their elected officials. The participants in these focus groups reported that they interact in some way with a local, state or national policymaker an average of 15 times during a year.

Focus groups were held in BC on June 11 and WC on June 12. Participants were diverse and included a registered nurse, classroom teacher, health clinic manager, Lutheran minister and a small business owner. (A representative of the Texas Interfaith Center for Public Policy attended each focus group as an observer.) Table 1 offers basic information about both counties and their participants.

Table 1:

Bastrop County (BC)	Williamson County (WC)
Population: 84,761	Population: 547,545
Poverty Rate: 13.2%	Poverty Rate: 5.8%
21 total participants: 18 white and 3 persons of color; 16 females, 5 males	
Participants for both focus groups were recruited through a questionnaire to ensure they were actively involved in civic affairs. We specifically sought individuals from the health care sector, education sector and the faith community.	

Rating Their County

Participants were asked to rate on a scale of 1-10 the health and well-being of residents in their respective counties. (Choosing a 10 meant residents’ health was outstanding, while a rating of 1 meant that residents’ health was poor.) Neither focus group rated their county highly. The average rating chosen by BC participants was 3.6, while the average rating for WC was 5.5. Given that BC has a much higher poverty rate, this gap was not surprising. Four of the eight WC participants chose a 5 or lower rating, while 12 of the 13 BC participants selected a rating of 5 or lower.

Overlooked Issues

When asked to name the “overlooked health issues” in their counties, participants of both focus groups generally shared the same challenges. These included mental health, affordability of care, diabetes, obesity, nutrition and diet, and transportation to or from care. In addition, participants in each county cited a few unique issues they felt were neglected. BC participants also cited language barriers, teen behavioral health, and the lack of health services for young women. WC participants also pointed to elder care and drug abuse.

None of the 21 participants volunteered dental health as an overlooked issue. However, when the moderator raised this topic, most participants immediately agreed that dental health in their counties deserved more attention from policymakers. Dental health is “an extremely big deal,” said one of the BC participants. “That’s where your health starts and it [affects] the rest of the body.” A participant

who volunteers at a food pantry said that dental care was one of the two health concerns she hears about regularly from clients.

Although participants were not asked for their party affiliation, there were no obvious signs of any partisan divide in how they discussed oral health issues. The only participant who cited involvement in a party (Republican county committee) complained that the dental care system was too expensive and said there were not enough dentists in rural parts of his county.

Knowledge Gaps

Participants were knowledgeable about some aspects of oral health, but discussions revealed several gaps in their awareness. Although knowledge varied, Table 2 reveals what most participants knew or did not know.

Table 2:

What Most of Them Knew	What Most of Them Didn't Know*
<ul style="list-style-type: none"> ● Dental care operates in a world separate from medical care, and that can create access problems. ● Dental care is unaffordable for many people in Texas. Even if someone is insured, the costs of premiums and co-pays can strain a household budget. ● Not all dentists accept their dental insurance or their child's insurance. 	<ul style="list-style-type: none"> ● Tooth decay is a disease process that can be prevented or halted with appropriate interventions. ● Texas' Medicaid program treats children and adults in a fundamentally different way. ● Dentists aren't the only people who can do an oral health risk assessment. ● Dentists are not required to accept Medicaid-enrolled patients.
<p><i>*Several WC participants were unaware of what dental sealants were and how they were helpful for children's oral health.</i></p>	

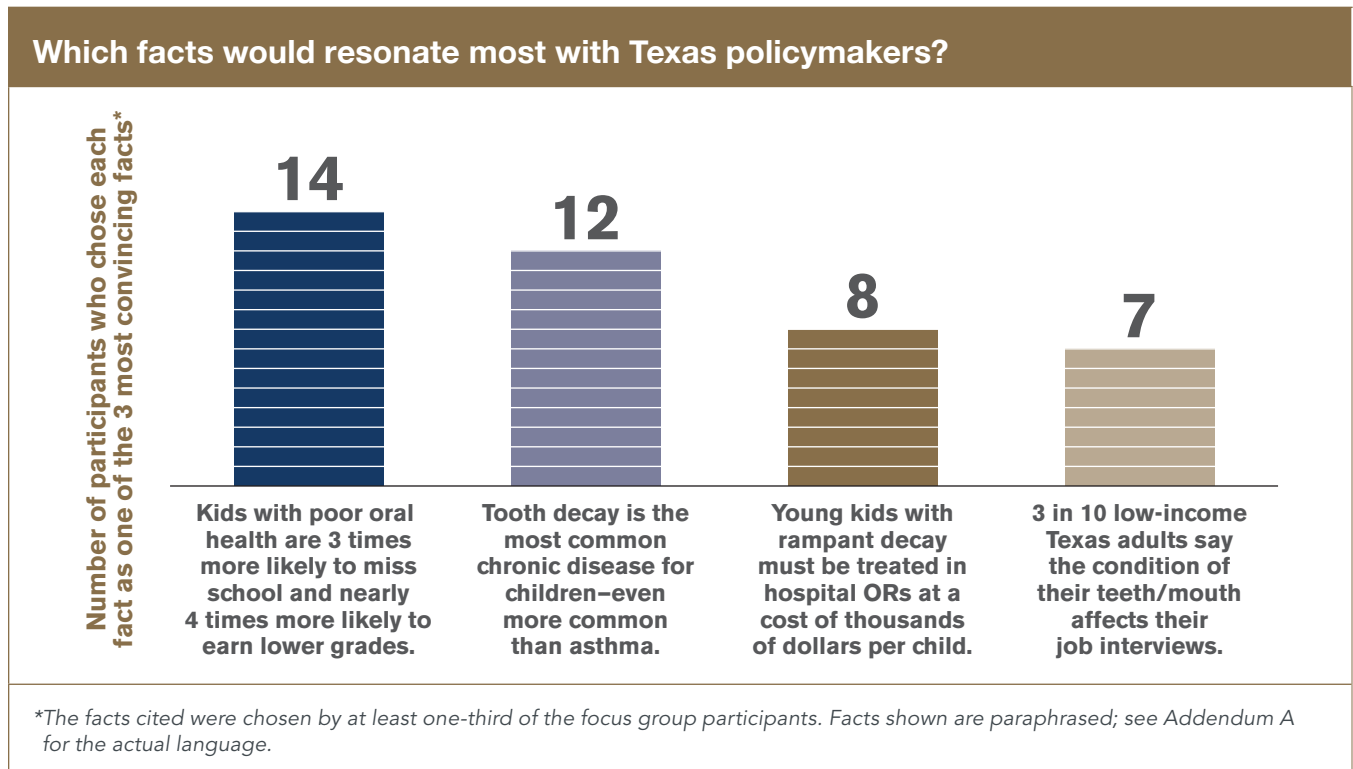
When discussing people in their county with poor oral health, a few participants pointed to the failure of adults to take responsibility for their own oral health and, if parents, to instill good dental habits in their children. Yet several participants cautioned against blaming people without fully considering the variety of challenges and barriers that they might face.

Most Persuasive Facts

A sheet with 10 dental health facts was circulated to each focus group (*see Addendum A*). Participants were asked to read them and choose no more than three that would be most likely to persuade Texas policymakers to view oral health as a priority. Overall, the higher rated facts were ones that related to the consequences of poor oral health.

Table 3 shows the four facts that were chosen by at least one-third of the 21 participants who attended the focus groups.

Table 3:



After making their choices, participants discussed the facts they felt would be most convincing to policymakers. The impact of poor oral health on school attendance and learning resonated with most of them. “There’s a relationship between education and success, [including] financial success,” said a WC participant. “So fixing something will have a positive impact later on down the road.”

A few participants talked about why they chose the job-related fact. “I’m involved in our hiring process,” said a WC participant, “and I see a lot of people come in and see the difference in how they present themselves.” A BC participant said that state legislators were enthusiastic about job creation “and so, if you were to say, ‘these guys can’t get a job because their teeth are holding them back,’ that’s going to make a big difference.”

The Barrier of Cost

Participants received and reviewed an infographic showing that cost was more likely to prompt adults to go 12 months without dental care than it was for delaying any of four other health services (medical care, prescription drugs, mental health and vision care). Participants were asked to write one or two

“... if you were to say, ‘these guys can’t get a job because their teeth are holding them back,’ that’s going to make a big difference (to policymakers).”

words summarizing their reaction to this infographic. One participant chose “wow” to represent her reaction.

Some participants were surprised that cost was a greater barrier to dental care than for the other areas of care. Yet several of them wrote “not surprised” on their scoring sheet. Many attendees in BC found it hard to believe the percentage (8.9%) wasn’t higher for people citing cost as the reason they did not get dental services. A BC participant commented, “I think if people could

afford it, they would go.” One participant in WC shared a personal story: “My dad recently got told he had a few cavities, and it would be around \$5,000 [to treat them]. It’s expensive—and we don’t have the money for it.”

Parent–Child Connections

In these focus groups, we explored the connections between parents’ oral health and that of their children. A graphic was shared from Connecticut showing that when their parents received dental care, Medicaid-enrolled kids were much more likely to get dental services themselves. Most participants weren’t surprised by this finding.

Participants were reminded that Medicaid dental benefits for Texas adults are limited to emergency services and do not cover an exam or other preventive care. A handout was given to participants, recommending that the state’s leaders provide more extensive dental benefits for all adults or only for parents. The handout offered an argument for each approach (*see Addendum B*). Participants were asked to rate (on a scale of 1 to 5) how convincing they felt each argument would be to policymakers. Choosing a higher number meant the argument was more persuasive.

In each focus group, participants rated the argument for parents’ coverage as more convincing. Counting all attendees, the parents’ coverage argument was rated an average of 3.54 on a 1-to-5 scale, while the “all adults” average score was 3.27. A few participants said they personally supported giving all Medicaid-enrolled adults access to preventive dental care, but they felt that policymakers would be more receptive to extending coverage to parents.

These responses suggest that advocacy for improved adult Medicaid benefits might be strengthened by talking about adults in the context of their families. Many adults are also parents, and this child-parent connection could be a helpful frame for messages.

Testing Messages for Adult Dental Coverage	Ratings
<p>Message 1 (promotes robust coverage for parents) When parents or caregivers get dental care, their children are more likely to receive dental services. Unfortunately, Texas' Medicaid program covers a variety of preventive services for children but none for their parents. Currently, only emergency dental treatment is covered for adults. Our state's Medicaid program should cover dental services for parents as soon as possible. By taking this step, we can improve the health of families, not just kids.</p>	3.54
<p>Message 2 (promotes robust coverage for all adults) People with unhealthy or missing teeth are at a disadvantage in the job market. To live and work without toothaches or other dental problems, adults need access to affordable dental care. But adults who are unemployed or in low-wage jobs usually cannot afford the cost of private dental insurance. Medicaid is their only realistic vehicle for accessing dental care. Yet Texas' Medicaid program only covers emergency dental treatment for adults. It's time to change that by giving all Medicaid-enrolled adults access to dental services—not just emergency care. It's a smart investment for better health.</p>	3.27



Risk-Based Care

Participants were asked to read a handout explaining the concept of risk-based care (RBC). Under this approach, children are given an oral health risk assessment to determine their risk level for tooth decay. Then each child receives the care and supports that reflect their individual risk. For example, children at high risk of cavities would need more frequent dental services, and their parents would receive more guidance on diet and other habits to keep their kids healthy.

Although Texas' Medicaid program has a reimbursement code for oral health risk assessments, there is no evidence that these assessments are commonly conducted by dentists, pediatricians or others.

Participants asked several questions about RBC and shared their initial impressions. "I think it [could] catch the attention of policymakers," said one participant, "because no one wants kids to be at risk." Most participants liked the concept, but several wondered whether existing access barriers would frustrate parents seeking to get the dental services that are appropriate to address their children's risk. Participants wondered:

- If parents would make time to get their children's risk assessed
- Whether existing access issues would impede families' ability to get the additional care their children need
- How much money RBC would cost or save

The discussion revealed that proponents of RBC need to provide clear explanations so policymakers and the public understand what oral health risk assessments are, who can conduct them and how the knowledge of a child's risk level could help ensure that they receive the services they need to avoid cavities.

Participants were given a handout with three brief messages in support of RBC (*see Addendum C*). After reading all three messages, participants were asked to name the message they felt would be most convincing to state legislators and health officials. No message performed noticeably better than the others.

Nearly all participants did not like the use of "risk-based care" as the term for summarizing this approach. Various participants said the word "risk" was overused, "worn out," or had a negative connotation. Several felt that "prevention" should be part of the name rather than focusing on risk.

One WC participant said that RBC would make more sense to policymakers if proponents could cite a specific child or family as an example. "Overall, you need a storyline," he remarked.

Key Lessons

- 1 Focus on the impact of poor dental health:** When asked to choose the oral health facts that they felt would be most convincing to policymakers, participants generally chose ones that revealed the *consequences*—rather than the prevalence—of poor dental health. Three of the top-rated facts focused on the educational or economic impact of oral health problems. Linking dental health to these areas gives policymakers a stronger reason to care.
- 2 Provide appropriate background:** Dental issues are not top-of-mind, which is one reason why there are significant gaps in knowledge. These gaps can make it tougher to get the attention of elected officials. For example, a majority of participants agreed that most policymakers are unaware that tooth decay results from a disease process. In addition, some focus group participants did not know that Texas’ Medicaid dental benefits cover preventive services for children but not for adults. Before making any “ask” of policymakers, advocates should provide crucial facts that fill these and other gaps.
- 3 Highlight the family connection:** When comparing the message supporting Medicaid dental coverage for all adults with the message focused on parents, most participants preferred the latter. Although several saw the value of providing preventive benefits for all adults, they felt that the parent-child connection would have greater appeal to policymakers. When talking about adults’ oral health, advocates should explore ways to frame this as a “family” issue, reminding policymakers that many adults are parents—so their oral health access and status has implications for kids’ oral health.
- 4 Talk about the system:** National research has shown that when asked about dental health issues, most Americans talk about it as an individual responsibility. Policymakers are likely to have the same tendency. This mindset can create an obstacle to policy action. Advocates’ messages should remind policymakers that adults and families are trying to navigate a system of care that is broken in various ways. Moreover, it’s worth pointing out that individuals’ oral health is affected by decisions that communities make, such as fluoridating the drinking water or funding bus routes that make it easier for low-wage people to reach dental services.
- 5 Communicate with clarity:** Influencers—the people who attended these focus groups—are more engaged and involved in the public dialogue around health issues. Yet even they may not understand many terms that health advocates use regularly. For example, one participant read a handout and then asked: “What does ‘health outcomes’ mean? It sounds vague.” This is a reminder that advocates who seek to improve dental health should opt for language that is widely understood, avoiding policy jargon and technical terms.

Addendum A:

Facts & Statistics about Oral Health

- 1 Tooth decay is the most common chronic disease of children and teens—and even more common than asthma.

- 2 Young children with a lot of cavities generally need to be treated under general anesthesia in hospital operating rooms. Data shows this kind of hospital treatment costs between \$5,000 and \$15,000 per child.

- 3 Texas is one of only 13 states that limit adults' Medicaid dental coverage to only emergency care, meaning low-income adults aren't covered if they need to get a cavity filled or to fix a chipped or cracked tooth that was caused by an accident.

- 4 By the time U.S. children reach the 3rd grade, roughly half of them have had at least one cavity. But in Texas, two-thirds of kids have had a cavity by this point.

- 5 In a 2015 survey, 3 in 10 low-income adults in Texas said the condition of their teeth and mouth affects their ability to interview for a job.

- 6 Research shows that children with poor oral health are nearly 3 times more likely than their peers to be absent from school. And teens with poor oral health are 4 times more likely to earn below-average grades.

- 7 Gum disease during pregnancy may be linked to low-birthweight babies and other adverse birth outcomes. Yet only 1 in 9 Texas women have a dental visit during pregnancy.

- 8 During a two-year period, more than 9,400 soldiers had dental emergencies that delayed or disrupted their deployment in Afghanistan. The Defense Department identified tooth decay as “a significant reason” why some military personnel are non-deployable.

- 9 Health economists found that adults with better oral health earn 2% more than their peers—and the wage “bump” is even higher for women.

- 10 Children with cavities in their baby teeth are 3 times more likely to develop cavities in their permanent (adult) teeth.

Addendum B:

The Adult-Child Dental Connection

Message 1:

When parents or caregivers get dental care, their children are more likely to receive dental services. Unfortunately, Texas' Medicaid program covers a variety of preventive services for children but none for their parents. Currently, only emergency dental treatment is covered for adults. Our state's Medicaid program should cover dental services for parents as soon as possible. By taking this step, we can improve the health of families, not just kids.

Rate this message by circling a number:

1 2 3 4 5

Message 2:

People with unhealthy or missing teeth are at a disadvantage in the job market. To live and work without toothaches or other dental problems, adults need access to affordable dental care. But adults who are unemployed or in low-wage jobs usually cannot afford the cost of private dental insurance. Medicaid is their only realistic vehicle for accessing dental care. Yet Texas' Medicaid program only covers emergency dental treatment for adults. It's time to change that by giving all Medicaid-enrolled adults access to dental services—not just emergency care. It's a smart investment for better health.

Rate this message by circling a number:

1 2 3 4 5

Addendum C:

Promoting Risk-Based Dental Care

Message 1:

Federal health experts report that “caries”—the disease that causes tooth decay—is the No. 1 chronic disease affecting children and teens. We know what the main risk factors are for this disease. Therefore, we have the ability to prevent it. We need to encourage pediatricians, dentists, nurses and others who see kids regularly to do an oral health risk assessment so we know their risk for tooth decay.

Knowing children’s risk level will help us provide the dental services they need to prevent or manage the disease from causing cavities. This will improve health outcomes and reduce the need for costly dental treatments.

Message 2:

Identifying kids who are at high-risk for cavities as early as possible can improve health and save money. Assessing a child’s level of risk can enable us to do that. And we can match dental services with a child’s risk level so that every kid has the opportunity to get ahead of the disease and stay healthy.

From depression to diabetes, our health care system screens people to understand their risk factor. We need to apply the same approach to oral health so we can direct care more appropriately to kids and make the best use of providers’ resources and time.

Message 3:

We shouldn’t have a one-size-fits-all approach to children’s dental health. We need to assess each child’s individual risk for tooth decay and provide the services that reflect their risk level. Some children might need to see a dentist more often than other kids. Some kids might need additional fluoride treatments.

When we do a risk assessment early, we can enable families to work more closely with health professionals to prevent or halt the progression of tooth decay.

Texas Interfaith Center for Public Policy

200 East 30th Street
Austin, TX 78705
512-472-3903
texasimpact.org

Children's Dental Health Project

1020 19th Street NW, Ste. 400 | Washington, DC 20036
202-833-8288
cdhp.org | @Teeth_Matter