Four Projects Aiming to Improve Population Oral Health

CareQuest Institute Continuing Education Webinar

February 10, 2022

CareQuest Institute for Oral Health®

APHA | ORAL HEALTH SECTION

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- Complete the **evaluation by February 18**.
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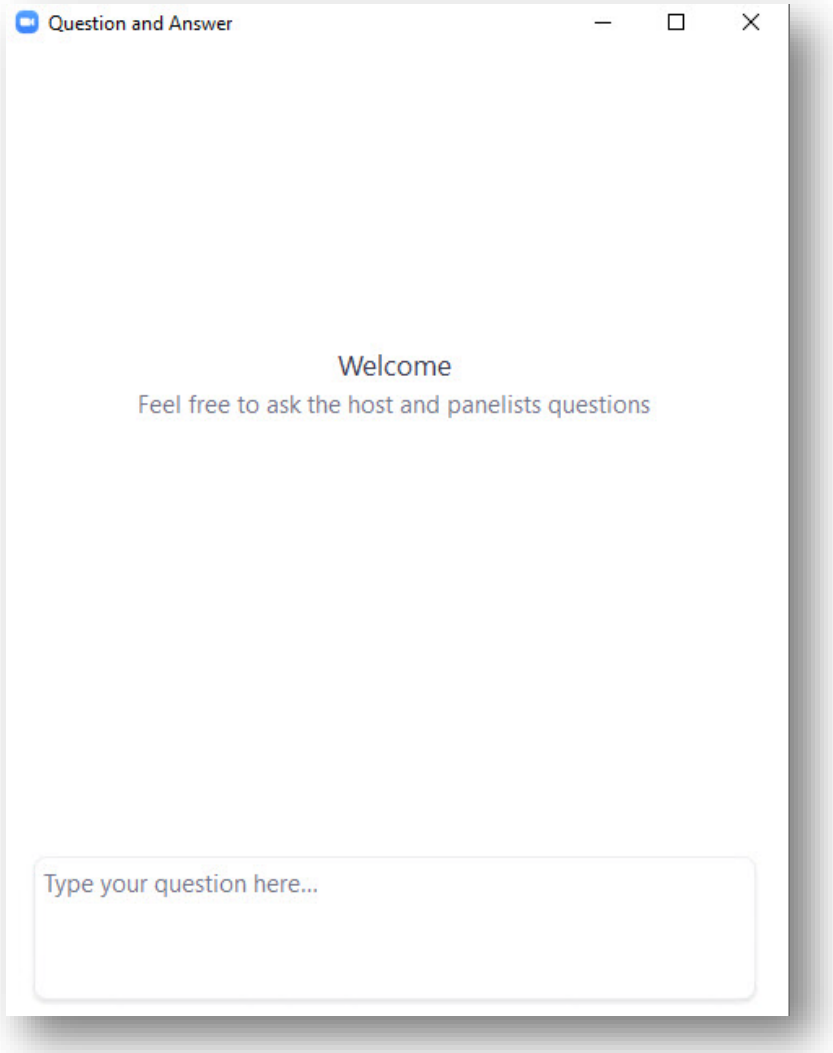
Question & Answer Logistics

- Feel free to enter your questions into the **Question & Answer box** throughout the presentations.
- We will turn to your questions and comments toward the end of the hour.



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Learning Objectives

At the end of this webinar, you'll be able to:

- Identify parental psychosocial factors and dental care disparities among children and adolescents with special health care needs.
- Discuss racial and ethnic disparities within oral cancer among Asian American and non-Hispanic white adults aged 50 and younger
- Recognize the utility of dental providers in HPV prevention efforts based on results from the National Health and Nutritional Examination Survey in 2015-2018.
- Discuss how visualizing county level data can better target dental safety net programs for children.

Our Strategy

Vision

A future where every person can reach their full potential through optimal health

Mission

To improve the oral health of all

Purpose

To catalyze the future of health through oral health

Click to add text

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APHA Oral Health Section Acknowledgments

The APHA Oral Health Section is grateful to the student award committee and reviewers for their hard work in making this award a success.

The APHA Oral Health Section is grateful for the generous support provided by CareQuest Institute for Oral Health for both awards.

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APHA Student Awards

- Anthony Westwater Jong Memorial Population Oral Health Pre-Professional Student Award
- Caswell A. Evans Population Oral Health Post-Professional Student Award

As a part of the awards, students receive mentorship opportunities, two years of APHA membership, APHA meeting registration, and travel support to the annual meeting.

Today's Presenters

CareQuest Institute for Oral Health

APHA ORAL HEALTH SECTION

Parental Psychosocial Factors and Dental Care Disparities among Children and Adolescents with Special Health Care Needs: A Stress Process Model

Arwa Z Gazzaz BDS, MPH, FRCD(C)

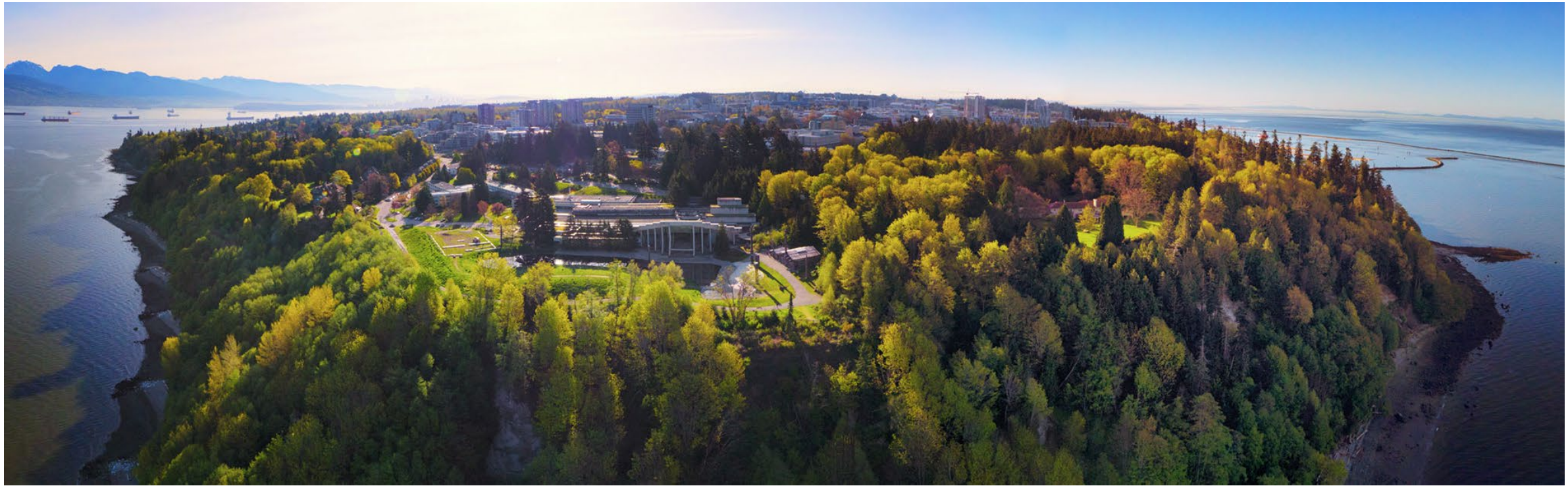
PhD Candidate, Department of Oral Health Science, Faculty of Dentistry

Co-authors: Dr. Richard M. Carpiano, Dr. Denise M. Laronde, Dr. Jolanta Aleksejūnienė

a place of mind

UBC DENTISTRY

Thursday, Feb 10th, 2022

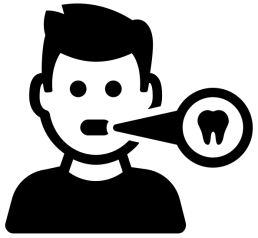


Learn more about why land acknowledgements is important: https://guides.library.ubc.ca/c.php?g=715538&p=5109932

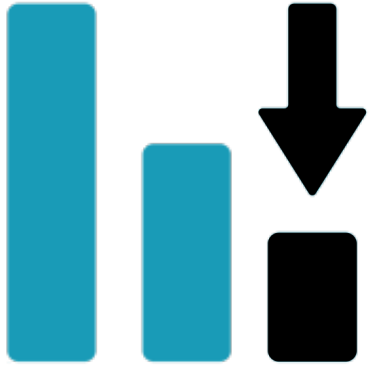
Land Acknowledgment

Background

Children with special health care needs



Unmet dental needs



Barriers to access to dental care

Family and parental factors

Background

Parents and caregivers of special health care needs

- *Daily home-based care (medication, preparing food, brushing, etc.)*
- *Visit to health providers*
- *Other-related issues to child's health*
- *Work–life balance*

Parental psychosocial factors

- *Stressors and resources*

Conceptual framework: The stress process model

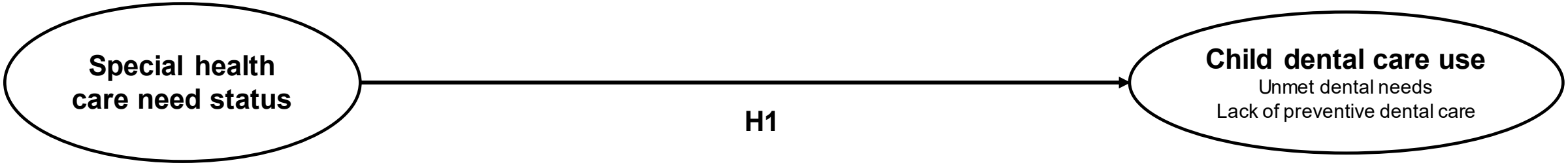
- *Explain how psychosocial factors (stressors and resources) lead to health outcomes.*

Study objectives

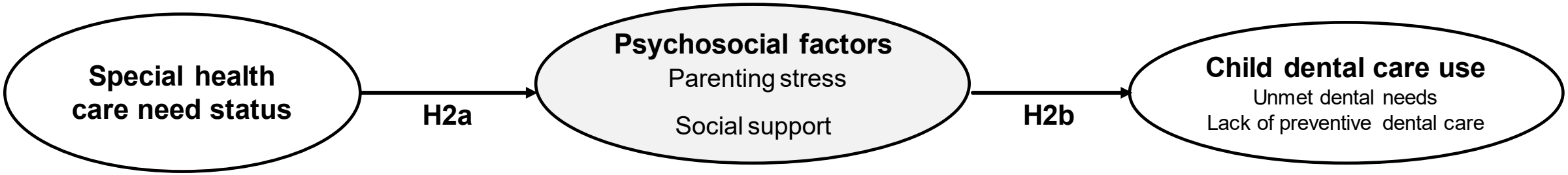
(1) To examine whether dental care varies between children and adolescents with and without special health care needs

(2) To explore the potential role of parental psychosocial factors in the association between child special health care needs and child dental care

Hypotheses


Special health care need status
H1
Child dental care use
Unmet dental needs
Lack of preventive dental care

Hypotheses


Special health care need status
H2a
Psychosocial factors
Parenting stress
Social support
H2b
Child dental care use
Unmet dental needs
Lack of preventive dental care

Hypotheses

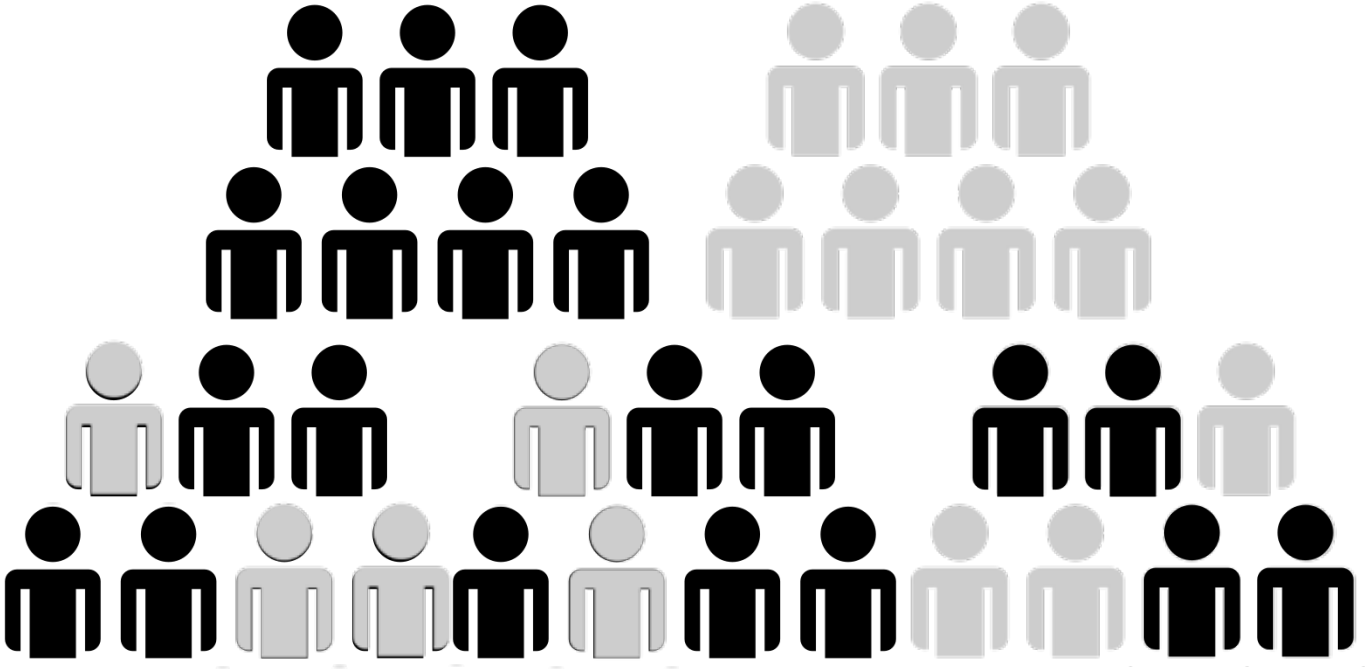

Special health care need status
Psychosocial factors
Parenting stress
X social support
H3
Child dental care use
Unmet dental needs
Lack of preventive dental care

Methods

National Survey of Children's Health
Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

Data source

The United States National Survey of Children's Health (2011/2012)



Excluded < 6 years old

Excluded participants with missing data

Final analytical sample (n= 59,175)

Created by Gan Khoon Lay from the Noun Project

Methods

Measures

Dependent variables

(1) Unmet dental needs (yes/no)

(2) Lack of preventive dental care use (yes/no)

Methods

National Survey of Children's Health
Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

Measures

Independent variables

(1) Child special health care need status

CAHMI
The Child & Adolescent Health Measurement Initiative

Three study groups

(i) None (ii) SHCN with functional limitations (iii) SHCN without functional limitations

(2) Parental psychosocial factors

Parenting stress (3-item scale; Cronbach's α = 0.7)

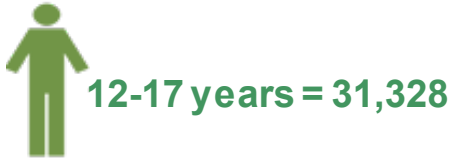
Social support

- **instrumental support** (4-item scale; Cronbach's α=0.9)

- **emotional support** (yes/no)

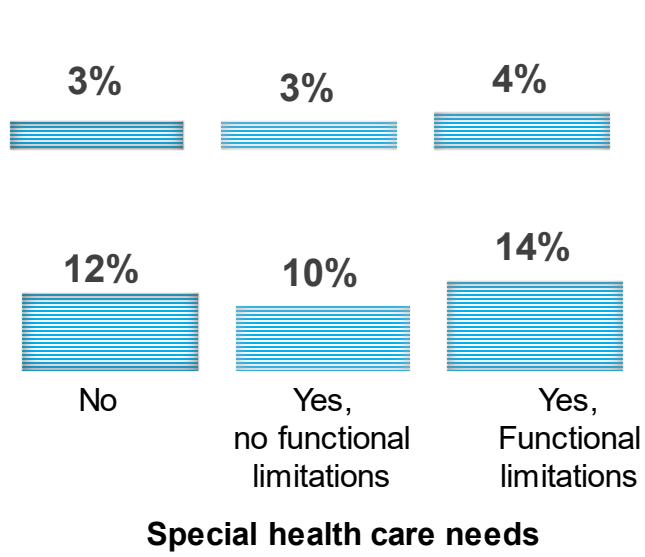
Data were analyzed using Stata software version SE/16 for Mac

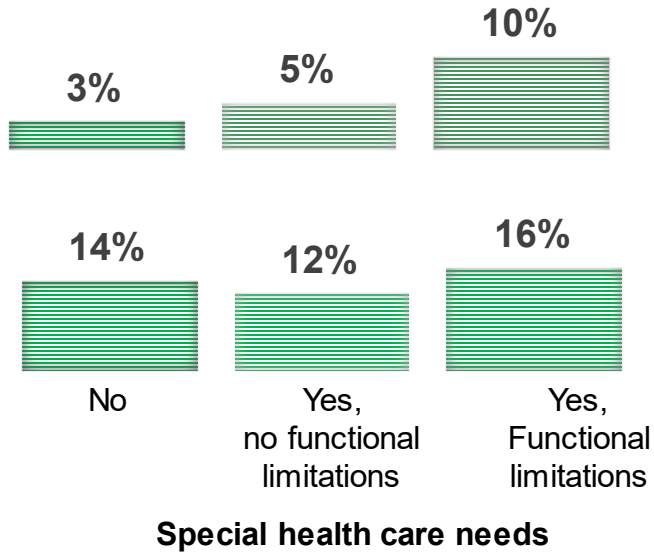
Characteristics of study sample



(1) Unmet dental needs

(2) Lack of preventive dental care use





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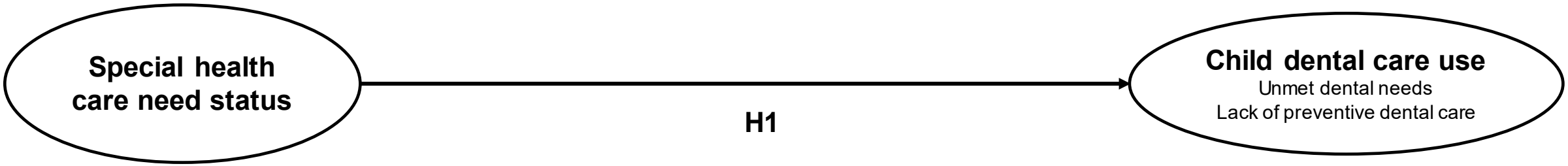

Special health care need status
H1
Child dental care use
Unmet dental needs
Lack of preventive dental care

Results (1)

***H_1*. Children with special healthcare needs are more likely to have unmet dental**

(1) Unmet dental needs

6-11 years

Special health care status	AOR (95% CI)
No	1.0 *(reference)*
Yes (no functional limitations)	1.2 (0.8, 1.7)
Yes (functional limitations)	1.4 (0.8, 2.6)

12-17 years

Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	1.6* (1.1, 2.3)
Yes (functional limitations)	3.2* (1.9, 5.3)

*AOR: Adjusted odds ratio; CI: Confidence interval

Results (1)

***H_1*. Children with special healthcare needs are more likely to lack preventive dental care**

(1) Unmet dental needs

(2) Lack of preventive dental care

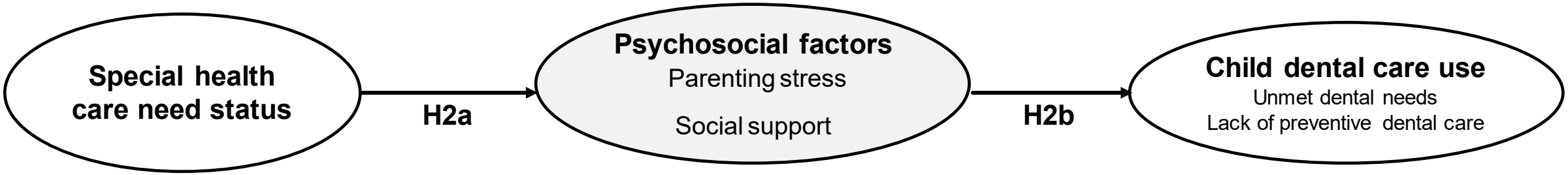
6-11 years

Special health care status	AOR (95% CI)
No	1.0 *(reference)*
Yes (no functional limitations)	0.8 (0.6,1.1)
Yes (functional limitations)	1.1 (0.7,1.7)

12-17 years

Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	0.9 (0.7,1.2)
Yes (functional limitations)	1.1 (0.7,1.5)

*AOR: Adjusted odds ratio; CI: Confidence interval


Special health care need status
H2a
Psychosocial factors
Parenting stress
Social support
H2b
Child dental care use
Unmet dental needs
Lack of preventive dental care

Results (2a)

H_{2a} **Parent of children with special healthcare needs are more likely to report higher parenting stress**

Parenting stress

6-11 years

Special health care status	B (95% CI)
No	1.0 *(reference)*
Yes (no functional limitations)	0.3* (0.3 ,0.4)
Yes (functional limitations)	0.7* (0.5, 0.8)

12-17 years

Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	0.3* (0.3, 0.4)
Yes (functional limitations)	0.6* (0.4, 0.7)

*B: Regression coefficient *AOR: Adjusted odds ratio; CI: Confidence interval

Results (2a)

H_{2a} **Parent of children with special healthcare needs are more likely to report lower social support**

Parenting stress

	Social support (instrumental) B (95% CI)
Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	−0.1 (−0.1, 0.1)
Yes (functional limitations)	−0.1 (−0.2, 0.1)

6-11 years

Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	−0.1* (−0.1, −0.2)
Yes (functional limitations)	−0.2* (−0.2, −0.1)

12-17 years

*B: Regression coefficient *AOR: Adjusted odds ratio; CI: Confidence interval

Results (2a)

H_{2a} **Parent of children with special healthcare needs are more likely to report lower social support**

6-11 years

Parenting stress	Social support (Instrumental)	**Social support (emotional)** AOR (95% CI)
Special health care status		
No		1.0 *(reference)*
Yes (no functional limitations)		0.9 (0.7,1.2)
Yes (functional limitations)		0.5* (0.3, 0.7)

12-17 years

Special health care status	
No	1.0 *(reference)*
Yes (no functional limitations)	1.1 (0.9,1.4)
Yes (functional limitations)	0.9 (0.6,1.3)

*B: Regression coefficient *AOR: Adjusted odds ratio; CI: Confidence interval

Results (2b)

H_{2b} **Parents with higher parenting stress and lower social support are more likely to report unmet dental needs for their children**

(1) Unmet dental needs

AOR (95% CI)

6-11 years

Parental psychosocial factors	
Parenting stress	1.1 (0.8, 1.3)
Social support (Instrumental)	0.6* (0.5, 0.8)
Social support (Emotional)	1.1 (0.7, 1.7)

12-17 years

Parental psychosocial factors	
Parenting stress	1.2 (0.9, 1.4)
Social support (Instrumental)	0.7* (0.5, 0.8)
Social support (Emotional)	1.1 (0.7, 1.7)

*AOR: Adjusted odds ratio; CI: Confidence interval

Results (2b)

H_{2b} **Parents with higher parenting stress and lower social support are more likely to lack preventive dental care for their children**

	(1) Unmet dental needs	(2) Lack of preventive dental care
		AOR (95% CI)
6-11 years		
Parental psychosocial factors		
Parenting stress		1.1 (0.9, 1.2)
Social support (Instrumental)		0.9 (0.7, 1.0)
Social support (Emotional)		0.9 (0.7, 1.3)
12-17 years		
Parental psychosocial factors		
Parenting stress		1.0 (0.9, 1.1)
Social support (Instrumental)		0.9 (0.8, 1.0)
Social support (Emotional)		0.9 (0.7, 1.2)

*AOR: Adjusted odds ratio; CI: Confidence interval

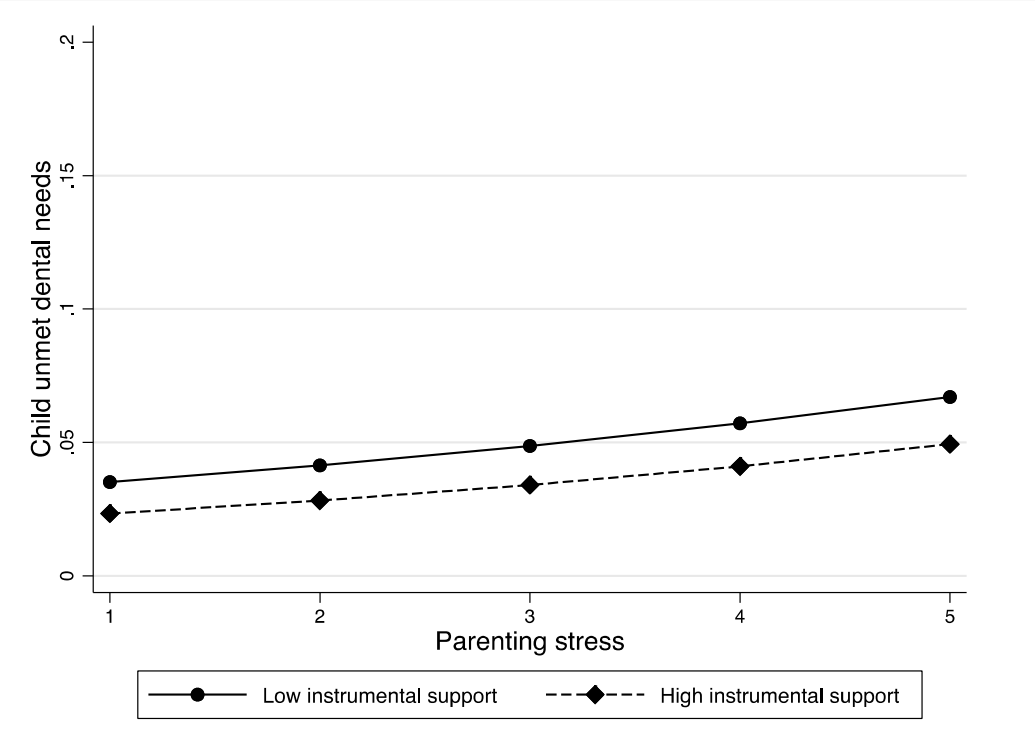

Special health care need status
Psychosocial factors
Parenting stress
X social support
H3
Child dental care use
Unmet dental needs
Lack of preventive dental care

Results (3)

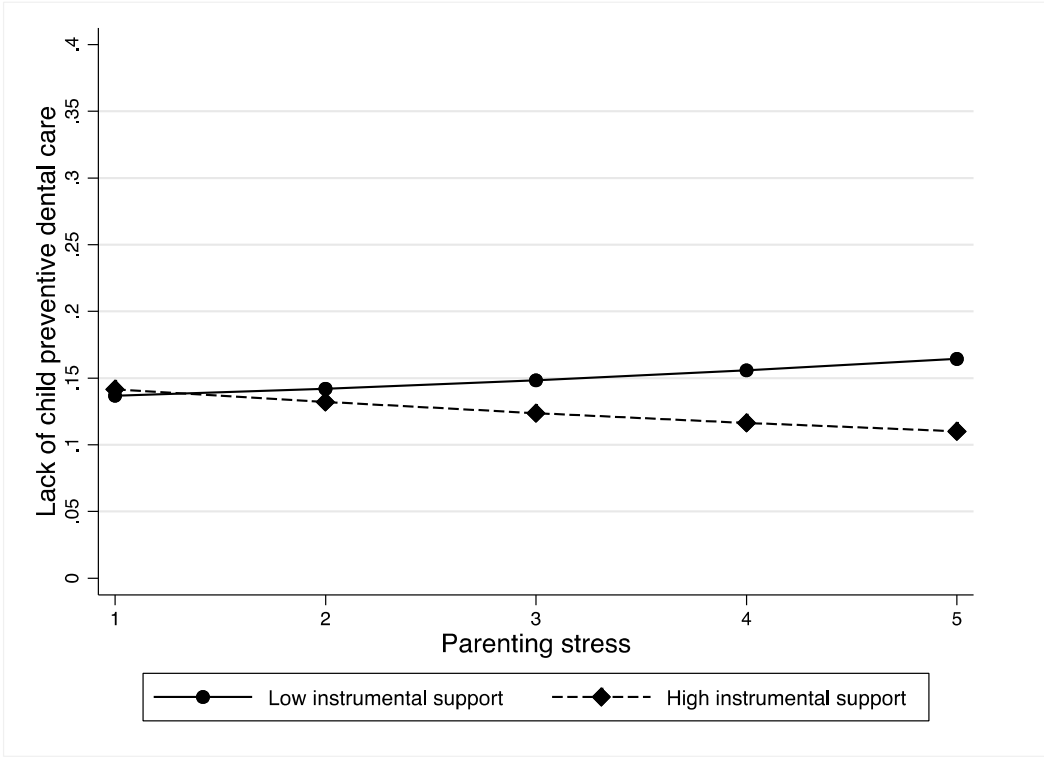
***H_3* Parental social support buffers the association between parenting stress and child dental outcomes**

12-17 years

(1) Unmet dental needs



(2) Lack of preventive dental care



Instrumental social support

*Predicted probabilities for child dental care outcomes

Summary of main findings

Disparities in child **unmet dental needs** based on special health care need status were observed in **adolescents**.

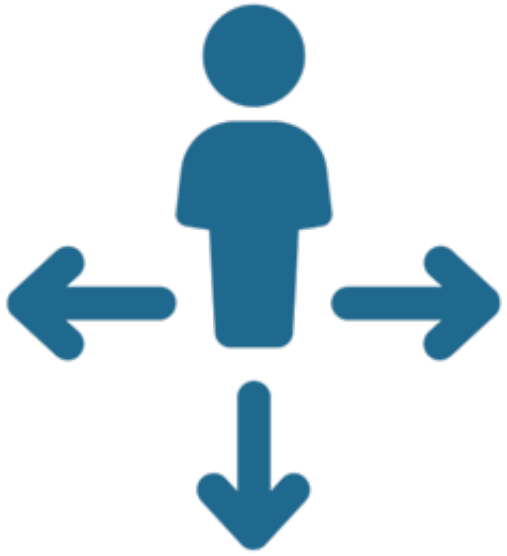
Parents of children and adolescents with special health care needs were more likely to report **higher parenting stress** and **lower social support.**

Parents of **adolescents** with special health care needs were more likely to report **lower** parental instrumental support and **higher** child unmet dental needs.

Parental social support **buffered** some of the effects of parenting stress on child dental care.

Implications and future directions

Special health care needs-based differences in dental care may represent an **unrecognized** oral health disparity



The importance of **parental psychosocial factors** in child dental care

Future studies could explore additional **psychosocial factors** in relationship with other oral health outcomes in children with special health care needs

Created by Adrien Coquet from Noun Project

Thank you

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Oral Cancer Screening Disparities Experienced by Low-income Asian Americans Aged 18-50

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Center for Asian Health
Lewis Katz School of Medicine
Temple University

Coauthors: Lin Zhu, PhD, Bohui Wang, ML, Di Zhu, Ming-chin Yeh, PhD, Grace X. Ma, PhD

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Background

- Asian Americans (AAs) have higher incidence and mortality rates of oral cancer.
- Risk factors: tobacco and alcohol consumption, diet, low HPV vaccination, etc.
- **Oral cancer screening**:
  - Oral cancer screening disparities
  - Identify high-risk/vulnerable AA populations who are less likely to receive oral cancer screen services

Center for Asian Health

Data and Analytic Approach

- National health and nutrition examination survey 2011-2018 (NHANES)
  - N= 1540 (478 AAs and 1062 non-Hispanic whites)
  - Ages 18-50
  - Low-income
- Bivariate analysis & multiple logistic regressions
  - Examine the association between demographic/behavioral factors and oral cancer screening
  - Identify the risk factors associated with oral cancer screening disparities

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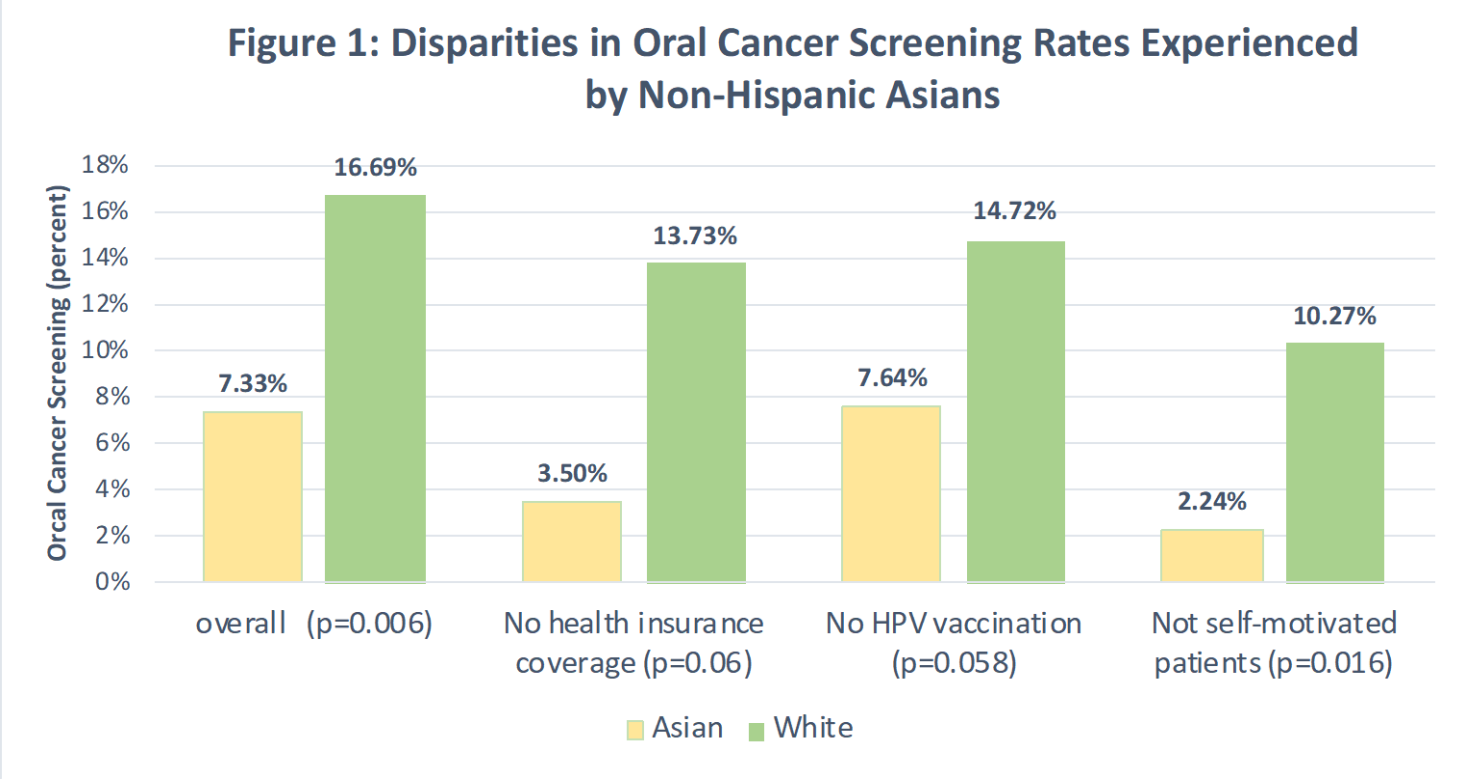
Results

Table 1: Demographic Characteristics And Oral Cancer Risk Factors By Racial Groups

	Asian (N=478)	**Whites (N=1062)**	**Total (N=1540)**	***p* value**
Mean Age (years)	32.22	31.34		0.216
Born in the US (%)				**<0.001**
Yes	20.87%	94.28%	84.59%	
No	79.13%	5.75%	15.51%	
Ratio of income to poverty levels	0.53	0.57		0.278
Health Insurance coverage (%)				0.934
Yes	72.69%	72.39%	72.43%	
No	27.57%	27.61%	27.57%	
HPV Vaccine Initiation (%)				.539
Yes	14.72%	16.68%	16.4%	
No	85.28%	83.32%	85.28%	
Dental Visit in past 6 month (%)				0.4204
Yes	36.54%	33.45%	33.86%	
No	63.46%	66.55%	66.14%	
Main reason for last dental visit (%)				**<0.001**
Self-motivated check-up visit	62.96%	52.72%	54.01%	
Other Reason	37.04%	47.28%	47.28%	
Told importance of oral cancer screening, (among self-motivated patients) (%)				**0.0635**
Yes	12.94%	23.54%	21.89%	
No	87.06%	76.46%	78.11%	

Center for Asian Health

Results



Center for Asian Health

Results

Table 2. Results of logistic regression on the likelihood of getting oral cancer screening by Dental Visit Frequency by Race

	Odds Ratio of Dental Visit Frequency	p value
Asian (N=478)	0.45	0.042
Whites(N=1062)	0.75	0.005

Note: controlled for gender, age, education, marital status, income, health insurance coverage, smoking, self-rated oral health status in both logistic regressions.

Center for Asian Health

Conclusion

- AAs experience oral cancer screening disparities.
- There is an urgent need of educational intervention to promote oral cancer screening for AAs, especially among high-risk subpopulations.
- It is important to improve dentists' awareness of AAs' oral cancer screening needs.

Center for Asian Health

Discussion and Next Steps

- Cultural barriers to oral health services
- Data limitation
- Community outreach to hard-hitting communities

Center for Asian Health

Acknowledgement

This study is supported by Anthony Westwater Jong Population Oral Health Pre-Professional Award. It is also partially supported by TUFCCC/HC Regional Comprehensive Cancer Health Disparity Partnership, Award Number U54 CA221704(5) (PI: Grace X. Ma, PhD) from the National Cancer Institute of National Institutes of Health (NCI/NIH). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the funding agencies.

Center for Asian Health

Thank you

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Dentists & HPV Vaccinations

What we can learn from NHANES

Megan Cloidt, DDS, MPH

February 10, 2022

CareQuest Institute for Oral Health™

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Background

- **Human papillomavirus (HPV)** is the most common sexually transmitted infection (STI) in the U.S. with nearly every sexually active person having an HPV infection in their lifetime (National Cancer Institute, 2021).
- HPV-related **oropharyngeal cancer** cases are rising, with an estimated 3,500 new cases per year in women and 16,200 per year in men (CDC, 2021).
- Dentists participate in detection of oral cancer by performing oral cancer screenings. **Dentists** do not routinely participate in primary HPV prevention, including counselling, referrals, and/or vaccinations (Daley EM, 2018; Griner SB, 2019; Harris KL, 2020).

Background

Why do dentists not routinely participate in primary HPV prevention, including counselling, referrals, and/or vaccinations?

- ✓**Uncomfortable** speaking about this topic to patients & parents
- ✓Self-perception of **lacking knowledge** in the subject matter
- ✓By and large, **state practice laws** do not allow dentists to administer vaccines (Daley EM, 2018; Griner SB, 2019)
  - Exception = Oregon allows dentists to administer vaccines, including the HPV vaccine

Objectives

1. To **determine the prevalence of HPV-unvaccinated adolescents and young adults who had a dental visit in the last year**, including those who did not have a medical visit.
   - *If this group represents a significant proportion of unvaccinated adolescents, there is the **potential** for oral health providers to fill this gap and play a critical role in the primary prevention of HPV-related cancers.*
2. To **examine an association between last visit to the dentist and HPV vaccination status**.

Methods

- A cross-sectional study was conducted using data from the **National Health and Nutrition Examination Survey (NHANES)** from 2015-2018, including participants **9-26 years**.

- Descriptive statistical analyses were conducted to characterize the study population and calculate the prevalence of HPV vaccination in adolescents and young adults, including those who had a dental visit in the last year but not a medical visit.

- Logistic regression analyses were performed to examine the association between last visit to the dentist and HPV-vaccination status.

Results

Of all participants, **38.6% were vaccinated for HPV**, with higher prevalence of vaccination in those with the following characteristics: female, older age, higher income, higher education level, and having medical insurance.

Table 1 – Prevalence of HPV Vaccination

Overall n	HPV Vaccinated n (%)	Not HPV Vaccinated n (%)
4,234	1,507 (**38.63**)	2,727 (61.37)

Data are presented as unweighted number (n) and weighted percentage (%). Chi-square tests and weighted t-tests were used. HPV Vaccinated is defined as receiving ≥1 dose of the HPV vaccine.

Results

- Participants who had a dental visit in the last year had an HPV vaccination rate of 40.8%.
- Of those who had a dental visit and were not vaccinated for HPV, 12.5% did not have a medical visit, which approximates **3,640,709 million adolescents and young adults**.

Table 2 - Last Medical Visit and Last Dental Visit Stratified by HPV Vaccination Status

		Dental visit in the last year n (%) 3127 (72.77)	**No dental visit in the last year** n (%) 1082 (27.23)	**p-value**
HPV Vaccinated (n = 1,502)		1164 (40.76)	338 (34.50)	<0.001
	Medical visit in the last year	1076 (93.14)	270 (79.84)	
	No medical visit in the last year	88 (6.86)	68 (20.16)	
Not HPV Vaccinated (n = 2,707)		1963 (59.24)	744 (65.50)	<0.001
	Medical visit in the last year	1720 (87.48)	467 (65.68)	
	No medical visit in the last year	243 (12.52)	277 (34.32)	

Data are presented as unweighted number (n) and weighted percentage (%). Chi-square tests were used.

Results

Having a dental visit in the last year **increased the odds** of being vaccinated for HPV (OR 1.69 [CI 1.26-2.28])

Table 3 – Association of HPV Vaccination Status and Select Variables			
	Point Estimate	95% Wald Confidence Limits	
Age (years)	1.10	1.07	1.12
Sex Female (ref=male)	2.35	1.74	3.18
Had a medical visit in the last year, Yes vs No (ref = no)	1.87	1.31	2.66
Had a dental visit in the last year, Yes vs No (ref = no)	1.69	1.26	2.28

ORs shown are for fully adjusted models, adjusted for age, ratio of income to poverty, BMI, sex, household income, race, education, insurance status, last medical visit, last dental visit, received Hepatitis A vaccine, received Hepatitis B vaccine.

Discussion

- This study suggests that approximately **3.6 million HPV-unvaccinated adolescents and young adults** had only a dental visit and no medical visit in the last year. This highlights the potential importance of **utilizing dental providers as an HPV prevention access point**.
- Our findings support the **recommendation for all dentists to recommend the HPV vaccine to their eligible patients**, especially considering the positive effect provider counseling can have on vaccine uptake.
- Further efforts are needed to motivate dental providers to discuss the HPV vaccine in the clinical setting.
- Scope of practice laws and lack of insurance reimbursement serve as **barriers** for dentists to administer the HPV vaccine.
- Given these findings and the findings of other researchers, **advocacy** efforts are needed to push forward necessary changes in legislation at the state level.

Dentists see a significant number of adolescents and young adults who are unvaccinated for HPV in a given year and could serve as an **access point for HPV vaccine delivery** in the future.

Publication

- This paper is currently published electronically in the Journal of Adolescent Health (JAH) – Articles Online First section.
- In print April 2022 (available online March 16, 2022)
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Thank you co-authors and mentors!

Thank You

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Visualizing County Level Data to Better Target Dental Safety Net Programs for Children

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CDC DENTAL PUBLIC HEALTH RESIDENT 2019-2021

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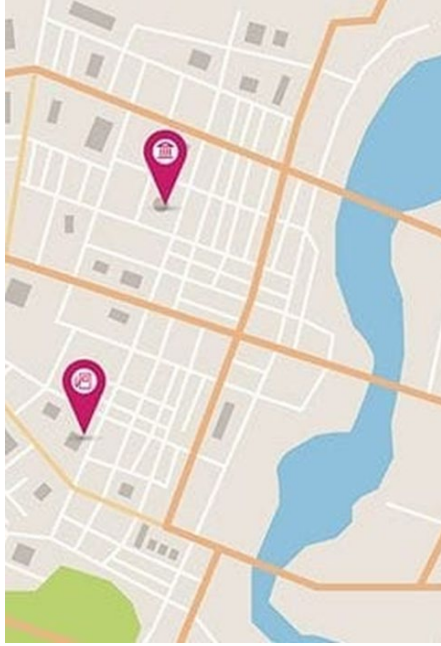
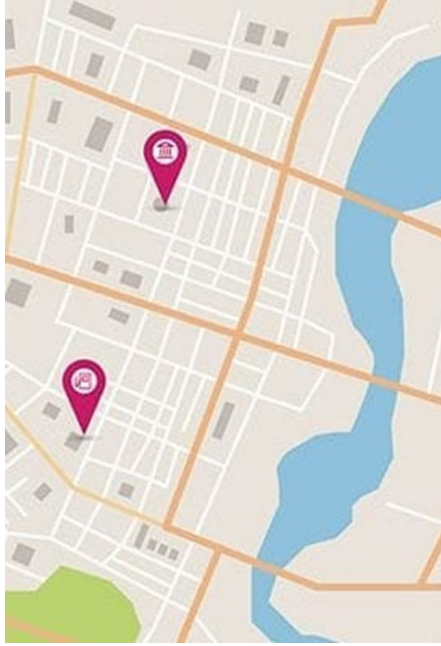
Brief Overview

- OBJECTIVE
- BACKGROUND
- METHODS
- RESULTS
- CONCLUSION

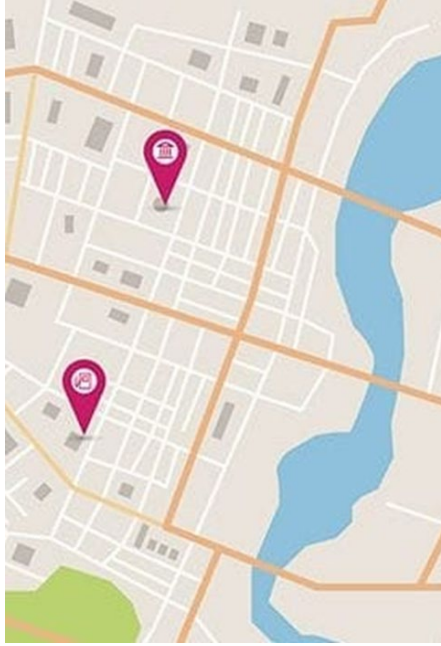


Objectives



- A visual perception of the allocation of current dental safety net programs in Georgia, via GIS mapping.
- Illustrate maldistribution of dental workforce and poor overall access to oral health prevention services.
- Highlight access to oral health prevention services disparities in counties with greater numbers of Health Professional Shortage Area (HPSA)

Background



- Untreated caries is one of the most prevalent childhood diseases
- It can result in pain and infection leading to missed school days and lower school performance
- Untreated caries is largely preventable with the use of dental sealants and fluoride
- Prevalence of untreated dental caries among children, age 6 to 9 years, 19% compared to similar age at the national level was (15.5%) 2013-2016
- Create a visualizing tool to assess how well current dental safety-net programs are allocated across the state.

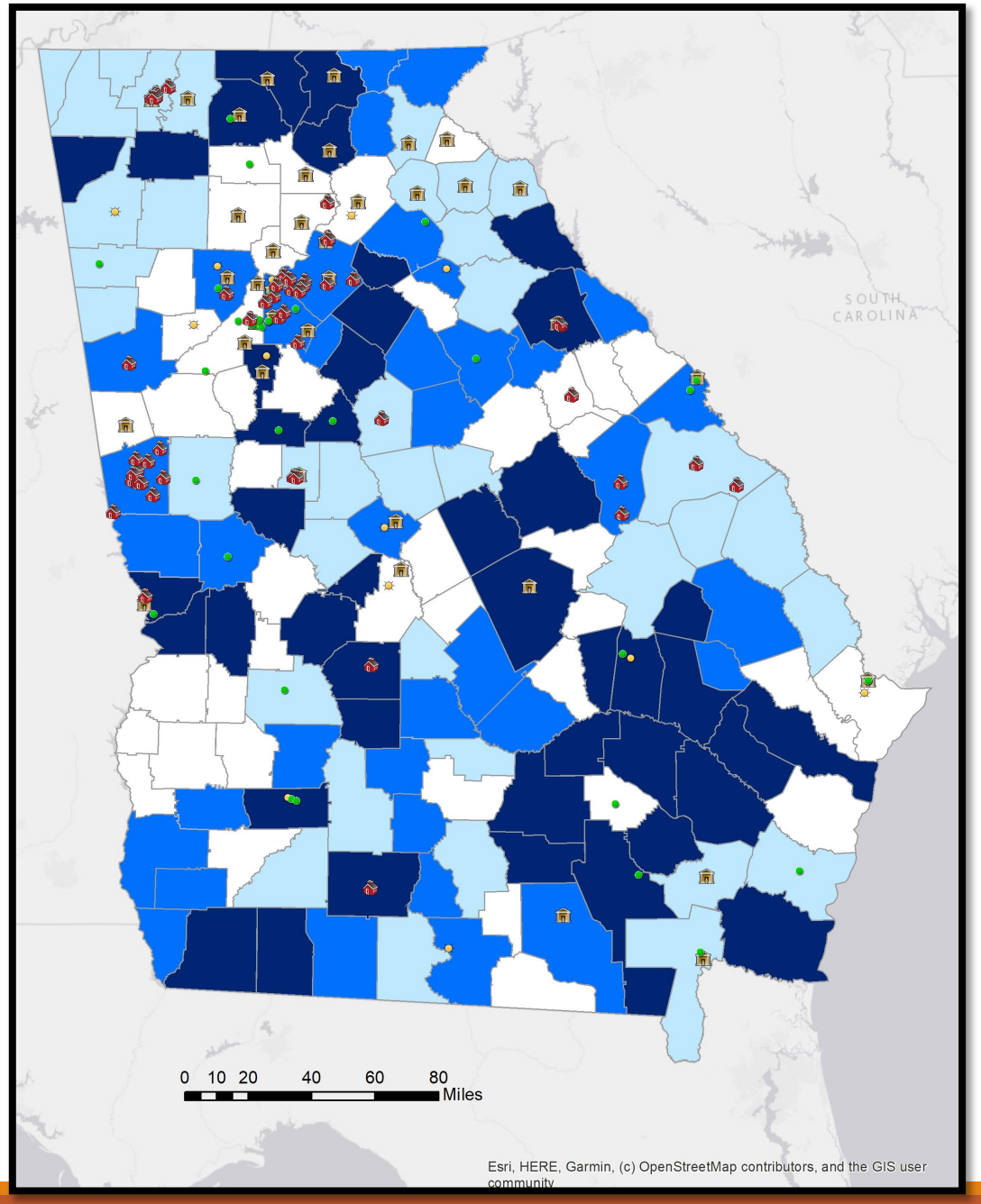
GA Counties by DHPSA and Caries 6-9 years old

Need for dental safety net programs for children aged 6-9 years

- high UD prevalence and high D_{short}
- high UD prevalence and low D_{short}
- low UD prevalence and high D_{short}
- low UD prevalence and low D_{short}

Current dental safety net programs

- school sealant program
- DPH site offering dental services
- FQHC offering dental services
- dental hygiene program serving community



Census Tract Categorized by DHPSA and Caries 6-9 years old in Cobb, Dekalb, Fulton, and Gwinnett Counties

Need for dental safety net programs for children aged 6-9 years

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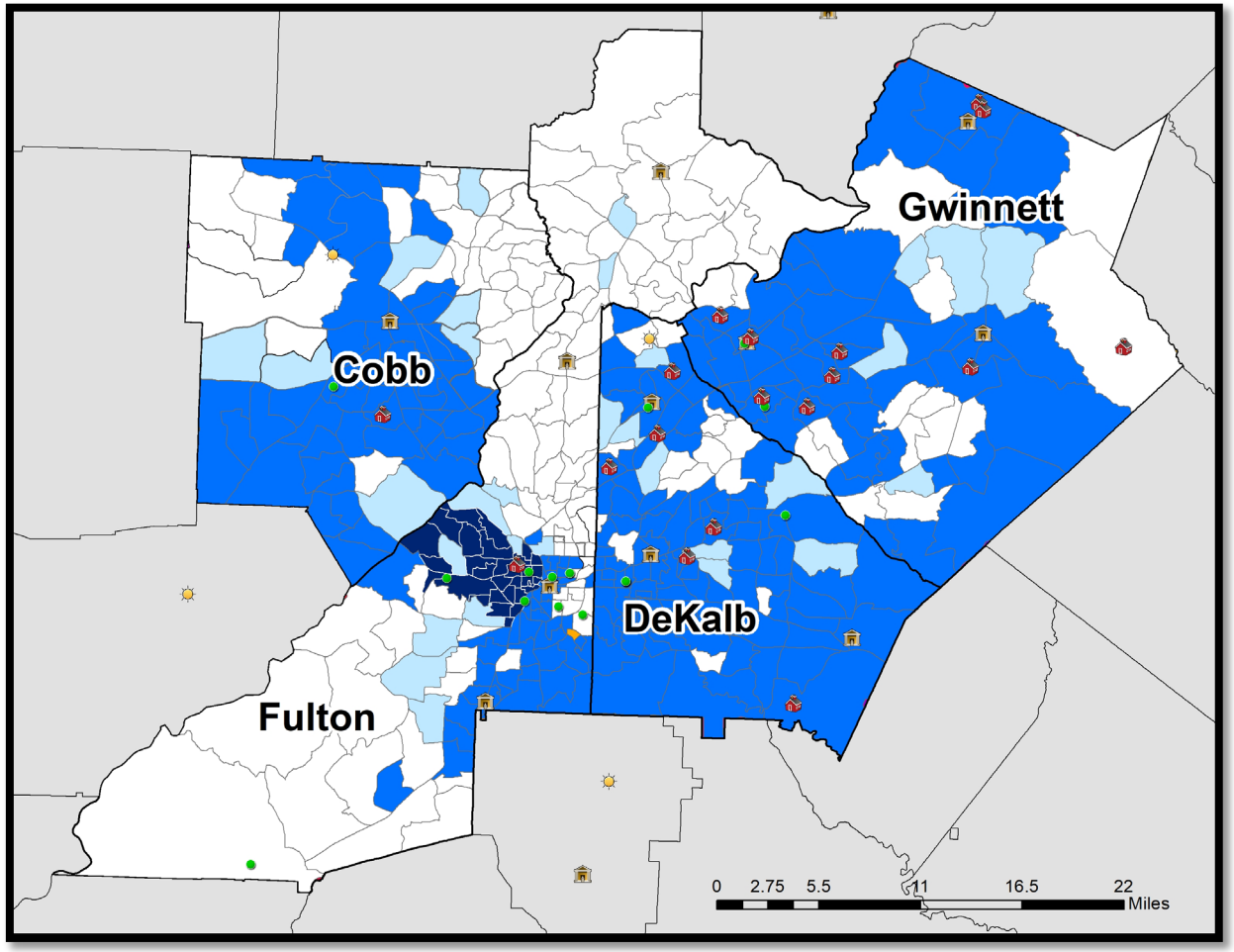
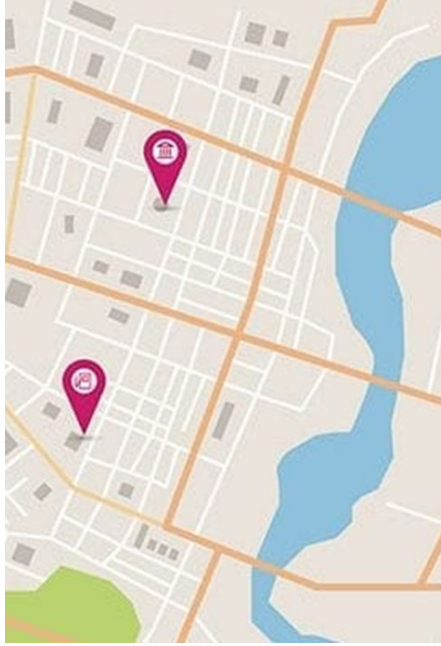


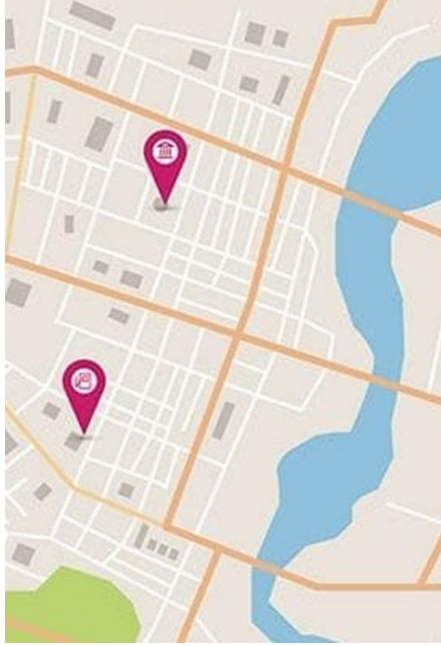
Methods



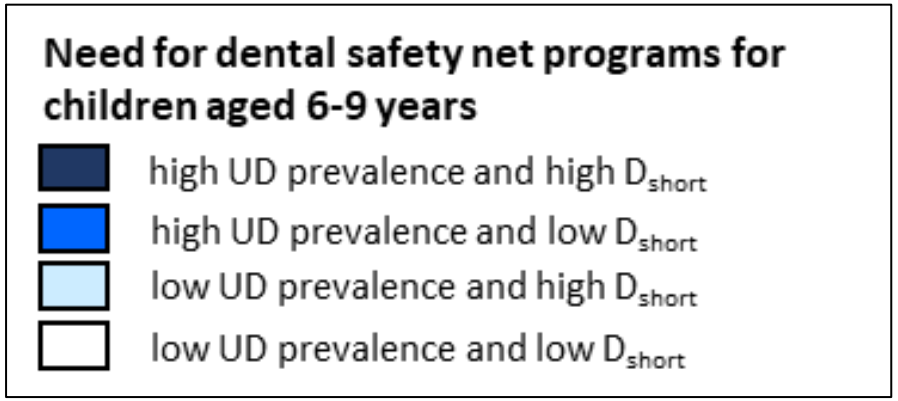
We used data from the Health Resources and Services Administration (HRSA) on the shortage of dental practitioners in each Georgia county designated as a geographic or population-based Dental Health Professional Shortage Area (DHPSA).

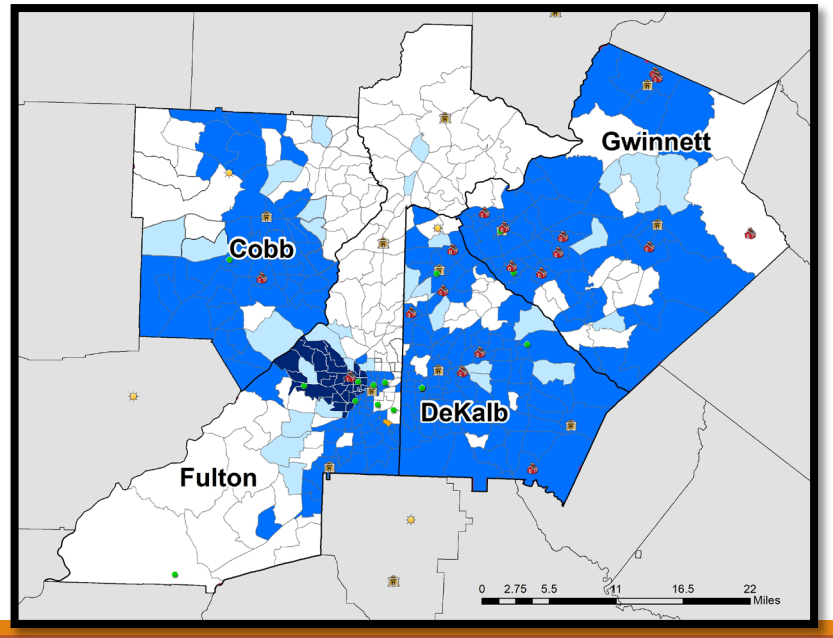
- Use of ArcGIS to associate datasets with each other by displaying Safety Net locations with dental access data in a single map by county.
- Relate dental workforce data to the Georgia map by displaying workforce data by county.
- Relate dental workforce data by displaying workforce data by census tract in the Atlanta metro counties.

Methods (continued)



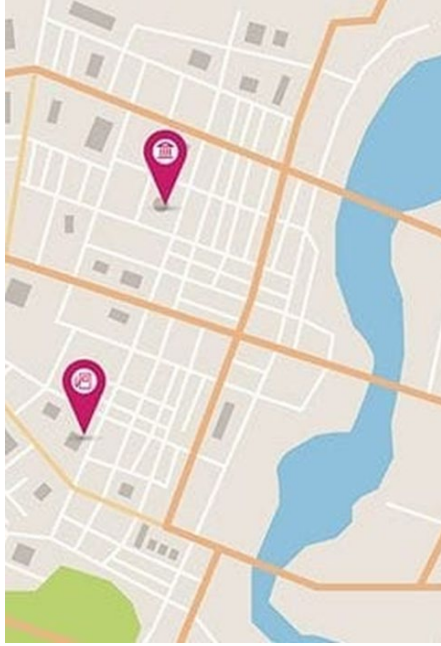
- We estimated need for dental safety net programs for each of the 159 Georgia counties and for each census tract in the four counties comprising metropolitan Atlanta: Cobb (120 tracts), DeKalb (143), Fulton (202), and Gwinnett (113).

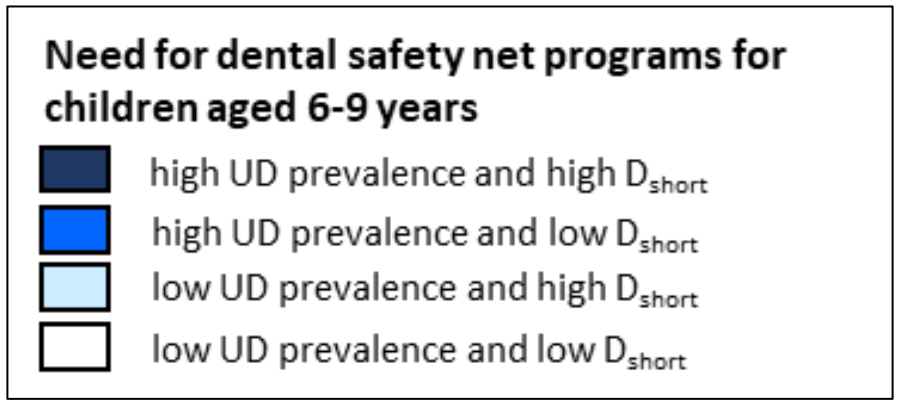


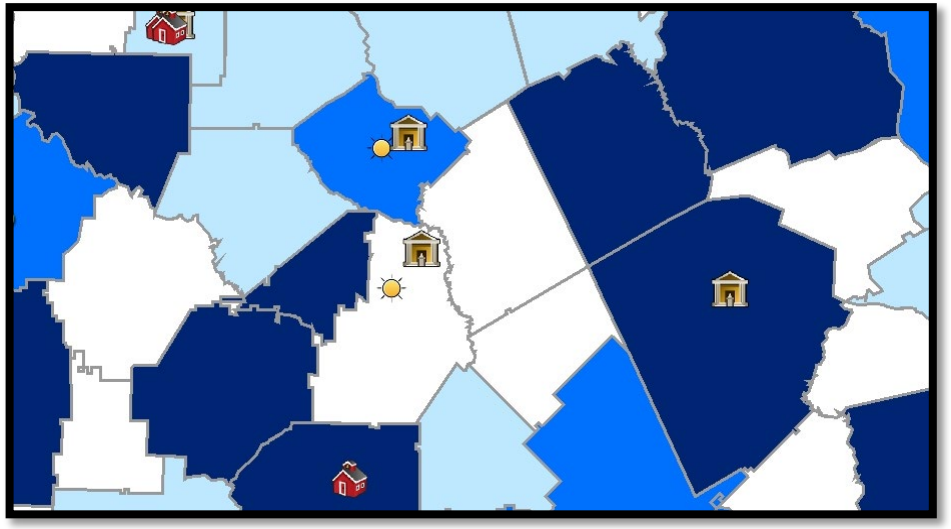


Methods (continued)

- We defined counties with estimated UD prevalence ≥ the median (20.1%) as having high UD prevalence (range: 20.1%–49.5%) and those with prevalence < the median as having low UD prevalence (range: 8.5%–19.9%).

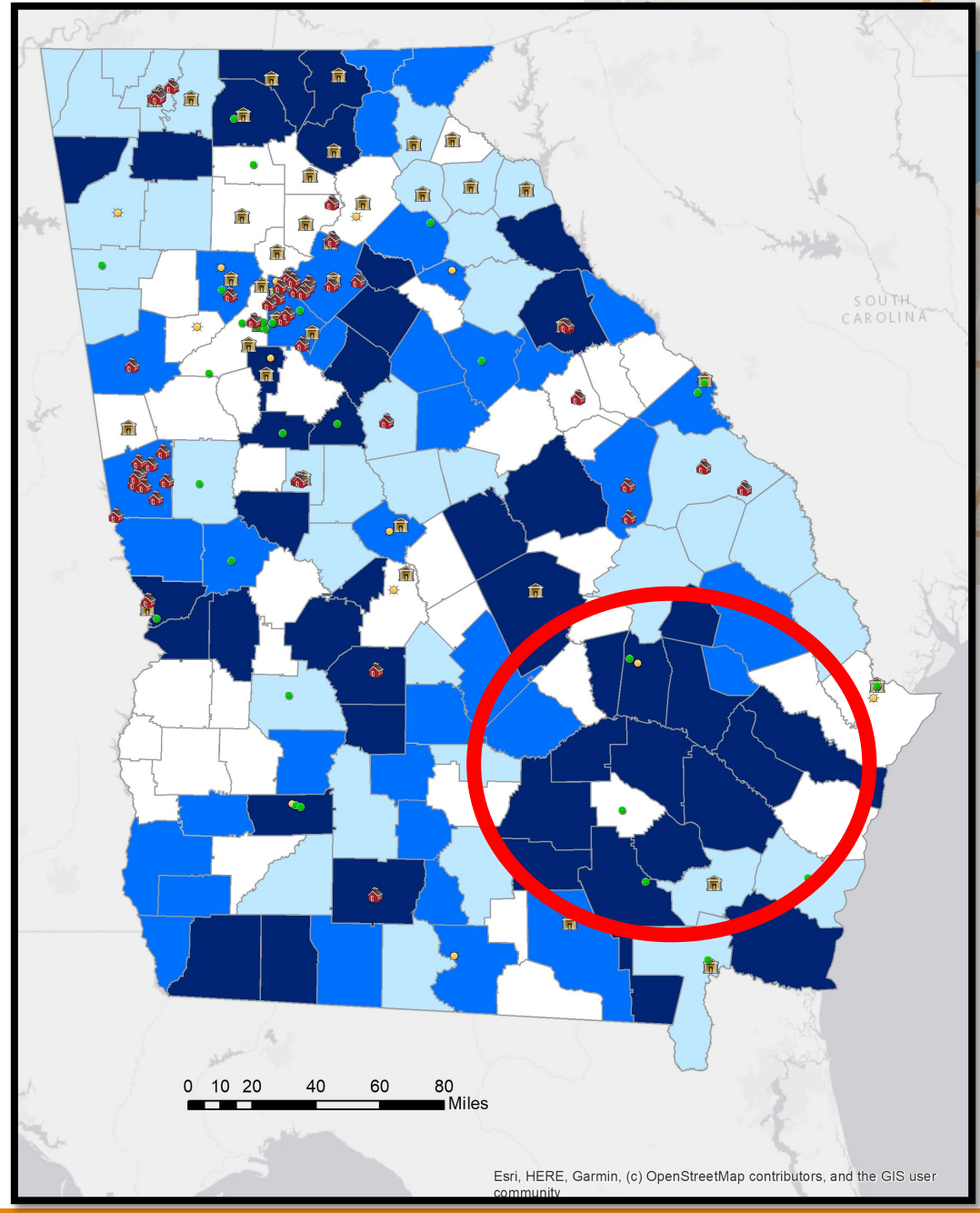






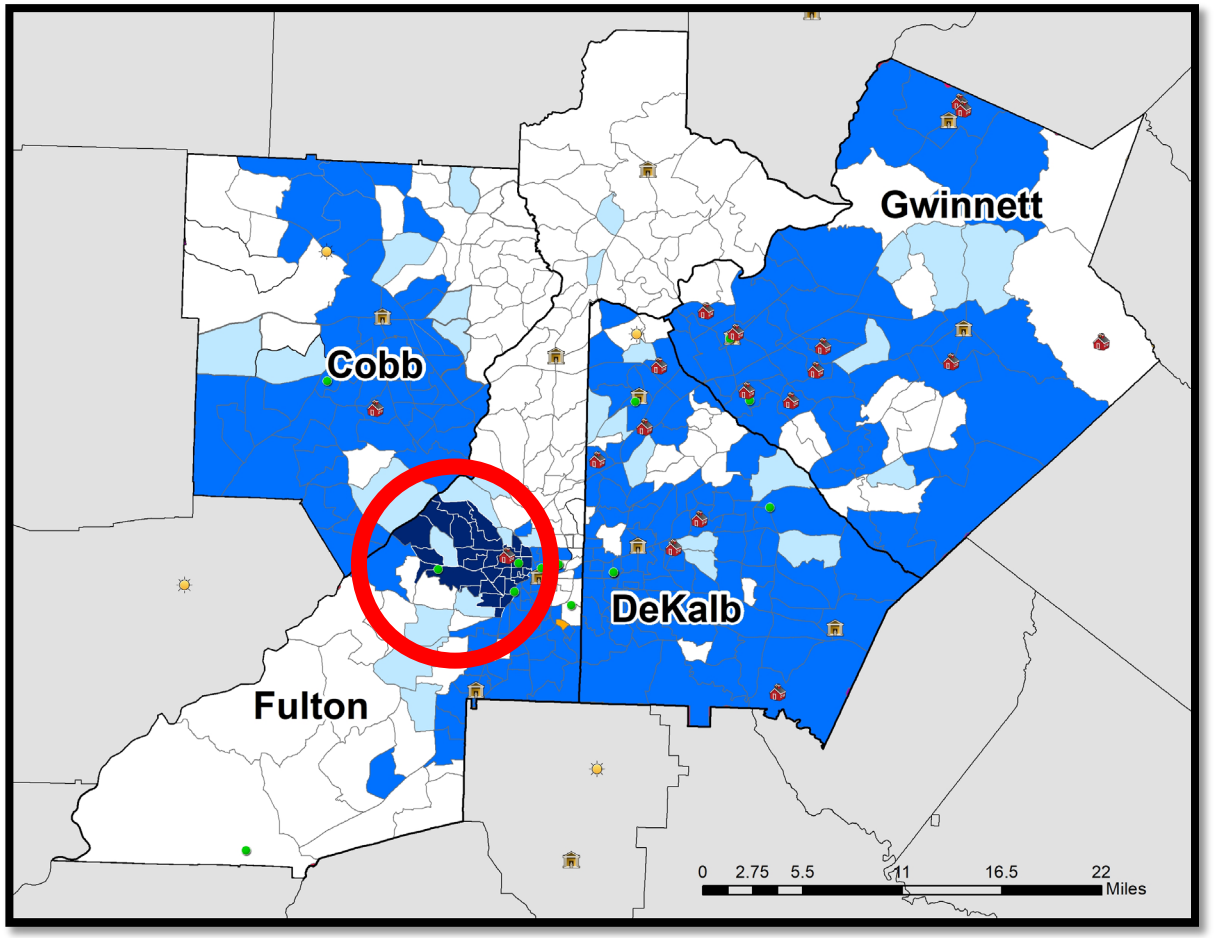
Results

- Our visualization shows good allocation of current dental safety-net programs. There is no indication of significant resource allocation in areas of low need. However, in high-need areas, there is heavy placement of programs in the metro-Atlanta area relative to the rest of the state. This is especially problematic in southeast Georgia where many of the highest need counties are located.

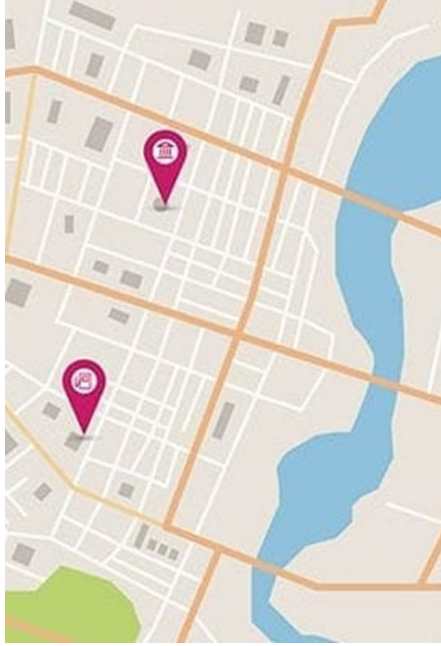


Results

- We also illustrate the importance of more refined visualization in areas with diverse populations, such as metro areas. At the county level, small pockets of need may be missed, as is evident here in the case of Fulton county



Conclusions



This visualization tool can help decision makers to assess how well current DSN are allocated across their state and gaps in allocation where needs could be better addressed in future program planning.

Thank you!

Contact Information

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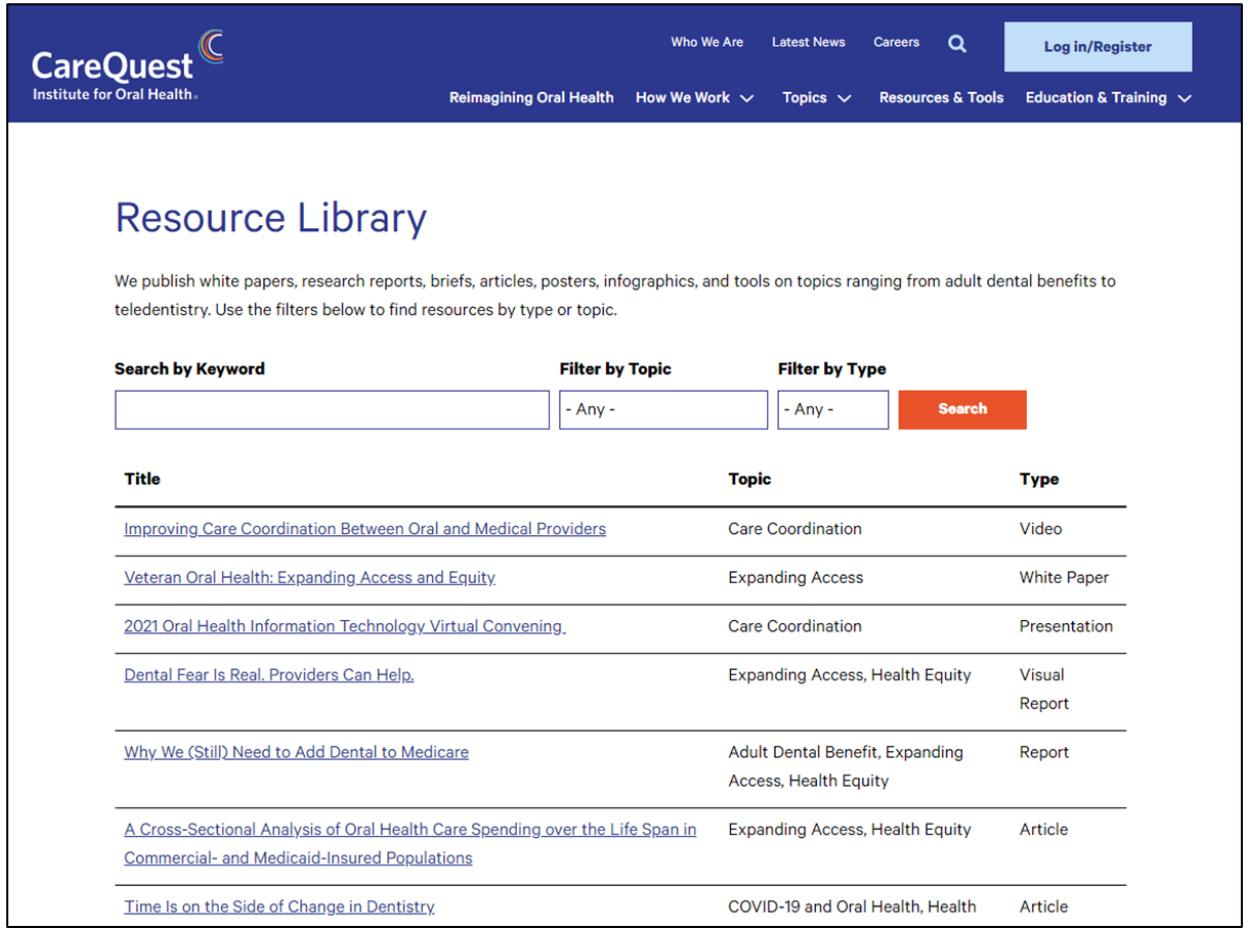
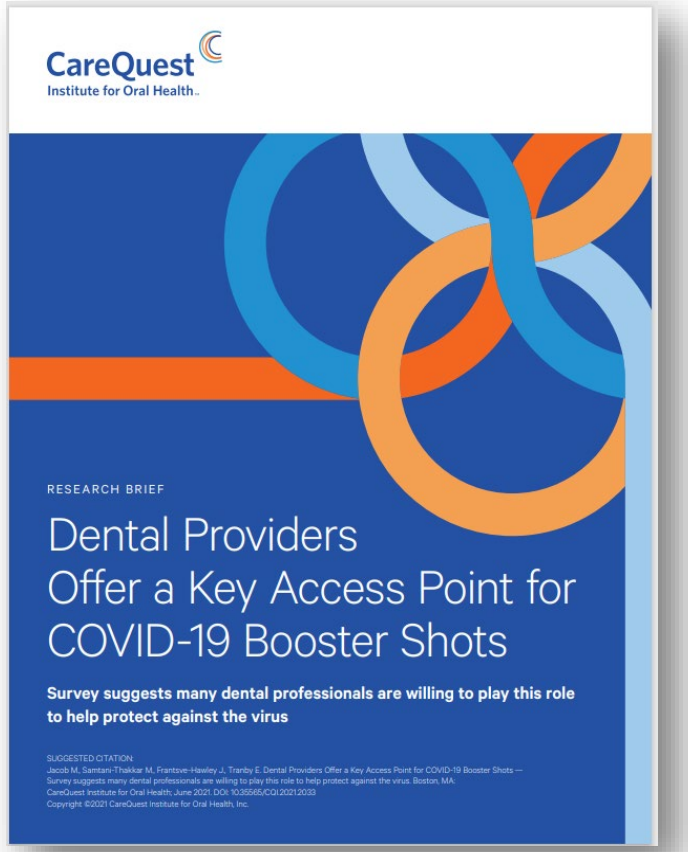
Questions

To Explore More Industry-Leading Research





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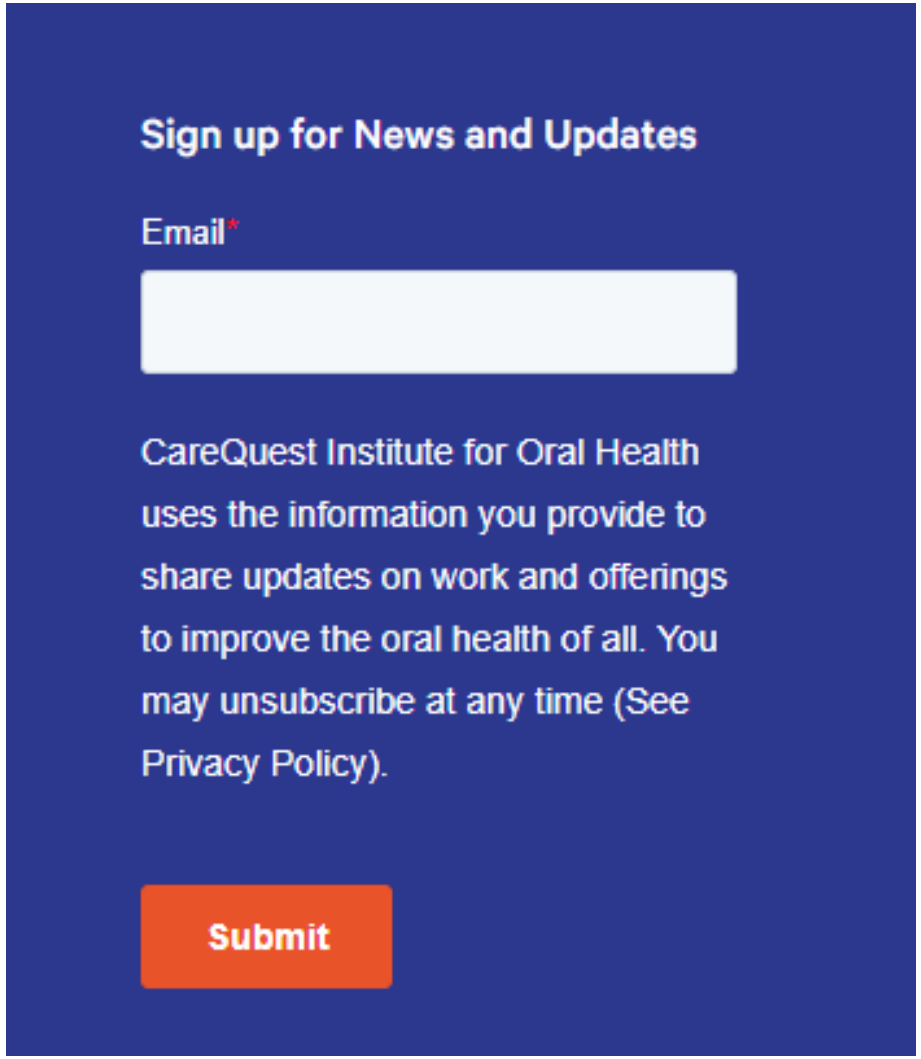

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