# Improving Oral Health Equity and Justice: The Power of Disaggregated Data

CareQuest Institute Continuing Education Webinar

June 6, 2024

# Housekeeping

- We will keep all lines muted to avoid background noise.
- We will send a copy of the slides and a link to the recording via email after the live program.
- We'll also make the slides and recording available on carequest.org.

## To receive CE Credits:

- Look for the evaluation form, which we'll send via email within 24 hours.
- Complete the evaluation by **Friday, June 14.**
- Eligible participants will receive a certificate soon after via email.

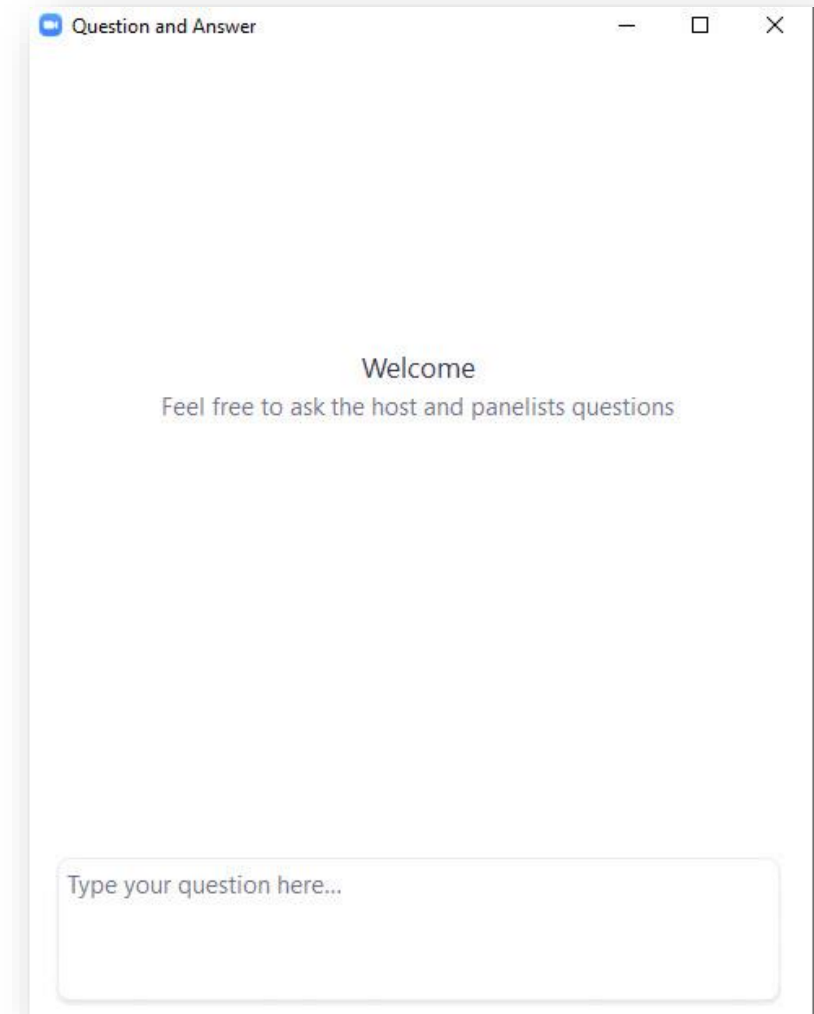
**We appreciate your feedback to help us improve future programs!**

The CareQuest Institute for Oral Health is an ADA CERP Recognized Provider. This presentation has been planned and implemented in accordance with the standards of the ADA CERP.

*Full disclosures available upon request

# 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.




CareQuest Institute for Oral Health®

# Thank You!

# Improving Oral Health Equity and Justice: The Power of Disaggregated Data

**WEBINAR | Thursday, June 6, 2024 | 5-6 p.m. ET | ADA CERP Credits: 1**

MODERATOR

**Candace Hsu Owen, RDH, MS, MPH**
Senior Director of Education and Strategic Partnerships, National Network for Oral Health Access

PRESENTER

**Christine Ko, PhD, MA, BA**
Research Manager, Association of Asian Pacific Community Health Organizations

PRESENTER

**Huong Le, DDS, MA**
Chief Dental Officer, Asian Health Services

PRESENTER

**Rosy Chang Weir, PhD, MS, BA**
Director of Research, Association of Asian Pacific Community Health Organizations

# Improving Oral Health Equity and Justice for Asian Americans, Native Hawaiians, and Pacific Islanders: The Power of Disaggregated Data

# Webinar Objectives

***The goal of this webinar is to:***

- Explain the importance of culturally responsive perspectives in the context of oral health disparities among AA and NH/PI communities.
- Assess how disaggregated data enhances the visibility and representation of AA and NH/PI communities in health statistics.
- Formulate strategies to leverage disaggregated data in creating targeted interventions for better oral health outcomes in AA and NH/PI communities.

- **AA:** Asian American
- **AA and NH/PI:** Asian American and Native Hawaiian/Pacific Islander
- **NH:** Native Hawaiian
- **PI:** Pacific Islander

# Mission & Impact

AAPCHO is dedicated to promoting **advocacy, collaboration, and leadership** that improves health status and access of AAs and NH/PIs, within the United States, the U.S. territories, and the Freely Associated States.

# Membership & Network

**32** member organizations including

**26** Federally Qualified Health Centers across

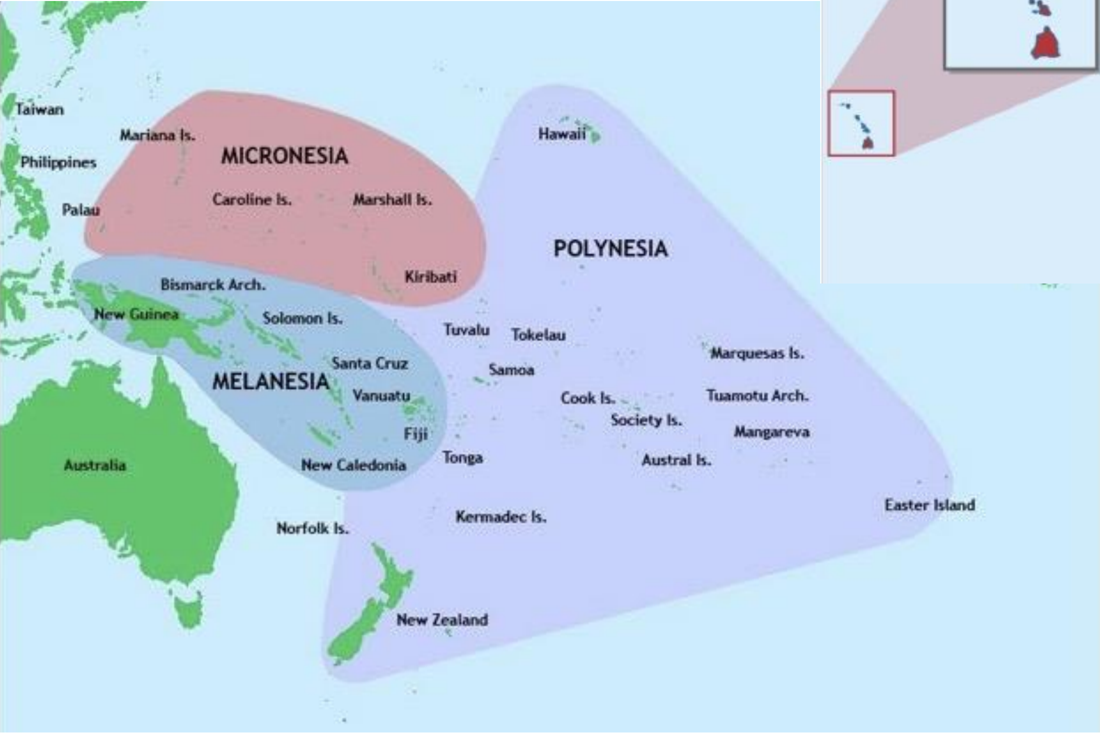
**11** U.S. states,
**1** U.S. territory and
**1** FAS nations

Serving over **650,000** patients annually

**Objective 1:** Explain the importance of culturally responsive perspectives in the context of oral health disparities among AA and NH/PI communities

# AA and NH/PIs Are Very Diverse!

# AA and NH/PIs Are Geographically Dispersed



# Asian Americans (AAs), Native Hawaiians (NH), Pacific Islanders (PIs)

- Asian Americans (AAs) and Native Hawaiians/Pacific Islanders (NH/PIs) are the fastest-growing racial or ethnic group with over **23 million residents** living in the continental U.S., Hawai'i, U.S. Territories, and COFA nations

- AAs and NH/PIs represent more than **50 racial and ethnic groups** and over **100 languages spoken**

- **24.7 million Asian** alone-or-in-combination residents in the United States in 2022

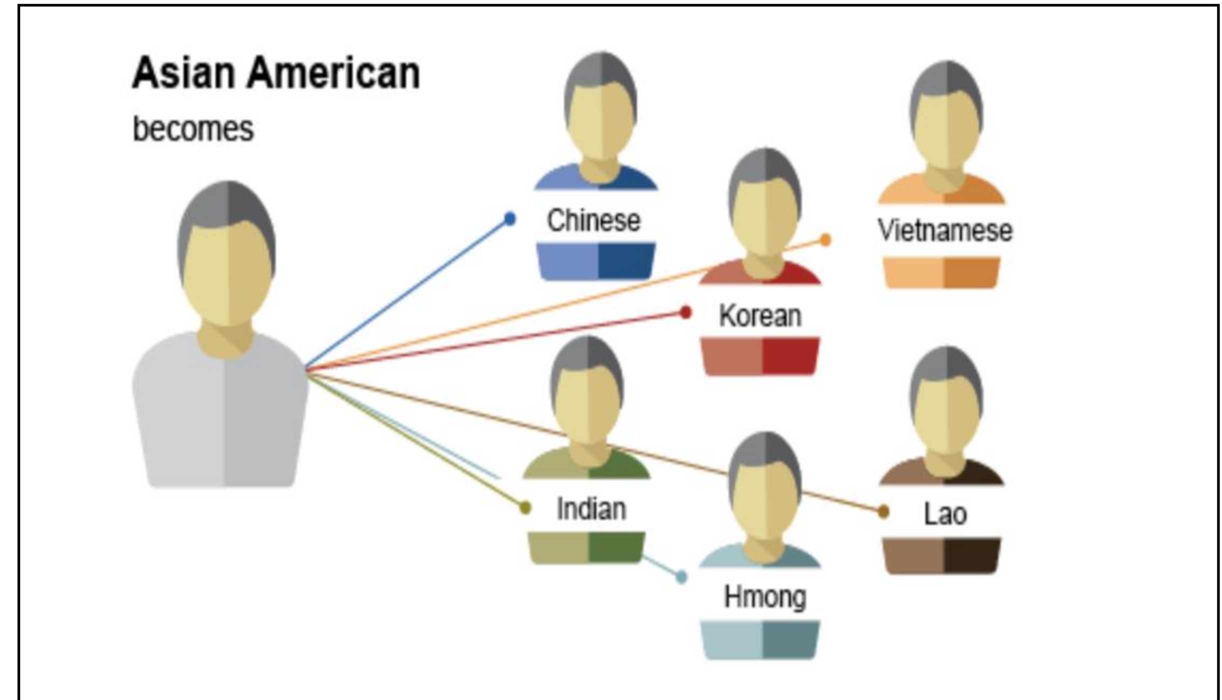
- **1.8 million Native Hawaiian and Pacific Islander** alone-or-in-combination residents of the United States in 2022

- AAs and NH/PIs are not only varied in country of origin, but have heterogeneous health risks, likely reflecting differences in genetic, socioeconomic, and environmental factors

# The Problem of Aggregated Data

**Aggregated** data collection often blurs diversity under a single AA and NH/PI label. It is high level and is a combination of multiple data sources. “In the aggregate” means “considered as a whole.”

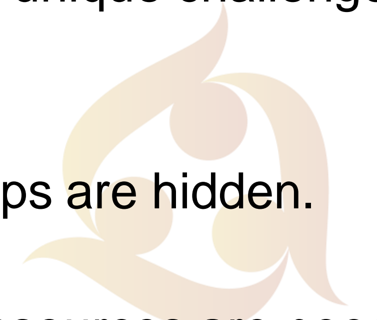
**Disaggregated** data collection means breaking down large data categories into more specific subcategories (racial and ethnic categories). By breaking down these categories into more specific subgroups, it enhances the understanding of health disparities.



# Avoid Using the Umbrella Label “AAPI” or “Asian Americans”

*The umbrella label “AAPI” or “Asian American” are not a culturally responsive way to address our communities’ subgroups. This is historically considered one of the ways that Western society has attempted to erase the distinct cultures and ways of life in various AA and NH/PI communities.*

- This label is shaped by years of US colonization and militarism in the Pacific Islands.
- The umbrella label “AAPI” diminishes the unique challenges faced by different AANHPI communities.
- Risk factors for diseases among subgroups are hidden.
- Culturally responsive interventions and resources are needed.



# Diverse Health Beliefs of AAs and NH/PIs

For these reasons, we'd like to center varying health beliefs across some of our populations as examples of who we are as diverse and unique subgroups:

- Laotian and Cambodian health beliefs and practices are often associated with religious and spiritual beliefs.
- Traditional health beliefs and healing practices are pervasive among some Chinese Americans.
- Korean health beliefs embrace traditional shamanism, herbal remedies, and Chinese and Western medical treatment modalities.
- There are five practices of traditional Hawaiian healing.
- Pacific Islanders rely on both Western medicine and traditional healing techniques.

Disclaimer: These descriptions of what makes AA and NH/PI communities different from one another are meant to illustrate a few examples about who we are. It's important to note that the examples provided are for educational purposes, and not exhaustive – and are not meant to exclude any individual or group. Our intention is to contribute to a broader understanding and appreciation of diversity within and across AA and NH/PI communities by providing educational context for health beliefs as examples, and we acknowledge that each community's experiences are shaped by a multitude of factors – including, but not limited to ethnicity, health beliefs, and cultural traditions.

# What’s the Difference?

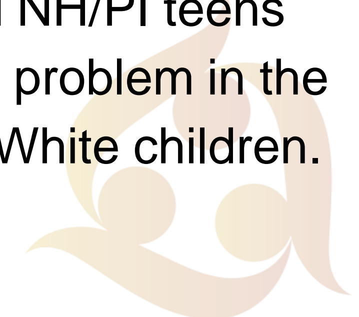
**Why is it important for people to know the difference?**

Understanding benchmark diseases in subpopulations sheds a different light on health disparities that have been hidden by aggregated data. This is why it’s important to know what makes each subgroup important in their own ways, which includes health beliefs.

*Please note that the descriptions above of diverse health beliefs are meant to illustrate a few examples about who we are. It’s important to understand that the examples provided are for educational purposes, and not exhaustive – and are not meant to exclude any individual or group.*

# Benchmark Oral Health Diseases in Subpopulations

- In California, **44%** of low-income Asian Americans and Pacific Islander (AA and PI) preschoolers had developed early childhood caries, one of the highest rates among all ethnic/racial groups.
- AA and PI children were also significantly more likely than White children to have teeth in suboptimal condition.
- In general, patients had untreated tooth decay compared with the national average of **18.9%.**
- **61.1%** of dental patients aged between **20 and 64 years** had a missing tooth compared with the national average of **51.8%.**
- **44%** of low-income AA and NH/PI preschoolers have early tooth decay—one of the highest rates among all racial groups in CA.
- **50%** of AA and NH/PI third graders have experienced tooth decay and 17% have experienced untreated tooth decay, compared to 40% and 14% of White children, respectively.
- **Over 21,000 or 6%** of AA and NH/PI teens missed school due to a dental problem in the past year compared to **8%** of White children.



# Oral Health Data Limitations

| Oral Health Indicators | Data Source | Availability of AA & NH/PI Data |
|---|---|---|
| Visits to dentist/dental clinic among adults aged >=18 yrs | CDC | No AA&NH/PI - Only White, Black, Hispanic, Other, Multiracial |
| Dental visits among children & adolescents aged 1-17 yrs | CDC | No AA&NH/PI - Only age and gender data available |
| Preventive dental visits among children & adolescents aged 1-17 yrs | CDC | No AA&NH/PI - Only age and gender data available |
| Preventative dental care before pregnancy | CDC | No AA&NH/PI |
| All teeth lost among adults aged >=65 yrs | CDC | No AA&NH/PI - Only White, Black, Hispanic, Other, Multiracial |
| Six or more teeth lost among adults aged >=65 yrs | CDC | No AA&NH/PI - Only White, Black, Hispanic, Other, Multiracial |
| No tooth lost among adults aged 18-64 yrs | CDC | No AA&NHPI - Only White, Black, Hispanic, Other, Multiracial |
| Population served community water systems that receive optimally fluoridated drinking water | CDC | No AA&NH/PI |
| **Oral Health Services at federally qualified health centers** | CDC | No AA&NH/PI |

**Objective 2:** Assess how disaggregated data enhances the visibility and representation of AA and NH/PI communities in health statistics

**Christine Ko, PhD, MA, BA**
Research Manager
Association of Asian Pacific Community Health Organizations
cko@aapcho.org

# Improving Oral Health Equity and Justice: The Power of Disaggregated Data

Huong Le, DDS, MA
Chief Dental Officer
Asian Health Services

# Asian Health Services (AHS)

**1974**- Founded as a one-room clinic with all-volunteer staff, mostly students from UC Berkeley. The center provided more than 1,500 medical visits in its first year

**1981**- Known for its advocacy, AHS joined a complaint with the Office of Civil Rights against Highland Hospital for discriminating against non-English speaking persons by its lack of language accessible services.

**1990-** AHS organized first-of-its kind public hearing on health issues affecting California's API population.

**2003**- First state-of the-art dental clinic opens with electronic health record (2nd clinic in CA to do so)

2**008**- First health center to host an AEGD residency in California

**2010**- Opened the first clinic in state that is co-located on campus of a junior college and a dental assisting program

**2014**- Started school-based program (3 sites)

**2016**- Launched $3 million capital campaign to create California's first dental clinic with integrated behavioral health services and 4 specialties

**2022**- Launched first mobile dental program

**2023**- Remote Preventive Dental Program

**2024**-Expanding to south county, AAAHC accreditation

**2025-2026**: AEGD Residency

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# AHS Demographics

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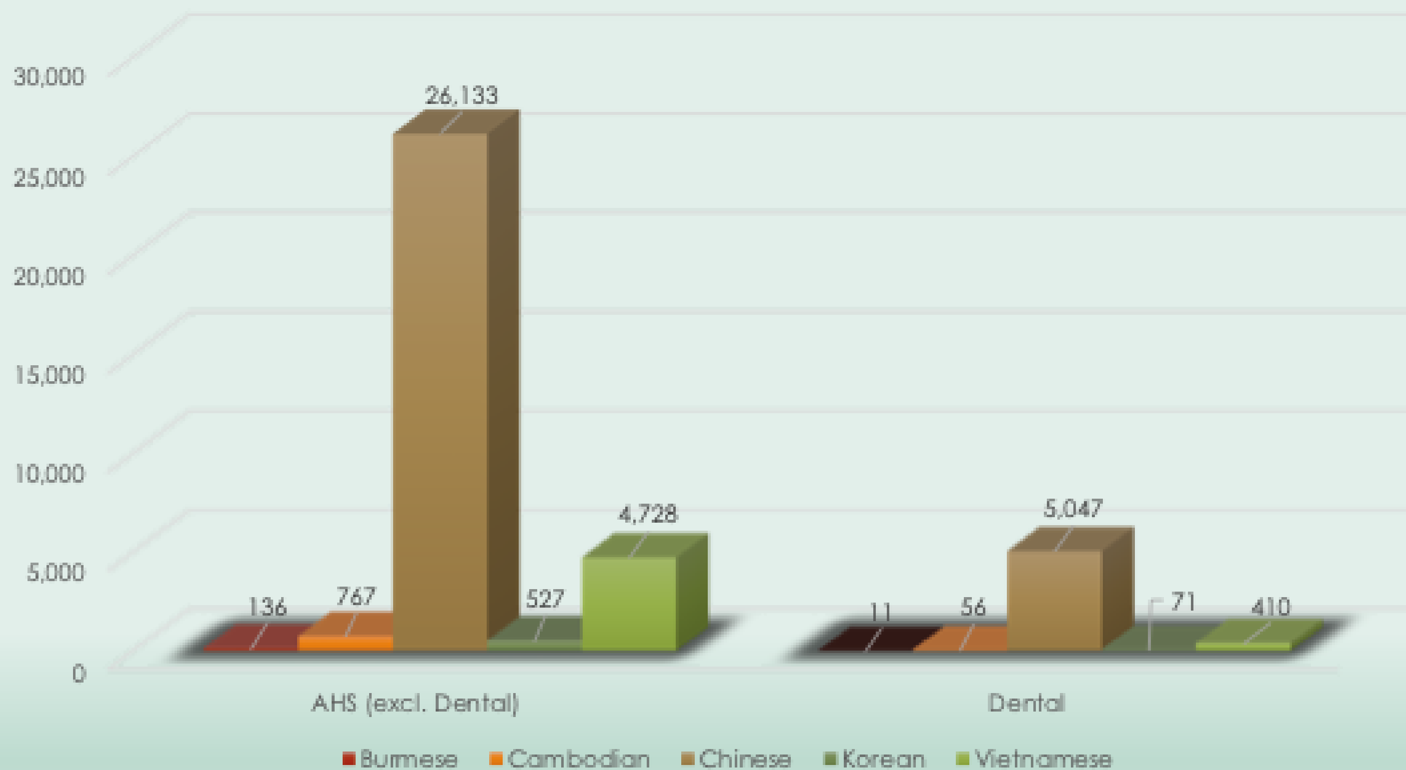
# PATIENT DEMOGRAPHICS




**** Only subpopulation data is included here*

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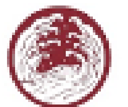
# Dental Department

- ✓ Dental sites: Main Dental, Weinberg Wellness Center, College of Alameda, School-based: Franklin Elementary, Oakland High, Lincoln Elementary, **2** mobile vans
- ✓ Community patients: over **50,000**
- ✓ Clinic patients: over **28,000**



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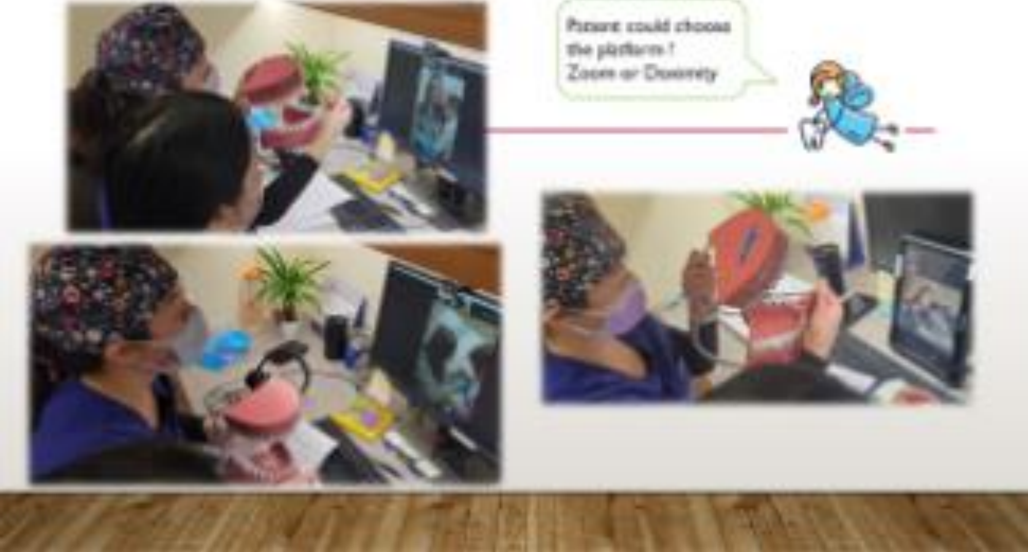
# Dental Innovations



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# AHS Dental Program Integrated Care Model and Teaching Health Center

- Comprehensive oral health care
- Depression screening
- Licensed clinical social worker in dental clinic
- Diabetes screening and HbA1C testing
- COVID testing (including PCR CUE test) and vaccination in dental
- Perinatal program
- Pediatricians and mA trained to provide fluoride varnish
- Community outreach- Head Start, school-based
- On-site specialists : oral surgery, pediatrics, periodontics and endodontics
- Drive-thru fluoride varnish program
- Remote preventive project
- Student externship program
- Future: AEGD in 2025-26

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# AAPI Dental Service Utilization

- Asian is the fastest growing minority group in North America
- Alameda County: Asian is **1.05 times** more than Caucasian and Hispanic populations since 2021
- Dental service utilization: only about **33%** of Asian children has preventive dental services in recent study in the last 5 years
- Asian children in Head Start and Kindergarten have higher caries incidence **45%** compared to **37%** in other populations

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# Caries

| Subpopulations | Overall% | Pediatric (18 and younger)% |
|---|---|---|
| Burmese | 70 | 79 |
| Cambodian | 23 | 44 |
| Chinese | 35 | 45 |
| Korean | 20 | 55 |
| Vietnamese | 26 | 41 |

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# Periodontal Conditions

| Sub-Populations | % |
|---|---|
| Burmese | 20 |
| Cambodian | 21 |
| Chinese | 29 |
| Korean | 47 |
| Vietnamese | 31 |

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# Diabetes

| Subpopulations | % |
|---|---|
| Burmese | 20 |
| Cambodian | 29 |
| Chinese | 21 |
| Korean | 35 |
| Vietnamese | 37 |

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# Depression

| Subpopulations | % |
|---|---|
| Burmese | 5 |
| Cambodian | 11 |
| Chinese | 5 |
| Korean | 11 |
| Vietnamese | 6 |

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# Treatment Considerations Using Data

**Understanding of data helps drive treatment plans:**

- **Burmese:** High caries incidence for both adults and pediatric, treatment should be more aggressive with preventive measures-OHI, fluoride frequency, motivational interviewing, family engagement
- **Korean:** High incidence of periodontal disease, depression and diabetes-these conditions have been proven to have a correlation-When patients are depressed, OH is the last thing on their mind, and dental treatment is not a priority. Periodontal disease results in more tooth loss. We did not provide data here, but Korean patients also are very much into cosmetics and implants. They don't want removable prostheses, like other subpopulations. Depression is also more prevalent among our Korean patients, especially the geriatric group
- **Vietnamese:** High incidence of diabetes and periodontal conditions-again there has been a high correlation of these two conditions. Diagnosis is made early, better prognosis. Start education Vietnamese patients at an earlier age.

Due to economic reasons, most patients want to follow treatment that is covered by Medicaid, except Korean patients who are much more into cosmetics, implants

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# Don't Forget Cultural Practices

- Cultural and economic situations can dictate treatment
- **Burmese:** Lowest socioeconomic subpopulations, usually goes with recommended treatment plans especially if insurance covers
- **Cambodian:** Like Burmese patients, will go with insurance coverage
- **Chinese:** May or may not follow recommended treatment. Dental tourism
- **Korean:** Will save money to obtain the most expensive like implants, veneers. Vanity is important
- **Vietnamese:** Will "bargain" and delay treatment. Like Chinese patients, Vietnamese patients are often dental tourism.

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# Data Sharing – Community Engagement

- AHS has 10 Patient Leadership Councils (PLC) for various communities, including Burmese-Karen, Cambodian, Chinese (Mandarin and Cantonese), Korean, Vietnamese and others.

  a) Using data to inform and engage with communities on their oral health practices
  b) Educate the Patient Leadership Councils on good oral health practices and disparities
  c) PLC members are patients living in the community and serve as the best ambassadors
  d) Hold meetings with the subpopulations as needed to ensure good dental practices and preventive care is being embraced and followed

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# Sharing Patients Stories With PLCs Using Data

- Depression: Korean has the highest BH referral rate
  - Female-middle aged patient and teenage patient

- Diabetes: Cambodian, Korean, and Vietnamese have higher prevalence
  - Young male patient scheduled for oral surgery

- Made impact in smaller populations

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**Huong Le, DDS, MA**
Chief Dental Officer
Asian Health Services
huongle@ahschc.org

**Objective 3:** Formulate strategies to leverage disaggregated data in creating targeted interventions for better oral health outcomes in AA and NH/PI communities

# Recent OMB Standards

- In March 2024, the OMB further **revised SPD 15** to require federal agencies to collect and report disaggregated race and ethnicity data by default.
- The revisions mark an important milestone to improving the nation's understanding of the needs of diverse communities, including AAs and NH/PIs.

**What is your race and/or ethnicity?**
*Select all that apply and enter additional details in the spaces below.*

☐ **American Indian or Alaska Native –** *Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.*

☐ **Asian –** *Provide details below.*
☐ Chinese ☐ Asian Indian ☐ Filipino
☐ Vietnamese ☐ Korean ☐ Japanese
*Enter, for example, Pakistani, Hmong, Afghan, etc.*

☐ **Black or African American –** *Provide details below.*
☐ African American ☐ Jamaican ☐ Haitian
☐ Nigerian ☐ Ethiopian ☐ Somali
*Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.*

☐ **Hispanic or Latino –** *Provide details below.*
☐ Mexican ☐ Puerto Rican ☐ Salvadoran
☐ Cuban ☐ Dominican ☐ Guatemalan
*Enter, for example, Colombian, Honduran, Spaniard, etc.*

☐ **Middle Eastern or North African –** *Provide details below.*
☐ Lebanese ☐ Iranian ☐ Egyptian
☐ Syrian ☐ Iraqi ☐ Israeli
*Enter, for example, Moroccan, Yemeni, Kurdish, etc.*

☐ **Native Hawaiian or Pacific Islander –** *Provide details below.*
☐ Native Hawaiian ☐ Samoan ☐ Chamorro
☐ Tongan ☐ Fijian ☐ Marshallese
*Enter, for example, Chuukese, Palauan, Tahitian, etc.*

☐ **White –** *Provide details below.*
☐ English ☐ German ☐ Irish
☐ Italian ☐ Polish ☐ Scottish
*Enter, for example, French, Swedish, Norwegian, etc.*

# Recommended Script for Disaggregated Data Collection

**Why Are We Collecting Demographic Data, How It Will Be Used, and How It Will Honor Individual Agency**

"We understand that many things can affect your health. **We are always looking to better understand our members' needs to improve the services we can offer. Would you be willing to help us learn more about you?** It should only take 5-10 minutes. Some of the questions are personal, and **you don't have to answer them if you don't want to. We protect everything that you share just like how we protect your health information.** Only members of the care team will have access to this information. **This information will help us make sure you're getting the care you want and need. Your decision to answer or to refuse to answer will NOT impact your ability to receive care."**

- [If administered in-person or orally over the phone: Do you have any questions before we get started?]
- [If administered on paper form: Please let us know if you have any questions or concerns by contacting XYZ]

*Enhancing Demographic Questions and Response Choices,* CIVITAS Network for Health, HL7 International, AHIP - National Virtual Focus Group (2024).

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# Recommended Script for Disaggregated Data Collection

**Example Script for Race:**

Please tell us your background. Check all that apply.

- Asian
- Black, African, or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native American, Alaska Native, or Indigenous
- Native Hawaiian or Pacific Islander
- White or European
- I don't know
- I choose not to respond

**Example Script for Language:**

What language do you feel most comfortable speaking about your health care? This can include a specific language and/or different types of sign language.

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# Recommended Script for Disaggregated Data Collection

**In-person at Care Setting*:*** If an interpreter in your preferred language was available right now, would you choose to use one for your health care visit?

- Yes
- No
- I do not know
- I choose not to respond

**In-person at Care Setting*:*** Are you comfortable using an interpreter if they are only available through:

- Telephone: Yes or No
- Video: Yes or No
- In-person: Yes or No
- I do not know
- I choose not to respond

**Paper Form Outreach Preferences:** How would you prefer to be contacted with information related to your health care?

- Phone Call
- Text Message
- Email
- Mailed Letter
- I do not know
- I choose not to respond

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# Recommended Race/Ethnic Categories for Data Collection

- Afghan
- Asian Indian
- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Carolinian
- Chamorro/ Chamoru
- Chinese
- Chuukese
- Fijian
- Filipino
- Hmong
- Indonesian
- Japanese
- Korean
- Kosraean
- Laotian
- Maori
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- Nepalese
- Pakistani
- Palauan/Belauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Samoan
- Sikh
- Sri Lankan
- Tahitian
- Taiwanese
- Thai
- Tokelauan
- Tongan
- Uzbek
- Vietnamese
- Yapese
- Other Race/Ethnicity (please specify)

# How to Collect Disaggregated Data: Training Resource

*The purpose of this document is to share how research can enhance equity and visibility, especially for communities who have been historically overlooked in data collection.*

- We recognize the rich tapestry of the AA and NH/PI communities by collecting data that reflects their true diversity.

- Collecting disaggregated data is an approach that will not only respect individual identities within such diverse populations, but also ensures that groups of unique individuals are not left invisible and undercounted in our policy-making efforts.

- It's not a one-size-fits-all approach when it comes to data collection.

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# How to Collect Disaggregated Data: Training Resource

**The Training Resource includes topics on:**

- Understanding AA and NH/PI communities, providing historical context and examples
- Why aggregated data contributes to an ongoing problem, and how this problem affects policy and advocacy
- What is disaggregated data?
- Why do we need Race/Ethnicity data?
- Steps for disaggregated data collection, including scripts and a detailed list of recommended race/ethnicity survey categories
- How to define "other races"
- Putting data into context

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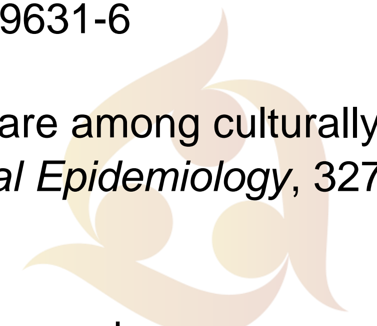

**Rosy Chang Weir, PhD, MS, BA**
Director of Research
Association of Asian Pacific Community Health Organizations
rcweir@aapcho.org

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# Any Questions for AAPCHO and AHS?

*Huong Le, DDS, MA, Chief Dental Officers (AHS)*
*Rosy Chang Weir, PhD, Research Director (AAPCHO)*
*Christine Ko, PhD, Research Manager (AAPCHO)*

**Candace Hsu Owen, RDH, MS, MPH**
Senior Director of Education and Strategic Partnerships
National Network for Oral Health Access
candace@nnoha.org

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## Missed Connections

### Providers and Consumers Want More Medical-Dental Integration

Oral health and overall health are inextricably linked. There is mounting evidence to suggest that poor oral health is related to a variety of chronic health conditions, such as high blood pressure, dementia, diabetes, and obesity. Despite this known connection, dental care is still largely siloed from medical care. The Centers for Disease Control and Prevention (CDC) estimates that integrating basic health screenings into a dental setting could save the health care system up to $100 million every year.[1]

CareQuest Institute for Oral Health conducted a nationally representative survey in January and February 2021 to assess consumers' perspectives on oral and overall health (n=5,320). CareQuest Institute also conducted a nationwide survey of oral health providers to assess perspectives and current behaviors related to interprofessional practice (n=377). Consumers and oral health providers described a lack of integration between medical and oral health care, and a desire for increased interprofessional collaboration.

Key Findings:
**Medical-dental collaboration is currently uncommon.**

63% of consumers report that their **primary medical doctor "rarely" or "never" asks about their oral health.**

33% of consumers report that their **oral health provider "rarely" or "never" asks about their overall health.**

45% of responding oral health providers report **"rarely" integrating their care with clinicians outside of dentistry,** with only 14% reporting it is **part of their "daily" practice.**

- **Less than a third** of consumers report **receiving general health screenings from their oral health provider.**
- **A majority (89%)** of adults report **never receiving a referral from their oral health provider to a non-oral health professional.**
- **Almost a fourth (24%)** of participating oral health providers report **currently implementing interprofessional practice.**

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# Webinar Evaluation

Complete the evaluation by **Friday, June 14** to receive CE credit. You will receive a link to the survey within 24 hours.

***Next Webinar:***

LGBTQIA+ Oral Health: Creating Inclusive Environments on **June 20 at 7 p.m. ET**

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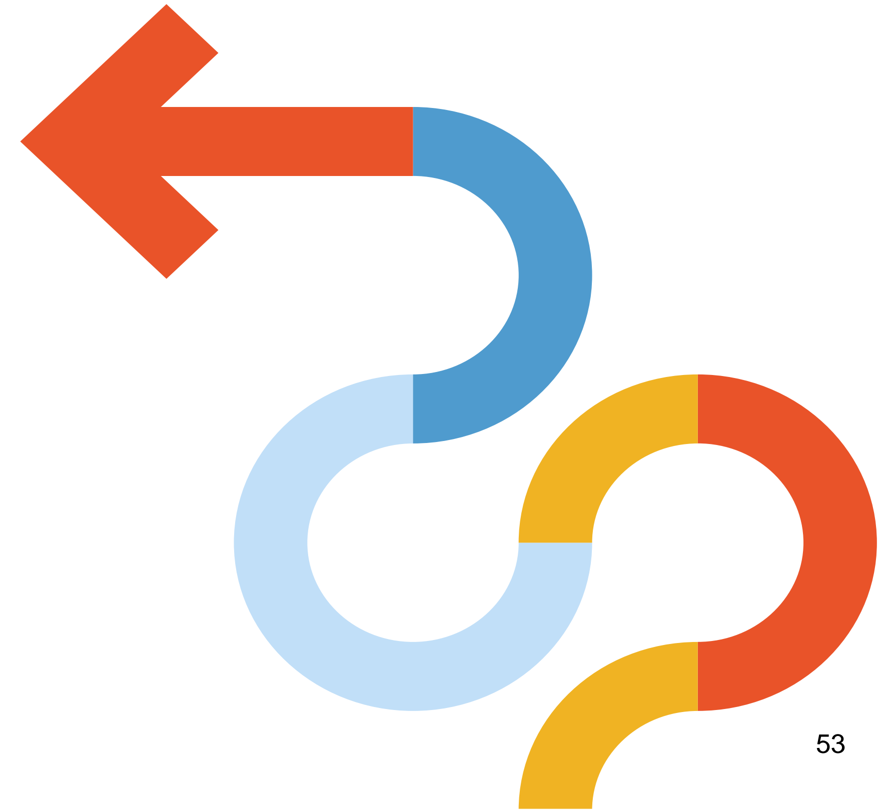

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